



# **Internationalization Process of Medical Services:**

A Comparative Analysis of the Current State of Medical  
Tourism in Medellin, Colombia and San Jose, Costa Rica

By:

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A thesis presented to the School of Business Administration at EAFIT

University in fulfillment of the thesis requirement for the degree of Master  
in International Business.

Medellin, Colombia 2012

## **Author's Declaration**

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

## **Abstract**

The world economy has been experiencing a progressive trend toward the internationalization of markets, and service industries have provided avenues to link geographically disperse economic activities. International entities and especially Western governments have liberalized their markets by fueling initiatives to deliver healthcare and other welfare services that thanks to advances in technology can now be traded more efficiently and faster. One flourishing sector has been the Medical Tourism industry; a way for developing countries to increase revenues, strengthen their economies and upgrading their national healthcare systems.

This research traces and compares the internationalization process and success factors of a sample of medical organizations from two Latin American cities, Medellin, Colombia and San Jose, Costa Rica. The Uppsala Model of Internationalization proposed by Johanson and Vahlne (1977, 1990, 2009), and some service internationalization strategies will serve to analyze data and find validity of this theory when applied to the services sector.

***Key Words:*** *Medical Tourism, Internationalization of Services, Medellin, Colombia, San Jose, Costa Rica, Uppsala Model, Service Internationalization Strategies*

## Resumen

La economía mundial ha venido experimentando una progresiva tendencia hacia la internacionalización de las empresas, y el sector servicios ha proporcionado vías para conectar actividades comerciales geográficamente dispersas. Muchas organizaciones, y en especial los gobiernos occidentales, han liberalizado sus mercados desarrollando iniciativas en servicios de salud y bienestar que gracias a los avances tecnológicos ahora pueden ser comercializados más rápida y eficientemente. Un sector realmente próspero en la actualidad ha sido la industria de Turismo Médico; una manera que los países en desarrollo han encontrado para aumentar sus ingresos, fortalecerse y actualizar sus sistemas de salud.

Esta investigación rastrea y compara los procesos de internacionalización y factores de éxito de una muestra de organizaciones médicas en dos ciudades latinoamericanas, Medellín, Colombia, y San José, Costa Rica. El Modelo de internacionalización Uppsala propuesto por Johanson y Vahlne (1977, 1990, 2009), y algunas estrategias de internacionalización de servicios son usados para analizar las entrevistas a estas organizaciones y encontrar validez de esta teoría en el sector servicios.

***Palabras clave:*** *Turismo Médico, Internacionalización de Servicios, Medellín, Colombia, San José, Costa Rica, Modelo Uppsala, Estrategias de Internacionalización de servicios.*

## **Acknowledgements**

This thesis would not been possible without the help and support of a number of people. This research allowed me to understand better the current state of the Medical Tourism industry worldwide and to discover the importance and potential of this sector in the Latin American Region.

I would like to thank my family and specially my beautiful daughter Valentina for her company and good vibes during this process. To my wonderful advisor Dr. Treutler for his wisdom, guidance and ongoing support. I feel privileged to have worked with such an expertise in the MT field. Thanks also to the Master in International Business professors at EAFIT University, who taught me the theoretical foundations of this research and made valuable comments and suggestions along the way.

To all the interviewees from Medellin, Colombia and San Jose, Costa Rica for opening a space in their busy agendas and letting me learn about their Internationalization processes. I am delighted to have met and talk to some of the most representative people in the MT industry.

Finally, I thank to all my MIB classmates. I am grateful to have shared the classroom with such a diverse and experienced group. They were all very supportive and professional.

## **Dedication**

*To all the women in my family, from Colombia and the USA.*

*I am proud to hold the first Master in four generations.*

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## **List of Abbreviations**

ANDI	National Industry Association
ACI	Colombian Association of Industrials
BPO	Business Process Outsourcing
CONPES	National Council for Economic and Social Policy
EPS	Health Promoting Entity
EU	European Union
FDI	Foreign Direct Investment
FOSYGA	Solidarity and Guarantee Fund
FTA	Free Trade Agreement
GATS	General Agreement on Trade in Service
HDI	Human Development Index
IB	International Business
ICONTEC	Colombian Institute for Technical Standards and Certification
ICT	Information and Communication Technology
IP	International Patient
IPS	Healthcare provider
IQnet	IQ Certification Network
JCI	Joint Commission International
MSO	Medical Services Organizations
MT	Medical Tourism
PND	National Development Plan
POS	Mandatory Health Plan
PTP	Productive Transformation Program
R&D	Research and Development
SBA	Strategic Business Area
SENA	National Learning Service
SISBEN	Sistema de Selección de Beneficiarios para Programas Sociales
SWOT	Strengths, weaknesses, opportunities and treats
TIC	Technology Information and Communication
UPC	Capitation Payment Unit
UN	United Nations
US	The United States
WHO	World Health Organization

# Introduction

## 1.1 Conceptual Background

The global trend toward the internationalization of service firms is a growing phenomenon happening especially in developing countries (Outreville, 2007). Primo-Braga (1996) explains this event as a reaction to the informal employment and chaotic urbanization increase, while in developed nations, this is owed to deindustrialization. Service industries provide avenues to link geographically disperse economic activities; services that were before considered non-tradable are now actively traded thanks to technological advances (Chetty, 2011).

Services are understood as “...deeds, performances, and efforts that provide benefit to customers” (Cloninger, 2000, p. 9). They can also be “activities that link two or more economic agents, with the objective to generate or prevent a given change in the current condition of a good or person, and that gives room to commercial relations, national or international, independently of the way contracts are made” (Dangond, 2008, p.3). According to Carneiro & Ferreira (2008), the most relevant difference between a good and a service is this last is intangible, heterogeneous, perishable, and its production tends to be inseparable from its delivery and consumption. Some services may be similar to goods in different aspects.

In the European Union (EU) service industries account for about 70% of the total GDP and employment, and 20% of transnational trade (Pluta-Olearnik, 2011). Meanwhile, in Latin-American and the Caribbean, services count for more than a half of the total exports in the region (Hurtado, 1998; BBVA, 2012).

Services are exposed to border policies and domestic regulations as any other industry. The General Agreement on Trade in Services (GATS)<sup>1</sup> presents guidelines on how to regulate and commercialize services worldwide (Holden, 2003; Pluta-Olearnik, 2011). Some of the commercial activities considered as services by GATS are communication, construction and engineering design, distribution, transportation, finance, tourism and

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<sup>1</sup> an important achievement of the World Trade Organization (WTO) during the 1994 ‘Uruguay Round.’

traveling, healthcare, among others. The agreement also describes four entry modes in which services can be commercialized:

- Mode 1, cross-border delivery;
- Mode 2, consumption abroad;
- Mode 3, commercial presence of a foreign supplier in the host country;
- and Mode 4, temporary movement of natural persons to another country to provide services (WTO, 2012).

Another important concept to understand in this analysis is the term ‘Internationalization’ described by Welch & Luostarinen (1998) as an “increase in involvement in international operations which can be outward or inward” (p.45). It also “refers to an expansion across borders in the core Strategic Business Area (SBA) of the firm and the degree of internationalization measured by the ratio of foreign sales to total sales” (Rugman & Brain 2003, p. 222). The internationalization process is the result of constant interactions between knowledge development and operations abroad, and the growing commitment of resources in the host country (Johanson & Vahlne, 1997).

However, given the nature of this particular research, which focuses on the internationalization of healthcare services, also known as Medical Tourism<sup>2</sup> (MT), this term will be defined as a set of activities<sup>3</sup> that a Medical Services Organization (MSO) in the Latin-American region performs on a foreign agent or person resulting in the promotion and increased consumption of medical services.

## **1.2 Medical Tourism Concept**

In order to understand the reasons why and how medical services providers internationalize, we first need to discuss the following concepts. First, the word ‘Health’ is defined by the World Health Organization (WHO) as “a complete physical, mental and social

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2 Also called “Healthcare Globalization,” “Health Vacation,” “Wellness Tourism,” “Medical Outsourcing” or “Generation Next Health Holidays” (Khan, 2010).

3 Medical treatments, surgical procedures, marketing, R&D, transplants, customer services, etc.

wellness, not just the absence of ailments and sickness”<sup>4</sup>. This complete state of wellness depends on economic, organic and situational factors that when are not satisfied force people to consider other alternatives and latitudes; “early civilizations [...] were drawn toward the healing properties of “bath” or “spring” waters, traveling long distances in order to obtain such benefits” (Khan, 2010, p.1).

The traditional model of international medical travel describes how patients from developing nations sought professionals and different treatments in highly developed nations since these services were not available at home (Horowitz, Rosensweig, Jones, 2007). For instance, advance medical centers in Europe and the United States used to be the only alternatives in the global market for international patients. However, current studies have shown an opposite activity; “...people from developed countries are traveling to developing countries for affordable healthcare” (Khan, 2010, p.1).

Renee Stephano (2012), the president of the Medical Tourism Association, defines MT as “patients traveling from one country to another for healthcare. The drivers can be different, sometimes is cost, some time is access. For the most part it is for better quality and more affordability.” MT constitutes a “form of tourism to preserve, enhance and retrieve physical and mental health of individuals that takes over 24 hours and less than a year” (Taleghani, Chirani, & Shaabani, 2011, p.32). This sector is divided into four specialties; healing medicine<sup>5</sup>, preventive medicine<sup>6</sup>, cosmetic medicine<sup>7</sup> and inspired wellness<sup>8</sup>.

The MT industry has been flourishing in developing nations, especially over the last two decades. Here we analyze the experiences of some MSOs from two cities in Latin-America ranked as leading competitors in international magazines like America Economia<sup>9</sup> and Ranking Web<sup>10</sup>.

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4 WHO. (2009). Health Cluster Guide. Retrieved from [http://www.who.int/topics/health\\_services/es/](http://www.who.int/topics/health_services/es/) Accessed on: 12/13/11

5 Promotes good health across multiple modalities to treat, understand and improve the quality of life (Mincomercio, 2009).

6 To prevent and identify risk factors (Ibid.)

7 Improvement of physical appearance and self-esteem (Ibid.)

8 The Social - satisfaction with relationships and social role performance ▪ Spiritual / mental - the degree to which a person feels positive and enthusiastic about oneself and life ▪ Physical / environmental - physical activity, healthy food

9 America Economia. (2012). Clinicas y Hospitales Ranking 2012. Retrieved from <http://rankings.americaeconomia.com/2012/clinicas-y-hospitales/ranking.php> Accessed on: 10-03-2012.

10 Ranking Web. (2012). Ranking Web of Hospitals. Latin America. Retrieved from [http://hospitals.webometrics.info/en/Latin\\_America](http://hospitals.webometrics.info/en/Latin_America) Accessed on: 09-14-2012.

### **1.3 Study Purpose and Research Objectives**

The focus of this project is to understand how MSOs from Latin-America have internationalized, and to confirm validity of the Uppsala Model proposed by Johanson & Vahlne (1977, 2009) when applied to the health care sector. The premises of this model are compared to the internationalization process followed by a sample of MSOs from San Jose, Costa Rica and Medellin, Colombia.

This analysis is expected to contribute to the International Business (IB) field of knowledge with a new case in which a theory, originally applied to manufacture industries, can also explain how medical services internationalize in a similar way. Exploring these processes allow us not only to discover effective business and marketing strategies but also to identify the regional and local forces that drive MT development.

### **1.4 Organization of the Research Paper**

This paper is divided into six sections. It starts with a clear understanding of the MT and Internationalization concepts, followed by an analysis of the MT industry context in two countries specifically. The theoretical framework used in this paper is the Uppsala Model of Internationalization proposed by Johanson and Vahlne (1977, 1990, 2009), which is then compared to the internationalization processes described by a sample of MSOs identifying common patterns and testing the three hypotheses proposed. Data collection methods and ethical considerations are explained. Finally, findings are presented followed by a discussion and conclusions.

## Literature Review

### 2.1 Context

The liberalization of trade in medical and social services has provided a wide variety of alternative treatments at a lower cost, and the possibility of enjoying the amenities offered by the places where these are performed. Although there are not accurate statistics that can reveal the actual global performance of this sector, there is evidence of an increase on the search for low pricing and qualified healthcare abroad (Horowitz et al., 2007). For instance, Deloitte's Medical Tourism report (2008) states that during the year 2007, an amount of 750,000 North Americans traveled abroad looking for affordable healthcare and different medical treatments. This represents an average of \$21 billion annual income to developing countries only from the US. The worldwide revenue of this sector is expected to reach the \$100 billion by 2012 (Herrick, 2007).

The growth of this particular sector in developing countries can also be explained by the spread of technological advances; medical procedures not covered by a regular insurance; long wait medical attention; different economic crisis suffered by developed nations, and regional integration among others (Deloitte, 2008; Khan, 2010; Taleghani et al., 2011). The most common procedures and services internationally on demand nowadays are “cosmetic surgery, dental procedures, bariatric surgery, assisted reproductive technology, ophthalmologic care, orthopedic surgery, cardiac surgery, organ and cellular transplantation, gender reassignment, and executive checkups” (Horowitz et al. 2007, p. 2)

The worldwide competition is already set. India and Philippines currently hold the highest percentage of medical tourists worldwide, followed by Malaysia, Singapore and Thailand (Ehrbeck, et al., 2008). These countries are well positioned in the international arena mostly because of cardiology and orthopedics (Horowitz *et al*, 2007). The success of these markets seems to be a joined effort between government efforts, professionals' recognition, infrastructure and accommodations, cutting-edge technology, high levels of bilingualism, qualified care, and just in general terms an overall positive atmosphere (Ehrbeck, et al., 2008).



On the other hand, Latin-American countries such as Brazil, Costa Rica, and Mexico hold high positions in the regional MT industry ranking<sup>11</sup>. Argentina, Colombia, and Uruguay seem to be still in the warm-up zone, working hard and getting ready to be internationally certified (Cortez, 2008; Kahn, 2010; Woodman, 2010). The region is also seen as a promising retirement land; Costa Rica and Mexico are targets for thousands of US veterans who are seeking for a friendly environment to retire, with affordable medical services that they cannot otherwise access at their home country (Pronacomer 2008; Kahn, 2010; Tattara, 2010). The region is recognized worldwide for procedures like cosmetic and plastic surgery, bariatric treatments and dental care (Horowitz et al., 2007).

### 2.1.1. Entry Modes Applied in Health Care Services Exports

As it was explained at the beginning, GATS describes four ways in which services can be commercialized. Bolis (2001) and Outreville (2007) apply them to the export of Health care services as shown in Table 2.1.

*Table 2.1 Entry Modes Applied in the Internationalization of Healthcare Services*

<b>Mode 1.</b>	Cross-border delivery	Includes shipment of information and/or services through traditional channels, or electronic delivery (e-health or telemedicine) <sup>12</sup> .
<b>Mode 2.</b>	Consumption abroad	Movement of consumers to a foreign country providing diagnosis and treatment services. The term medical tourism exemplifies this mode <sup>13</sup> .
<b>Mode 3.</b>	Commercial presence <sup>14</sup>	Establishment of healthcare providers or firms in the sector outside their home nation through FDI (equity or non-equity forms).
<b>Mode 4.</b>	Temporary or permanent movement of personnel <sup>15</sup>	Providing services abroad is relatively significant as a mode of trade in health services compared to other services. This will

11 America Economia. (2012). Clinicas y Hospitales Ranking 2012. Retrieved from

<http://rankings.americaeconomia.com/2012/clinicas-y-hospitales/ranking.php> Accessed on: 10-03-2012.

12 These are in developed and developing countries.

13 Consumption abroad was originally limited to travel to specific places and benefit from natural amenities, such as hot springs and spas.

14 The most common way of foreign participation (mainly in hospitals and specialized clinics) is to invest in existing facilities or enter a joint venture with local partners or alliances to develop health care networks and chains.

15 This is basically due to the labor-intensive nature of these services based on universal scientific knowledge.

		require sponsorship of a firm in contentment host country policies and regulations.
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*Source:* Bolis (2001) and Outreville (2007)

These entry modes are especially important when describing the ways MSOs approach other markets and in what way. Some of these entry modes can result in alliances and eventually turn into regional clusters. According to Porter (1998), competitive success occurs within a sector with strong local and regional demand. It boosts innovation, high-quality standards and classification.

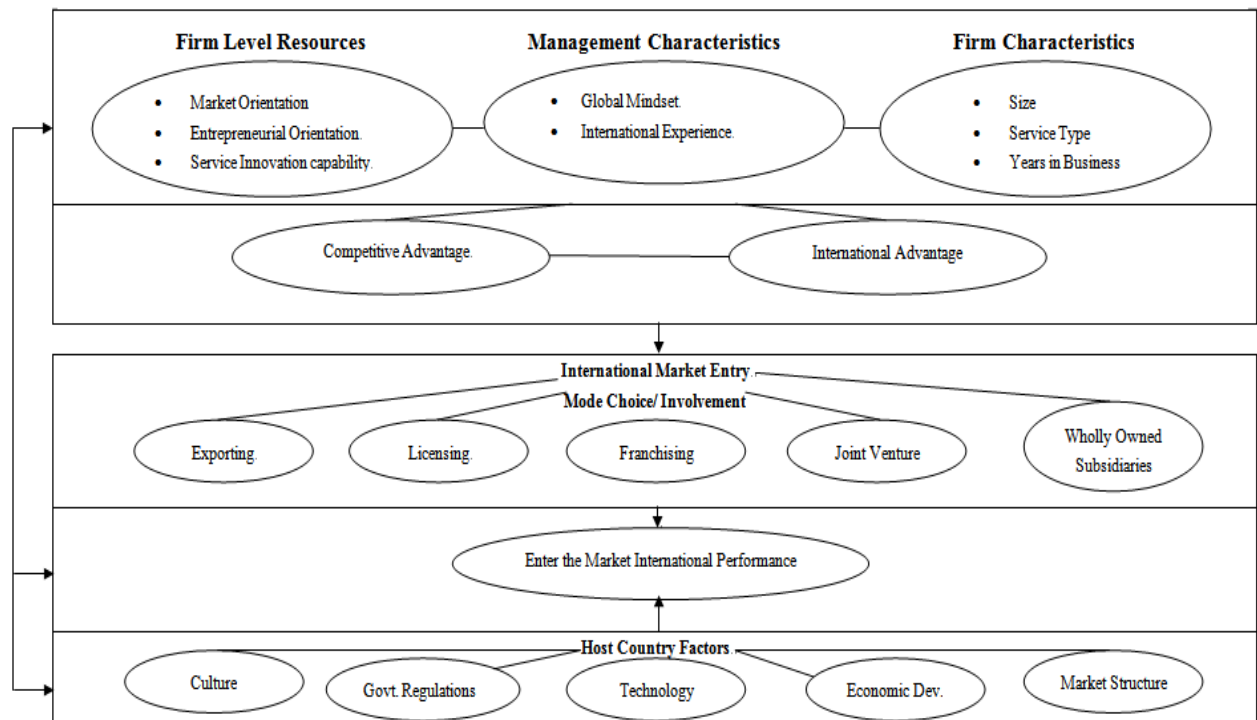
### **2.1.2 Internationalization Strategies Applied in Medical Services**

Internationalization strategies are very diverse; therefore a firm can design its own strategy according to its goals and needs. Pluta-Olearnik (2011) proposes a set of strategies suitable for the internationalization of medical services. He claims that depending on the level of contact between providers and consumers, firms require high expertise and professional credentials as well as a great deal of control over the distribution channel. In this case, Foreign Direct Investment (FDI), subsidiaries and branches, and Mergers and Acquisitions (M&A) are suggested in this particular field.

In the article "Foreign direct investment in the health care sector and most-favored locations in developing countries," Outreville (2007) describes some determinants to invest on MSOs abroad; "cultural distance, country risk, governance level of socio-economic development, and availability of quality inputs" (p. 305). For host countries, FDI represents a source of capital, complements domestic private investment, and contributes to economic development and transfer of technology (Ibid).

On the other hand, Javalgi & Martin (2007) suggest a framework for the internationalization of service firms that assesses different elements within the organization, strategies to internationalize, and target market considerations. These aspects must be clearly defined and mapped before starting to Internationalize. From Top to Bottom Figure 2.2 describes some indicators to understand better where the organization is and where does it want to go.

Figure 2.2 Framework for Internationalization of Services



Source: Javalgi & Martin (2007)

### 2.1.3 Accreditations to Medical Services Providers

Furthermore, concerns about quality and safety in any medical or cosmetic procedure are common when considering MT. International organisms and governments have created standards that can guarantee transparency in all processes performed by medical services providers. For some people, an international or national accreditation makes a difference while making a decision.

#### 2.1.3.1 Joint Commission International (JCI)

The Joint Commission International is considered the most important accreditation given to medical organizations worldwide. This certifies the quality, safety, and efficiency standards that a medical firm must fulfill to be able to compete in the international arena; “Health care providers everywhere must keep pace with globalization and match demand for high-quality, accessible care” (JCI, 2012). JCI was created in 1994 and so far has made presence in more than 90 countries.

### **2.1.3.2 International Society for Quality Health Care (ISQua)**

Founded in 1985, the International Society for Quality Health Care (ISQua) promotes and supports continuous improvement in the safety and quality of health care worldwide. With certified medical organizations in more than a 100 countries in the five continents, the ISQua provides guidelines to reach world class levels (ISQua, 2012).

### **2.1.3.3 IQ Certification Network (IQnet)**

The IQ Certification Network (IQnet) was originally created in 1990. This network provides different types of certifications that should be present in any organization or firm. The ISO 9001 certifies on business management quality. They help manufacture and services firms to achieve business objectives and follow up processes. The ISO 14001 certifies on environmental sustainability, and the OHSAS 18001 certifies on effective management of Occupational Health and Safety (OHS). These and many other certifications can be provided depending on the business purposes and type (IQnet, 2012).

Countries have also designed their own parameters and indicators to certify medical organizations providers. Examples of national certifications are PROMED from Costa Rica, Acreditacion Nacional de Excelencia en Servicios de Salud from Colombia and many more.

### **2.1.4 Success Factors in MT**

Several interviews to some of the most representative professionals in the MT industry were performed in order to identify some key success factors for a medical organization to internationalize. These factors are listed in Table 2.2. Notice that authors descriptions lead to a set of common aspects such as, joining a cluster, good reputation and international recognition, certification of professionals and facilities, excellent management of marketing tools, transparency in pricing and efficiency, clear internationalization strategies and high levels of bilingualism.

Table 2.2 Key Success Factors for a Medical Organization to Internationalize.

Author	Concepts
<b>Ehrbeck, Guevara, and Mango (2008)</b>	<ul style="list-style-type: none"> <li>• Having a clear strategic development plan;</li> <li>• Quality shall be equal or higher than the one offered in the patient's country of origin;</li> <li>• World class sufficient infrastructure ;</li> <li>• Low prices;</li> <li>• Professional human resources;</li> <li>• Accessibility.</li> </ul>
<b>Stephano (2012)</b>	<ul style="list-style-type: none"> <li>• Transparency in quality;</li> <li>• Transparency in pricing;</li> <li>• Being able to identify who the doctors are and what services they have offered.</li> </ul>
<b>Rua-Acosta (2012)</b>	<ul style="list-style-type: none"> <li>• Work with competitors. Joining a cluster and working together creates an overall positive atmosphere. Organizations can benefit from the group in different ways.</li> <li>• Individually, organizations should respect each other. Reference to competitors must be positive.</li> <li>• Getting certified by international accreditation bodies like JCI, AAAHC and AAAASF.</li> <li>• Internationalization must be induced by creating conditions (legal and environmental) as similar as possible to the target market. Language and cultural aspects must be taken into account during this process.</li> <li>• Marketing tools. Good English use in all communicates, website and marketing tools properly translated.</li> </ul>
<b>Cardenas (2012)</b>	<ul style="list-style-type: none"> <li>• Brand and quality differentiation</li> <li>• The second language in all scenarios as a city culture.</li> <li>• A website that has all the elements in different languages.</li> <li>• An office or a clearly defined process for each organization to serve international patients.</li> <li>• Reputation is a key factor. Doctors and dentists that are certified and recognize internationally.</li> </ul>
<b>Cook (2012)</b>	<ul style="list-style-type: none"> <li>• Must be a facility that has quality services, that has something special about it.</li> <li>• Find out what your Niche is, what procedures can you compete with, better prices</li> <li>• Surgeons with experience and success rates.</li> <li>• If you have all that, you have the recognition and a certification like the JCI or something similar.</li> <li>• Good country image. What is the perception of the country, how far away is the population you want to attract.</li> <li>• Provide quotes, doctors interested in the program, and a group of people called International department who work together, that can answer e-mails quickly and effectively, giving the information patients need, and transportation.</li> <li>• Facilitators to promote our services throughout their websites, but if we have a website please make sure it has correct English, it's well positioned, its style and friendly for people to have access.</li> </ul>

These aspects are later compared to the internationalization process of the research MSOs sample from San Jose and Medellin.

### **2.1.5 MT Facilitators**

It is also important to add that the term Tourism in MT involves also other type of industries and services that are important to complement the International Patient (IP) experience abroad. Hotels, transport, airlines, recreation, marketing agents, insurance companies and more are called “Facilitators.” These “provide pricing of healthcare services, options for hotels and aftercare facilities, travel and tourism options for the patient’s medical trip” to potential patients (Stephano, 2009). Also, Facilitators bring valuable information to insurance companies; it is useful for instance, to assess the suitability of patients and providers (Enderwick & Nagar, 2011).

In a conversation with Mauricio Castillo (2012), International business director at Coomeva prepaid medicine, he explains briefly this process:

We have an International Business division that acts as MT facilitator. We manage the referral and care of patients in logistics, administrative, financial and healthcare. Our approach is to work B2B. not directly with patients, but insurers, and governments abroad. We currently have agreements with thirteen international institutions in eight countries allowing a steady flow of patients every year. Usually we sign a contract with a customer or insurer; we show them our service portfolio and become what is called one-stop shopping. They have access to a clinical network in Colombia, to hotels, transport and more. If something goes wrong and the patient dies we handle the entire process of repatriation of the body. We take care of all that and then send you a bill for services rendered to the insurer. We focus only on highly complex events.

Another type of Facilitator agent might focus on the marketing area mediating between hospitals and IPs. Luis Alejandro Rojas (2012), from THG – Travel Healthy Group explains this process:

First, IPs visit our website and get informed about the procedures and treatments offered at the organizations with which we work. If they are interest, they contact us. Also, our website has the function to provide online quotations on medical services, logistics and transport. Once, IPs make a decision, we support them pre –during and pos attention. This process allows us to maintain the good image of the medical services organization, and possible referrals or word of mouth.

Mr. Rojas states that the majority of IPs that Colombia is currently receiving are nationals who reside in the United States, Canada and Spain. There is also a large market to develop in the Caribbean countries, specifically from Aruba, Curacao, Dominican Republic and also Puerto Rico.

All these aspects are important to understand how MT develops in every context. Given the nature of this study, we need to then contextualize MT in two scenarios mainly; Costa Rica and Colombia.

## **2.2 Medical Tourism in Costa Rica**

Costa Rica is located in Central America; it is one of the most promising MT destinations in Latin America. A recent country report provided by HIS Global (2012) presents a positive panorama regarding Costa Rica's economic growth. Labor market should continue to strengthen over the years 2012-13 thanks to the transformation of manufacture, mining, and tourism industries. The overall economy is expected to expand 5% during 2012 (Ibid.).

Because of its geographical proximity Costa Rica's main trading partner is the United States (Deloitte, 2008). Several studies<sup>16</sup> demonstrate that US patients are saving between 30%-40% of the total cost for procedures and healthcare services they have to pay at home when traveling to Costa Rica; dental and cosmetic procedures are among the most requested services.

Besides the number of US citizens that visit Costa Rica every year for medical purposes, there is also a wave of retirees considering this and other Latin-American countries as possible destinations to retire (PRONACOMER, 2008). The forecast shows an amount of 900,000 to 2.3 million US seniors going to live abroad within the next few years (Mincomercio, 2009). Between the US and EU there are 60 million people at the age of 65 that is expected to grow 50% more by the year 2025 (Ibid.); these people will most likely require high complexity procedures not covered by regular insurances. Just in the US there

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<sup>16</sup> Deloitte (2008); Ehrbeck et al.(2008).

are about 50 million adults without health insurance (Mincomercio, 2009).

In a conversation with Mr. Brad Cook (2012) from the Medical Tourism Association in Costa Rica, he mentioned that the large US population living in Costa Rica corresponds mostly to retirees and multinational employees. Therefore, US insurance companies have seen the need to establish different types of alliances with MSOs in Costa Rica; to their advantage is the number of bilingual cosmetic surgeons and physicians usually trained in the US, besides a desirable nurse to patient ratio (Horowitz et al., 2007). It is also important to mention that most insurance companies verify professional credentials and certifications before reaching an agreement with any foreign MSO. In Costa Rica, and specifically in San Jose, there are currently three MSO that count with the JCI accreditation. They are Hospital Clinica Biblica and Clinica CIMA (JCI, 2012).

The *Programa Nacional de Competitividad y Mejora Regulatoria* (PRONACOMER) is a program designed by the government of Costa Rica, the ministry of health and the Costa Rican tourism institute. These have promoted the creation of an association Public/Private, with the aim to position the country internationally as a world class medical tourism destination, and as a center of high quality complex medicine. “Medical tourism is no longer a possibility of savings in plastic surgery and other treatments, but instead, it is now the only solution to the health concerns of millions of uninsured patients worldwide” (PRONACOMER, 2008, p. 32). Table 2.3 presents a SWOT analysis of the MT industry in Costa Rica.

### **2.2.1 PROMED**

A medical organization cluster was formally founded in 2008. The Council for the International Promotion of Costa Rica Medicine (PROMED) “brings together health service providers, health professionals, tourism service providers, academia, and other marketers of goods and services related to health and tourism,” coordinating different functions and bringing the sector concerns to higher levels in government (PROMED, 2012). This non-for-profit institution formulates standards to guarantee the quality and confidence on healthcare services offered by organizations in the cluster. PROMED has a national approach. With nearly five million people in Costa Rica, the hub of MSOs is mainly located in the



Central Valley, San Jose.

Some statistics recently published by PROMED revealed that a total of forty-eight thousand patients entered the country in 2011 laying revenues for about 675 thousand dollars. This amount was higher than the one generated by coffee exports from January to September same year (Brenes, 2012). Just in the central Valley, San Jose, there are 1,223 business linked to MT with an average of 38 procedures performed by each center. While in other areas, there were identified 109 clinics with an average of 16.3 patients. To determine the total amount of centers, PROMED filtered the list of MSOs certified by the Ministry of Health, by regions, location and, website accessibility (Ibid.).

In 2010, PROMED reported a total of 36,000 IPs (20% more than the previous year) generating 504 thousand dollars in profits. However, PROMEDs Executive Director, Massimo Manzimo declared these figures not to be precise. Data was provided by PROMEDs associates that represent about 50% to 60% of MSOs nationwide. He claims figures are only estimates since it has been difficult to access representative data in every institution. Government is still responsible for measuring the sector (Brenes, 2012).

Also, PROMED also included a qualitative study to IPs through interviews performed in different MSOs. Results show that most IPs learned about Costa Rican MT through Internet. 50% of the surveyors cared about the MSOs and physicians certifications as an important factor to make decisions. The cluster has join efforts with other sectors and governmental institutions in order to make more scientific studies and creating statistics that can represent the progress of the cluster. "Hospitals are the main sources of data and are helping a lot" says Dr. Acosta-Rua (2012).

Table 2.3 Medical Tourism SWOT Costa Rica

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Decades of experience and development in the best qualified medical tourism in Latin America.</li> <li>• Appropriate condition to be selected as a retirement destination.</li> <li>• The medical tourism industry is the platform to develop a Health City, as a vehicle to develop a knowledge-based economy.</li> <li>• Available land field at the northwest of the Central Valley to develop the health cluster Master Plan</li> <li>• Touristic places and other areas to develop retirement projects.</li> <li>• Bilingual physicians (Horowitz et al., 2007).</li> <li>• PROMED</li> </ul>	<ul style="list-style-type: none"> <li>• The current economic model is based on primary production or manufacturing "offshore".</li> <li>• There is one last "land bank" available located in the West Central Valley region to be used in mega developments.</li> <li>• Need to insert the country into a knowledge economy.</li> <li>• The basis of scientific R&amp;D is loose and scattered, unable to make a significant impact still.</li> <li>• Statistics are based on estimates. Organizations are still reserved and will not disclose information on how many international patients do they have and what specialties are on demand.</li> </ul>
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>• The global population aging has opened two huge markets for Costa Rica: Medical Tourism and destination Retiree.</li> <li>• Medical Tourism and Retirement are based on low labor cost and retiree's lifetime savings.</li> <li>• The market economies of retirees and medical tourists open space for large corporations and insurance funds retirement and pensions.</li> <li>• OBAMACARE</li> </ul>	<ul style="list-style-type: none"> <li>• When the U.S. experiences a financial crisis, Costa Rica feels it as well.</li> <li>• Medical Tourism regional competition includes Panama and the southern neighbors. They are developing high value-added clusters in transport, Logistics &amp; distribution, financial centers, insurances and Reinsurances, high Technology, Software, Multimedia, etc.</li> </ul>

Based on Horowitz et al. (2007); PRONACOMER (2008).

## 2.3 Medical Tourism in Colombia

Colombia is geographically located in a very strategic place; with access to two oceans, limiting with five countries, and a time zone that agrees with important cities in the US East Coast. In spite the harsh recession that the country experienced during the 1990s, its economy has been recovering thanks to important economic measures made by recent presidential campaigns (Datamonitor, 2011). Its current GDP 5.7% has been fueled by the economic opportunities of the Free Trade Agreement (FTA) with the US (CIA, 2012).

The country still ranks poorly on the Human Development Index (HDI), an indicator of the UN development program that measures poor living standards. Out of a set of 169 countries, Colombia's position in this rank is the 79<sup>th</sup>; "nearly 60% of the Colombian households live below the poverty thresholds" ((Datamonitor, 2011, p.4). However, while the country presents a slide growth in the Information and Communication Technology (ICT) sector, research and development (R&D) seems to lag behind. Different industry sectors undermine the importance of innovations and patent awards to remain and survive in a competitive international arena (Datamonitor, 2011).

Colombia counts with a robust welfare system. Government has created different programs to manage the health care system appropriately. The Social Security Institute (Instituto de Seguridad Social in Spanish) opened in 1993 is in charge of assisting the low income population with medical services, subsidies and other benefits (Datamonitor, 2011). The SISBEN (Beneficiary Selection System for Social Programs) is a system implemented to obtain specific data across states, districts and municipalities that allows the classification of poor people ensuring them healthcare.

In Colombia the competition among MSOs led to a price war during the second half of the 1990s which still continues (Bardey & Castaño, 2007). Quality was compromised since technical quality is not fully observable to patients (Ibid), and as a result, predatory lenders could reduce risk without losing market share, at least in the short term. To solve this issue, providers proposed for several years a tariff base below which no payment contracts may be negotiated per event.

Regarding MT, the sector seems to be still raw in many aspects<sup>17</sup>. MSOs need to undergo changes in human resources, legal norms and standards (Mincomercio, 2009). Even though the access to the US market is a comparative advantage, the country must increase its hospital infrastructure, insufficient to cover the internal demand in some regions (Ibid.). As for bilingualism levels, the country is in disadvantage when compared to other countries<sup>18</sup>.

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<sup>17</sup> Perceived quality, number of personnel working in the sector, bilingualism, perceived risk and safety, customs procedures, infrastructure and innovation (R&D) (Mincomercio, 2009).

<sup>18</sup> While India holds the highest levels in the chart with 100% bilingual physicians and nurses, and Thailand has 80% bilingual doctors and 50% nurses, Colombia counts with a critical 55% of physicians that are bilingual and only 8% of the nurses speak Basic English levels (Mincomercio, 2009). This situation tends to worsen with the decreasing demand on

MSOs productivity can exponentially improve with competition; however, it is still difficult to determine the total number of exports performed by the sector. Some studies have used quality indicators, such as mortality rates, competences, and market concentration, but still the results are ambiguous (Bardey & Castaño, 2007).

A report presented by the Ministry of Commerce in Colombia (2009) showed that 2.2% of the tourists that visit the country every year are medical tourists; most of them were interested in cosmetic surgery, prosthodontics and restoration, cardiovascular interventions, bariatric surgeries, and in vitro fertilization (Garavito, 2007; Mincomercio, 2009). 29% of this population that visited the country during the year 2008 cared about service quality as an important factor to make a choice; 21% because of low pricing, and the same percentage did it because of technological advances in medicine (Mincomercio, 2009). Out of the 7,000 IPs that were attended in 2008, the majority came from the Colombian Diaspora in the US; 9% were US born citizens, 7% from Spain, 21% from the Caribbean, 18% from Surinam, and the remaining figures from neighbor countries such as Panama, Venezuela, Ecuador and other countries (Ibid.).

The National Development Plan (PND in Spanish) 2010-2014 has undertaken sector-specific investments, land reforms and education in order to create employment and reduce poverty rates. The plan is expected to lay revenues for about 6.3 billion dollars from IPs by the year 2032 (Mincomercio, 2009). In 2010, it was created the CONPES<sup>19</sup> 3678 or Productive Transformation Program (PTP)<sup>20</sup>, which has not only moved economic sectors like electric energy, textiles, graphic communication, BPOs, TICs, and MT, but also, has promoted other supportive networks like SENA<sup>21</sup>, and partial certifications by the ICONTEC and ISQUA (CONPES, 2010).

The MT report made by ANDI<sup>22</sup> (Jurado & Estupinan, 2010) presents a map with the

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medical services related academic programs.

19 Consejo Nacional de Política Económica y Social República de Colombia Departamento Nacional de Planeación.

20 “The PTP Improves productivity and sector competitiveness; facilitates coordination between public and private actors; helps sectors and companies to benefit from the opportunities arising from trade agreements, to have a stronger export supply; It helps to improve the quality of life of Colombians as a result of good performance of productive sectors and companies that generate more and better jobs” (PTP, 2012).

21 Servicio Nacional de Aprendizaje or National Learning Service

22 Asociación Nacional de Empresarios de Colombia or Colombian Entrepreneurs Association

strategic regionalization of the MT sector where Antioquia, Santander, Valle del Cauca and Cundinamarca will develop the curative, preventive, and cosmetic medicine type of business, while the Caribbean and the Coffee-grower axis will focus on Inspire Wellness medical tourism. Also, regions like Cundinamarca, the Caribbean and Antioquia count with Free trade zones<sup>23</sup>; which can be attractive for FDI during the Free Trade Agreement (FTA) with the US<sup>24</sup> (Garavito, 2007).

All resources should be administered by Bancóldex. In Antioquia for example, the government plan has been embraced by the Medical and Odontological Services Cluster, the tourism cluster, Proexport and the ACI<sup>25</sup> (Jurado & Estupinan, 2010). Claudia Perdomo (2012) MT advisor at ANDI, explains the importance of PTP and the role of this institution in the development of MT industry,

Our role is basically to support the private sector and the initiatives that the MT industry has by bringing all proposals, especially concerns about trade barriers to the Ministry of Health which has designed the PTP. This partnership is a public/private partnership. We have a strategic plan for 2012 focused primarily on the four columns PTP brings leadership they are Human Resource, Infrastructure, Building and industry promotion, standards and regulation.

Mr. Moreno-Diaz (2012), regional director at Saludcoop Rionegro, described several ways in which public and private MSOs obtain resources to maintain their business and eventually internationalize. For instance, in the case of private MSOs, these get resources from contracts with EPS in the following ways:

By UPC: where EPS and MSOs agree on attending a given number of patients on a monthly base. By event: where MSOs charges the EPS or health insurance company on the attention of a patient's emergency or urgent procedure. By charging fees to FOSYGA<sup>26</sup> or finally by individual consult or own means.

The amount collected from the previous sources has to be distributed into payments to suppliers, administrative fixed expenses, saving funds, and investments in technology and development. These must correspond to the pre-established quality policies of the MSO and

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23 Centers of massive industrial development with fiscal benefits.

24 Colombia gives special considerations to facilitate foreign patients' immigration (Garavito, 2007).

25 Agencia de Cooperacion e Inversion de Medellin y el Area Metropolitana.

26 According to the provisions of Article 218 of Law 100 of 1993 and Article 1 of Decree 1283 of 23 July 1996 which regulated the operation of the social security system, the Solidarity and Guarantee Fund (FOSYGA) is an account under the Ministry of health and Social Protection whose resources are devoted to health investment (FOSYGA, 2012).

controlled by the help of auditing companies.

Furthermore, he also mentioned that private MSOs can also apply for different public bids and governmental development plans. A well designed expansion plan can be supported by programs like Plan Vallejo<sup>27</sup>, the Productive Transformation Program<sup>28</sup> (PTP in Spanish), and more. In the case of Public MSOs resources are directly provided by the government on a monthly budget base. These organizations are mostly located in municipalities and directed to attend general public and specially subsidized individuals with low income or benefited by SISBEN. Special procedures are generally hired directly with private MSOs. They also receive resources from Lottery, tobacco and liquor business taxes.

As this research focuses on San Jose, Costa Rica and Medellin, Colombia, it is important to mention that in the case of Medellin, there have been two main institutions that represent the healthcare clusters in the city. They are the Medical and Dental Services Cluster and Salud Sin Fronteras. These two institutions will be briefly presented next.

A SWOT analysis of the MT sector in Colombia is proposed in Table 2.4

### **2.3.1 Medical and Dental Services Cluster**

Colombia and specially Medellin city have been recognized as an important center of medical R&D. Famous procedures like refractive surgery, cardiology, Hakim Valve (Hydrocephaly), transplants, oncology treatment and plastic surgery of high quality standards are performed in this city. The Medical and Odontological Services Cluster<sup>29</sup>, the City hall of Medellin, Mincomercio, ProAntioquia, and Proexport Colombia under the MTA<sup>30</sup> sponsorship, have designed an internationalization campaign based on the PTP called Medellin Health City (Medellin Health City, 2011). This institution integrates important private and public Medical and odontological service firms as well as other economic sectors in order to promote the MT. Medellin Health City campaign displays a detailed list of

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27 The Plan Vallejo is the formulation of economic policy in Colombia that allows the entry of raw materials, inputs and capital goods duty-free, in exchange for exports equivalent (Productos de Colombia, 2010).

28 The PTP, is a public-private partnership created by the Ministry of Commerce, Industry and Tourism, which promotes productivity and competitiveness of sectors with high export potential, through more efficient coordination between the public and private sector (PTP, 2012).

29 as part of the Chamber of Commerce of Medellin to Antioquia

30 Medical Tourism Association

treatments and pricing. Some of the most advanced firms in the Internationalization process are the Hospital Universitario San Vicente Fundacion<sup>31</sup>, Hospital Pablo Tobon Uribe, Clinica Las Americas, among others.

*Table 2.4 Medical Tourism SWOT Colombia*

<b>STRENGTHS</b>	<b>WEAKNESSES</b>
<ul style="list-style-type: none"> <li>○ Strategic Location.</li> <li>○ National Development Plan and Medical Tourism Focus Plan.</li> <li>○ Integrated welfare system.</li> <li>○ Growth in the TICs sector.</li> <li>○ Free trade zones.</li> <li>○ Facilitate foreign patients Immigration process.</li> <li>○ Health Services Clusters</li> <li>○ Tariff regulations</li> </ul>	<ul style="list-style-type: none"> <li>○ Poor HDI ranked 79th (60% of the Colombian households live below the poverty thresholds).</li> <li>○ Changes on human resources, legal norms and standards in the Medical industry.</li> <li>○ Economy based on primary sources</li> <li>○ Low bilingualism levels in comparison with other Latin American and Asian medical tourism destination countries.</li> <li>○ No accurate records on Health services exports.</li> </ul>
<b>OPPORTUNITIES</b>	<b>THREATS</b>
<ul style="list-style-type: none"> <li>○ Diaspora in the US, and Spain. Inflow of patients from the Caribbean, and the neighbor countries</li> <li>○ Join forces with public and private industries and auditory firms to develop the PTP.</li> <li>○ FTA with US. Participation in international healthcare Congresses. Few alliances with hospitals in the US<sup>32</sup> OBAMACARE.</li> </ul>	<ul style="list-style-type: none"> <li>○ To promote and commercialize Medical services internationally it is important to be certified; only two medical institutions in the country are accredited by the JCI.</li> <li>○ Refional competitors: Costa Rica, Brasil, Mexico.</li> </ul>

Based on Garavito, 2007; Mincomercio, 2009; Jurado & Estupinan, 2010; CONPES, 2010; Datamonitor, 2011; JHMI, 2012.

### 2.3.2 Salud Sin Fronteras

In 1998 a group of medical organizations in Medellin and PROEXPORT joined forces to create a special health services export program to promote the sector internationally; this program was named Salud Sin Fronteras. It is integrated by the eight medical organizations in the city<sup>33</sup>. The group has selected a service portfolio to offer mainly to Nicaragua, Panama, El

<sup>31</sup> also located at the Free Trade Zone.

<sup>32</sup> JHMI (2012). Home. John Hopkins Medicine International. International Collaboration. Fundacion Santa Fe de Bogota.

<sup>33</sup> Cardiovascular Clinic, Clinica Las Americas, Clinica Oftalmologica San Diego, Clinica el Rosario, Clinica las Vegas, Hospital Universitario San Vicente Fundacion, Hospital Pablo Uribe Tabón and Clinica Medellín.

Salvador, Honduras, Aruba, Curacao, Guatemala and other nations with high demand for medical infrastructure, scientific expertise and high complexity procedures. These countries send their people to the United States and other developed countries in the health sector (Giraldo & Gómez, 2001).

Felipe Giraldo (2012), executive director at Salud Sin Fronteras shared some interesting statistics generated by the group. A total of 2.023 patients visited different facilities during 2011, from which 20% came from Netherlands Antilles, 18% from USA, 6% from Spain, 4% from Venezuela, 3% from Panama and Aruba respectively, 2% from Ecuador, Canada and Israel respectively, and the remaining total from other latitudes in small percentage. 10% of this population requested plastic surgery, 7% general medicine, 6% orthopedics, 5 % ophthalmology and Cardiology and more. IPs also present patterns of seasonal demand. For example, June, July and August displayed an average between 8% to 12% frequency, while February, March, April and May visits are lower, but still very close in numbers. Also, 53% of the international patients surveyed by the group are men, and 29% of visitors are in ages between 48 and 63 years old.



## Theoretical Framework

### 3.1 Uppsala Model of Internationalization (Johanson & Vahlne, 1977, 2009)

The ‘Uppsala model of internationalization’ proposed by Johanson & Vahlne in 1977 has been an important contribution to the international business studies. This was revised 32 years later by the authors in 2009. The model focuses on the relevance of the cognitive process on the incremental decision making and the step by step emerging course of internationalization (Johanson & Vahlne, 1977).

According to the authors’ empirical observations, firms will tend to internationalize when certain cognitive conditions are appropriate to start with direct exports to a single country, through an agent; then, the firm establishes a sale subsidiary, and the last step comprehends the full production abroad (Johanson & Vahlne, 1977). They also affirm that exporting is a way of reducing the costs related to market development<sup>34</sup>.

Another important feature of the internationalization process described by Johanson & Vahlne (1977) is that it happens first in neighbor countries because of ‘psychic distance’<sup>35</sup>. In this sense, the firm will start its process in close countries and gradually move to more psychic distant markets (Ibid). “The larger is the psychic distance the larger is the liability of foreignness<sup>36</sup>” (Johanson & Vahlne, 2009, p.1412). By making two main assumptions, uncertainty avoidance and bounded rationality, the approach explains that firms change by learning from the different experiences they gain when operating in a foreign market. Therefore, the level of commitment<sup>37</sup> abroad is learning-driven. They claim that the “lack of knowledge”<sup>38</sup>, is an important obstacle to decision making connected with the development

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34 “Even if investment is necessary in the future, exporting helps to determine the nature and size of the market” (Johanson & Vahlne, 1977, p.28).

35 Factors that make difficult to understand foreign environments (Johanson & Vahlne, 1977). Psychic Distance is explained in terms of cultural dissimilarities, education, upbringing, business culture, language, government structure and industrial development level.

36 A term that describes foreign companies’ low survival rate than local companies for many years after they begin their operations (Johanson & Vahlne, 2009).

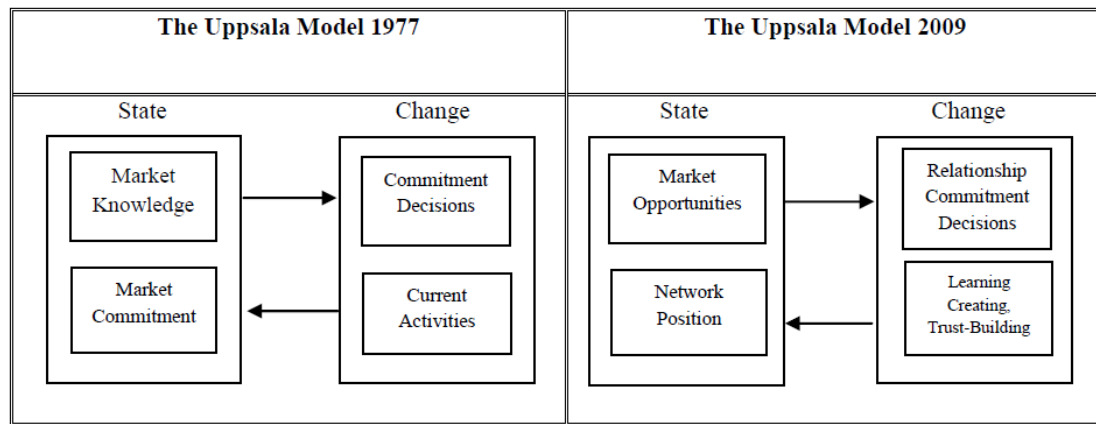
37 Defined by the authors as “the product of the size of the investment times its degree of inflexibility” (Johanson & Vahlne, 2009, p. 1412).

38 “Knowledge refers to the present and future demand and supply, to competition and to channels for distribution, to

of international operations” (Johanson & Vahlne, 1977, p. 26)

The scheme and posterior reform are presented in Figure 3.1 and complete description of every component is offered in appendix A.

Figure 3.1 Uppsala Model of Internationalization 1977 and 2009.



Source: Johanson & Vahlne (1977, 2009).

Johanson & Vahlne (1977) cite Penrose (1966) when describing different types of knowledge. For instance, the objective knowledge can be taught, while experiential knowledge is acquired during the development of an activity, thus, gaining skills in a particular labor<sup>39</sup>. When internationalizing, the firm lacks these types of knowledge in foreign operations, therefore, it must be gained through the process; “the less structured and well defined the activities and the required knowledge are, the more important is experiential knowledge” (Ibid, p.28). It is important then, to find the right balance between general knowledge and market-specific knowledge when performing operations abroad.

Opportunities for the firm come depending on how alternative decisions are raised and how they are made (Johanson & Vahlne, 1977). Issues are mainly identified and handled by the units of the organization directly related to foreign operations and those who work in the target market. The firm can also find opportunities in a foreign market through customers abroad (Ibid).

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payment conditions and the transferability of money and those things vary from country to country and from time to time” (Johanson & Vahlne, 1977, p.28). Then the lack of knowledge is due to differences between countries with regards to language and culture (Ibid)

39 it can never be transmitted, and produces a change in the individual (Johanson & Vahlne, 1977).

In *The Uppsala Internationalization Process Model Revised: From liability of Foreignness to Liability of Outsidership* (2009), the authors add two more components of the internationalization process of the firm. First, markets represent networks of relationships in which firms are bounded to each other and to a considerable extent. And second, learning and building trust and commitment happens thanks to relationships as well. If a firm attempts to enter a foreign market where it has no relevant network position, it will suffer from a ‘liability of outsidership’<sup>40</sup>. The new model adds the “recognition of opportunities” (Johanson & Vahlne, 2009). Needs, skills, strategies, and networks connected to the firm represent opportunities to increase market knowledge.

Authors also added “Network position” to “Market commitment”, where it is believed that the internationalization initiative emerges within a network once the firm has positioned in the local market and benefits from the learning, trust and commitment building of partners. Furthermore, in the change variables, the term “current activities” becomes “learning, creating, and trust-building” (Johanson & Vahlne, 2009). Here authors emphasize the speed, intensity, and efficiency of the learning process, creating knowledge, and building trust; these are concepts of intellectual and social capital.

Finally, they highlight the importance of relationships to the “Commitment decisions” component. In this way, the firm is autonomous to decide whether to increase or decrease its levels of commitment to one or more relationships within the network. Johanson & Vahlne (1990) analyze several studies affirm that the lack of market knowledge is not longer an impediment to internationalize, and that the world is becoming more and more homogeneous, so that such thing as “psychic distance” will tend to disappear.

This approach was originally designed to explain the internationalization processes of manufacture industries, however, Coviello & Munro (1997), Trujillo et al. (2006), and Petrou (2008) have applied the model to explain the internationalization process of service firms. In the Uppsala Model of 1977, the authors considered this model of internationalization as a good fit for empirical observations, and to find validity in this approach, they recommended two types of empirical studies:

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40 A firm that lacks positioning in the relevant network is defined as an outsider (Johanson & Vahlne, 2009).

1. One or two case studies where the model explains empirical situations<sup>41</sup>.
2. A comparative study of the internationalization process of different firms<sup>42</sup>. “Firms that differ with respect to those factors also differ with respect to the patterns of internationalization” (Johanson & Vahlne, 1977, p.30).

Let us remember that the main purpose of this model is to understand foreign investment behavior and to highlight the importance of some factors that affect the decision-making process of firm internationalization. This research might serve as a new example where the Uppsala Model is applied to the services industry while understanding how a sample of MSOs from San Jose, Costa Rica and Medellin, Colombia have internationalized.

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41 These cases should give an account of internationalization variables, market commitment and market knowledge and how do these factors evolve during the internationalization process (Johanson & Vahlne, 1977, p.30).

42 Factors like size, technology, product line, home country and others, laid against the model affect the course of the firm internationalization in many ways (Ibid).

## **Methodology**

### **4.1 Hypotheses**

Based on the previous theory, there were formulated the following hypotheses focused on three factors Choice of Geographical Locations, Entry Mode and Internationalization Strategy Choice, Foreign Venturing Motivation:

#### ***Choice of Geographical Locations:***

H1: Medical services organizations from Latin-American countries are likely to internationalize to neighbor markets given the principle of ‘psychic distance’ described by Johanson & Valhne (1977, 2009).

#### ***Entry Mode and Internationalization Strategy Choice:***

H2: Medical services organizations in Latin-American countries will start their internationalization following a step-by-step process as suggested by the Uppsala Model.

#### ***Foreign Venturing Motivation:***

H3: Medical services organizations from Latin American countries are likely to be driven by relationships to enhance reputation and knowledge when entering foreign markets.

### **4.2 Research Methodology**

In order to find answers to our three hypotheses, we use the Case Study which “tries to illuminate a decision<sup>43</sup> or set of decisions why: they were taken, how they were implemented, and its outcome” (Schramm, 1971). It consists of an empirical enquiry that investigates a current event within its own context, especially when gaps between reality and a specific event are not obvious (Yin, 2003). In other words, the case study covers and understands contextual conditions related to the research question (Ibid). This research is a multiple-case analysis in which the internationalization processes followed by a sample of MSOs from two cities, Medellin and San Jose, are compared to the Uppsala Model of Internationalization while trying to find common patterns and factors of success.

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<sup>43</sup> Individuals, organizations, processes, programs, neighborhoods, institutions and even events (Yin, 2003)

#### 4.2.1. Unit of Analysis

Our units of analysis are large size MSOs in advance internationalization process from two Latin-American cities. Samples names were kept in anonymity as per interviewees' request. Therefore, samples from Medellin, Colombia, four in total, are named Mde1, Mde2, Mde3, and Mde4. Samples from San Jose, Costa Rica, three in total, are identified as SJ1, SJ2 and SJ3. These are described in table 4.1 and table 4.2

Table 4.1 Sample Profiles from Medellin, Colombia

Sample	Description
<b>Mde 1</b>	<ul style="list-style-type: none"><li>• A private MSO, nonprofit foundation. Specialized in high complexity level procedures and an important medical teaching center recognized by universities. They are leaders in medical R&amp;D.</li><li>• Active since 1970, but its history dates back to February 12, 1946, when ANDI Foundation signed the act establishing a hospital that provided services to the employees of the companies affiliated with such entity.</li><li>• Its current capacity counts with 371 beds and 77 Intensive care units. They have about 1750, and approximately 11 people in charge of the International Patient department.</li><li>• Its infrastructure is qualified as advanced or World Class.</li><li>• They began the internationalization process in 2005 and are getting ready for the first JCI assessment.</li><li>• This MSO is a member of the Medical and Dental Services Cluster and Salud Sin Fronteras.</li><li>• Their service portfolio includes: Oncology, Urology, Trasplants, Traumatology, Cardiology and Cardiovascular Surgery, Thorax Surgery, Orthopedics, Pathology, Neuro Surgery and Neurology, Obesity Integral Treatment Program, General Reconstructive Plastic Surgery, Gastroenterology, Spine Progam, Minimal Invasive Surgery, Executive Checkup.</li></ul>
<b>Mde 2</b>	<ul style="list-style-type: none"><li>• A private MSO founded in 1988. It was initially intended as a basic unit, but then consolidated as a clinical and consulting project. In May 1989, the clinic was formally presented in an International healthcare fair with great success.</li><li>• In the year 1990, they contracted CONINSA to design and build the clinic complex. Stacks were sold to the public delivering all the offices in Phase I the same year with excellent results.</li><li>• It was officially opened in 1992 with more than 88 offices, 12 stores, 42 rooms, 5 operating rooms, 2 delivery rooms, and other services like Laboratory, Radiology, Emergency Room, ICU adults and neonates.</li><li>• Its strategic location, surrounded by hotels and shopping centers force them to increase their capacity by the second half of 1993. They implemented laundry and food areas in Phase II with 70 new offices and 20 rooms more.</li><li>• On August 25, 2010 was inaugurated Phase III, area with modern facilities to provide the</li></ul>

	<p>community with greater efficiency and comfort in the emergency room and inpatient rooms, continuing in this way a rapid expansion.</p> <ul style="list-style-type: none"> <li>• They currently count with 194 beds and 7 Intensive care units. With more than 700 employees and 7 dedicated to IP office. Their infrastructure is considered as advanced and formally began their internationalization process in 2005, and it is also a member of the Medical and Dental Services Cluster and Salud Sin Fronteras.</li> </ul>
<b>Mde 3</b>	<ul style="list-style-type: none"> <li>• A private and academic MSO which history dates back to 1912. The hospital also a foundation developed thanks to philanthropic donations from industries, church and wealthy individuals at that time. Also counted with the experience and knowledge of medicine scholars from the main university in the city.</li> <li>• The hospital was designed by a French architect who built 13 pavilions; considered a gigantic project back then.</li> <li>• The hospital was formally opened in 1926 attending Antioquia Railroad workers and other type of patients.</li> <li>• This foundation is an incubator of the best surgeons and physicians in the state that has transcended national and international levels. Many medical specialties achievements are referenced in scientific records. A teaching and service agreement was signed 1948 between this important university and the hospital to regulate relations. These have made important contributions to science.</li> <li>• The foundation is composed by a children pavilion founded in 1940, the University hospital, and Specialized center located in a free trade zone and opened to the public in 2011.</li> <li>• Between the three centers they have a capacity of 842 beds and 49 intensive care units. Currently the count with more than 2400 employees and consider their units as advanced world class and high complexity infrastructure.</li> <li>• Their internationalization process began in the year 2000. Back then, there was an important demand of services proof of their leadership in performing complex procedures such as transplants, cardiology, orthopedics, gastroenterology, oncology, among others, and the recognition of their international specialists in different academic settings.</li> <li>• The hospital has designed a program for international patients requiring highly complex care that has attracted IP s from Venezuela, Panama, Dominican Republic, Uruguay, Ecuador, United States, Mexico, among others.</li> <li>• It is a current member on Salud Sin Fronteras and the Medical and Dental Services Cluster.</li> </ul>
<b>Mde 4</b>	<ul style="list-style-type: none"> <li>• A private MSO and business group established in 1989 by a group of healthcare professionals. Comprises 14 legally independent companies located in a medical complex composed by three buildings (a mall, a medical tower, and a Clinic) and complementary services such as pharmacy services, orthopedics unit and vaccination center.</li> <li>• Currently the group has 223 beds, 26 ICU and 6 people in charge of communications and IPs. Its infrastructure is considered as advance world class.</li> <li>• Its internationalization process began in the year 2000 when the board of directors saw the need to design an internationalization plan to promote the clinic abroad, and the creation of a special unit responsible for channeling all communication and marketing strategies that the company needed to serve the country and other nations like the Caribbean and Central American countries.</li> </ul>

	<ul style="list-style-type: none"> <li>• This MSO belongs to Salud Sin Fronteras Cluster.</li> </ul>
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*Table 4.2 Sample Profiles from San Jose, Costa Rica*

<b>Sample</b>	<b>Description</b>
<b>SJ1</b>	<ul style="list-style-type: none"> <li>○ A Private MSO founded by a couple of missionaries in 1921 who saw the need to create a medical institution given the high rates of infant mortality and malnutrition. Life expectancy back then was about forty years. The couple dedicated their lives to provide free medical services to this population.</li> <li>○ By the year 1968 there had significant progress in the national healthcare. Infant mortality rate dropped considerably and nurses prepared with great professional excellence. Since then they made alliances with institutions in other countries like Mexico.</li> <li>○ Funds to support the MSO were made by the Mission. Soon, the organization ran out of resources and the hospital had to close.</li> <li>○ However, another group of missionaries were interested in having a partnership and together they created a medical association in 1968. The association will charge services to those who could afford to pay generating profits this way.</li> <li>○ Nowadays, one-third of the total profits designed to Social Action.</li> <li>○ They count with more than 120 beds and about 800 employees.</li> <li>○ Their internationalization process began in the 1970s in part because of IPs demand. Many US multinationals settled down in the country forcing hospitals to create new business units that could support international health insurance companies.</li> <li>○ Their infrastructure is considered as advanced and its International department is managed by 10 people.</li> <li>○ They count with the JCI certification and a PROMED member.</li> </ul>
<b>SJ2</b>	<ul style="list-style-type: none"> <li>○ A Private MSO which initial idea was to create a geriatric center. However, the initiative evolved into a center of medical specialties.</li> <li>○ It was officially opened in 1999, beginning operations in 2000.</li> <li>○ They count with the strong support of the International Hospital Consortium, the largest hospital chain in Latin America, and the certainty of the professionalism of all specialists that comprise our medical staff.</li> <li>○ Adjacent to the hospital is a seven-story medical office building, offering physical therapy facilities and a plastic surgery practice &amp; spa and several retail services. .</li> <li>○ They have been certified by the JCI, what places them at the height of the most renowned hospitals in the United States.</li> <li>○ They are ready to consolidate as leaders in health tourism region and thus also respond to the trend of rapid increase in the adult population and residential needs specialized medical care.</li> <li>○ A large and expanding facility with 400 physicians, with an entire wing devoted to IPs specially U.S. veterans</li> <li>○ Has other facilities of its type are located in: Mexico, Brazil and US.</li> <li>○ The hospital counts with medical and surgical patient units; Intensive Care Unit and Neonatal Intensive Care unit.</li> </ul>



	<ul style="list-style-type: none"> <li>○ It counts with a JCI accreditation and it is a member of PROMED.</li> </ul>
<b>SJ3</b>	<ul style="list-style-type: none"> <li>○ A private and university hospital MSO operated by a prestigious university</li> <li>○ With a basic infrastructure and 52 employees. 5 of them are in charge of IPs.</li> <li>○ They provide integral healthcare services with high standards of excellence and professionalism to individuals and corporate users.</li> <li>○ Its internationalization process is very recent 2008, and their specialties are: outpatient medical care, plastic and reconstructive surgery, maxillofacial, <a href="#">laparoscopy</a>, and <a href="#">and</a> at a corporate level, offers medical evaluation and health diagnosis to companies.</li> <li>○ They are current members of PROMED, certified by it and the AAAASF.</li> </ul>

#### 4.2.2 Data Collection Methods

This research is mostly based on qualitative data, although it also includes quantitative. Information was extracted from primary sources such as interviews, phone calls, teleconferences, and questionnaires solving, as well as, secondary sources such as indexed journals, websites, periodicals, governmental reports and corporate material.

##### 4.2.2.1 Interviews

Yin (2003) claims that “interviews are an essential source of case study evidence because most case studies are about human affairs” (p.45). A set of 22 questions were formulated corresponding to the hypotheses generated from the Uppsala Model. Interviews lasted between 20 to 30 minutes that were recorded and transcript. The questionnaire contained open ended and Yes No questions.

#### 4.2.3 Data Analysis

The comparative method is described by Sartori and Morlino (1994) as "the analysis of a small number of cases, less than twenty two [...] in order to highlight their reciprocal differences; thus preparing the scheme to interpret the way each context undergoes contrasting changes” (p.678). Each of the 22 questions formulated displayed quantitative and qualitative data. They are then tabulated making comparisons between cities and among MSOs. Then the correspondence to the theory is assessed.

#### **4.2.4 Ethical Considerations**

An agreement of consent was always presented to each interviewee giving the options of anonymity of organization, interviewee, or both at the moment of publication. The purposes of the research were clearly explained to participants, and the consent form was designed in Spanish; preferred language of participants. Another ethical consideration was the use of indexed journals, official data, and other resources, quoting authors appropriately to acknowledge the work others have done in the MT field of knowledge. Finally, by checking correspondence of the information presented to original sources guarantees the rigurocity of the analysis.

## Findings

### 5.1 Analysis

As it was explained before, interviews were based on 22 questions designed to trace the internationalization process of a sample of MSOs from two different cities, Medellin Colombia and San Jose, Costa Rica. The following analysis will present a general description of these processes.

MSO samples from Medellin claimed to have a relative advanced infrastructure that allows them to compete in the global market. Conversely, two out of the three MSO samples from San Jose said to have an advanced infrastructure. Sample Mde1 and Mde2 started their internationalization in 2005, while Mde3 and Mde4 began a little bit earlier in the year 2000. In the case of San Jose, the three samples present each a dissimilar internationalization year. SJ1 started its process as early as the 1970s, SJ2 did it in the year 2000 and finally SJ3 seems to be one of the newest in the internationalization process that began in 2008.

When talking about the internal and external factors that led them to internationalize, samples expressed different reasons in common.

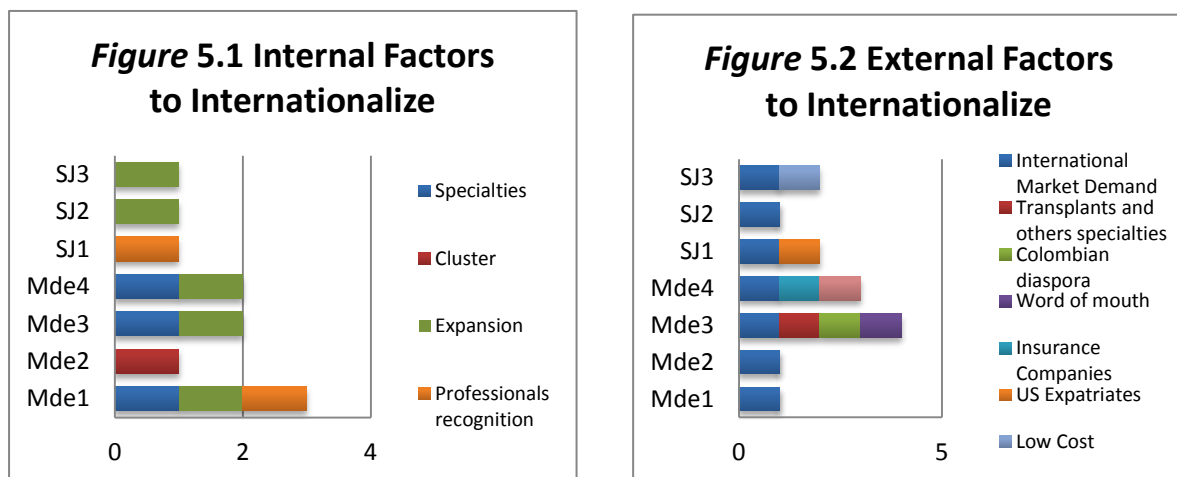


Figure 5.1 presented four major internal drivers; professionals' recognition internationally, a strong desire to expand operations given the local and international market demand, a diverse services portfolio, and the will to be part of a MSO Cluster which could impulse all initiatives as a group.

Figure 5.2 presents in the same way, the external drivers to internationalize. The MSO sample group from both cities felt the pressure of and increasing international market demand for medical and dental services. This forced them to invest in infrastructure and to prepare in order to fulfill local and foreign needs. Other external factors included the word of mouth<sup>44</sup>, insurance companies trying to establish supporting networks to attend US expatriate and Colombian Diaspora abroad. The demand for transplants and other specialties was considered by Mde3 as part of these factors.

While internationalizing healthcare services, it is important to have a clear concept of who an International Patient is. In Medellin, Mde2 interviewee defined the IP as “an individual, national or international, that has lived in a foreign country for more than 5 years.” This MSO distinguishes between two types of visitors; a person who comes from a foreign country for any particular reason and, Colombians who has resided abroad for more than 5 years. These IPs can consult the MSO for two reasons; spontaneous/emergency and programmed, who have previously contacted the organization. Furthermore, Mde3, considers the IP as “a foreign agent who comes seeking for medical services and who does not reside in the country.” Likewise, to Mde4, an IP is “an individual, national or foreign, permanently residing abroad or citizen, who comes here to have a procedure.”

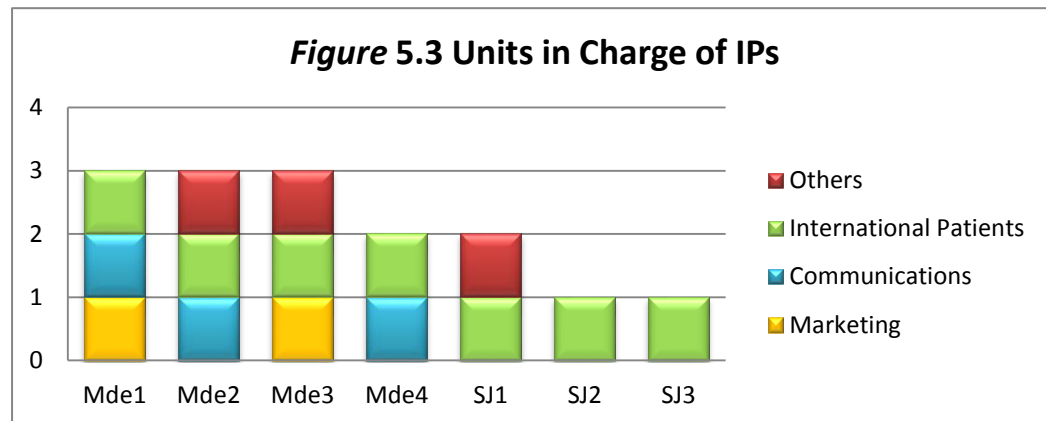
In San Jose, SJ1 described who the IP is not; “the foreign resident who lives in this country (Costa Rica),” and “the tourist visiting the country for reasons of leisure, recreation and else, who comes and gets sick for whatever reason.” Therefore, its correct definition is “who consciously and by his/her own research, makes the decision to go to a foreign country to get a treatment that can be less expensive and still well qualified.” Then, SJ3 commented that an IP is “any individual who is not a permanent resident in Costa Rica.” Mde1 and SJ2 did not provide a definition for this term.

Regarding to what departments or units of the organizations are in charge of the attendance of IPs, Mde1, Mde2, and Mde3 claimed it to be a joint efforts between three departments; these can be a combination between Communications, Marketing, Recruitment and Sales, Customer service, and a formal IP office. Mde4 and SJ1 said that only two

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<sup>44</sup> a technique that consists on referrals usually from relatives and friends

components were involved, while SJ2 and SJ3 have a sole office in charge. It is important to mention that in the case of San Jose, MSOs originally counted with an insurance affairs office before formally opened an IP office. Figure 5.3 briefly represents the previous statements.



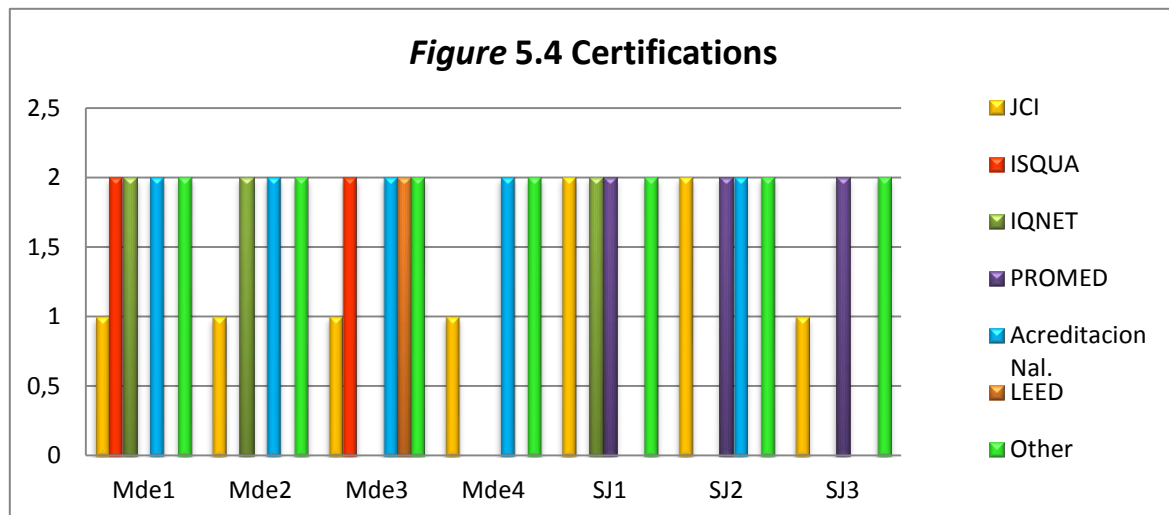
MSOs can internationalize some units first than others. This is the case when a specific department or specialty has more demand. For instance, SJ1 claimed that the very first unit recipient of all foreign inquiries and affairs was the insurance department. The remaining units were developing along the way. Sample Mde1, Mde2, Mde3, Mde4 and SJ3 said to have internationalized as a whole not partially. Interestingly, as it was described in the sample profile section, SJ2 can be considered as a “Born Global.” This MSO is a wholly owned subsidiary that makes part of a large group of clinics in Latin America and the US. It was designed specially to serve US veterans in the country and then opened to local patients as well.

These two groups offer a wide variety of services in which they are considered the best in the market. By counting the number of specialties they each advertize in a service portfolio, we can say that MSOs from Medellin have an average of 11 treatments and procedures that they can openly commercialize internationally. These specialties include Urology, Orthopedics, General reconstructive and plastic surgery, Gastroenterology, and executive checkups. In San Jose, the number of commercialized specialties is a bit lower than the one from Medellin’s group, but still important. They count with an average of 8.6 treatments and procedures that also include Urology, Orthopedics, Plastic and reconstructive maxillofacial and Cardiology among others.

In our Literature Review, we mentioned the increasing relevance of learning a second language as a culture and tool to internationalize. For Latin-American enterprises and in this case for MSOs, bilingualism (English/Spanish) has opened great opportunities to receive patients not only from our greatest market in the US, but also from English speakers from all over the world. In this sense, there were originally stated three main categories in which bilingualism levels could be measured in an organization; administrative staff % level; physicians and Dentals% and Nurses and other personnel %. Sadly, there were no formal records of this indicator in all surveyed MSOs. There was obtained a general estimation of what these levels could be.

For instance, although Mde1 does not count with a precise number of bilingual personnel, they certainly have made alliances with English institutes, where employees can have 50/50 financial support when enrolling in bilingual programs. 222 employees were tested using the ISPEAK system sponsored by the PTP obtaining the following scale: A1 118, A2 27, B1 68, B2 8, and C1 1. Mde4 has also taken advantage of the ISPEAK program with 180 employees currently been trained. Their approximate bilingual values were: Administrative staff 10%, Physicians and Dentals 70%, and Nurses and other personnel 3%. In the same way, SJ3 gave the following approximated values: Administrative staff 25%, Physicians and Dentals 90%, and Nurses and other personnel 15%. By comparing SJ3 to Mde4, we can clearly see a slide difference in the values. Estimated values of these indicators from SJ2 and Mde3 were not obtained. Finally, Mde2 and SJ1 only declared that at least 100% of the personnel working at the IP department were bilingual.

Accreditations in MT are also significant quality indicators that can weigh heavily on decision making, possible alliances and FDI. As it was explained at the beginning of this paper, the JCI is so far the highest certification of quality that a MSO can obtained. Other certifications are valuable as well to assess the current status of the organization in different aspects. Figure 5.4 presents a correlation between the number of samples interviewed from each city and the current certifications they each hold.



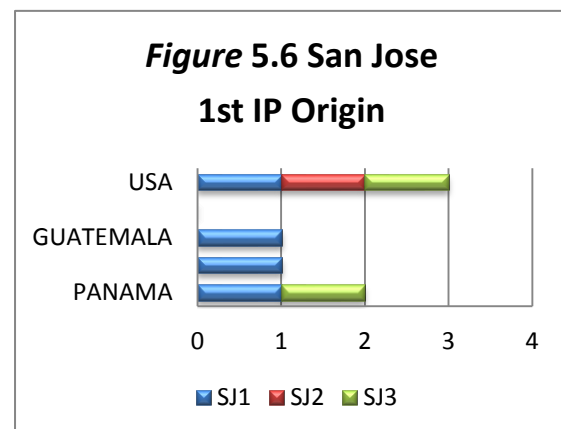
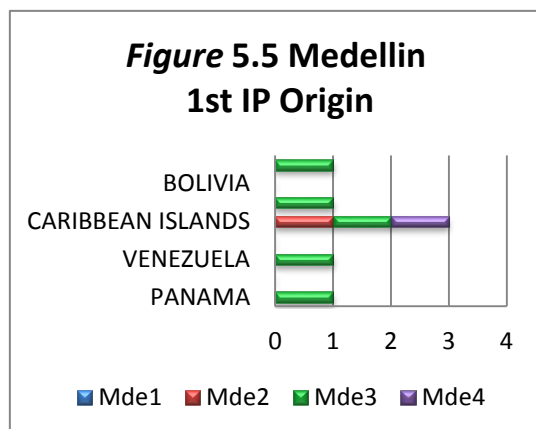
By giving the values 0= Do not have, 1= In process, and 2= Do have, it is recognized that only two samples, SJ1 and SJ2 have obtained the JCI accreditation. The remaining samples, Mde1, Mde2, Mde3, Mde4 and SJ3 are gaining experience by obtaining other types of certifications that can guarantee as well their quality and remarkable standards in all procedures.

While discussing if the MSO experienced an increase in the IP number after obtaining any credentials, Mde1 said, “A certification should not be obtained just because of the amount of potential patients it can receive. Certifications are standards to know how well prepared we are or not. Recognition and confidence is what we get.” Mde2 claimed that there were no outstanding variations, but the general acknowledgement of the scientific and commercial community. "What we look for by getting these certifications is to be prepared in terms of infrastructure, endowments and else." Mde3 and Mde4 highlighted that what they could get out of a certification was recognition and community trust. In the case of San Jose, for SJ1 certifications are part of a whole process. “A certification itself does not make what we know as MT. It does not guarantee, nor causes more or less patients. The process itself is what makes the difference.” SJ3 stated that “a certification allows us to perform more complex procedures on international patients but it is not the only reason to justify the increase of incoming patients.” SJ2 did not provide an answer to this question.

On the other hand, interviews described different versions of how MT has occurred in Medellin and where did patients come first. Most organizations do not count with accurate statistics on the volume of IPs and their origin since the beginning of internationalization. A

part of that is the lack of clear indicators to survey IPs when they visit the hospital for any reason. Others prefer not to disclose any information to competition. In Medellin, none of the MSOs offered a balance on this performance. However, Mde2 and Mde4 claimed that the internationalization of the medical services in Medellin was favored by a commercial airline that connected several destinations in the Caribbean islands to the city. First IP they attended at their facilities were from the Caribbean Islands. Mde3 agreed with the previous statement but also added that IPs came as well from countries like Panama, Venezuela, and Ecuador which neighbor nations, and Dominican Republic. All samples from Medellin mentioned that the word of mouth from has brought nationals residing abroad or Colombia's Diaspora from the US, Spain and other latitudes. Figure 5.5 depicts the previous premises.

As for the sample of MSOs from San Jose, Patients used to come first from Guatemala, Nicaragua, and Panama. Also as it was explained in the Literature Review, US citizens working in multinationals were also attended in San Jose. Figure 5.6 presents a chart with the origin of first IPs attended at San Jose's facilities.

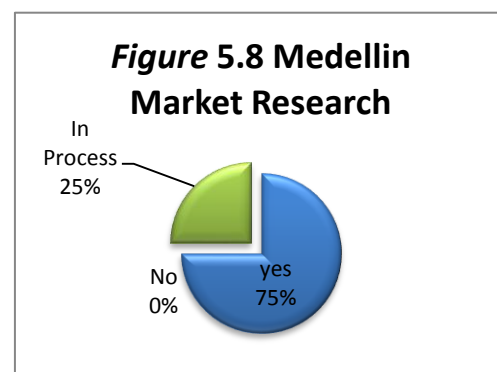
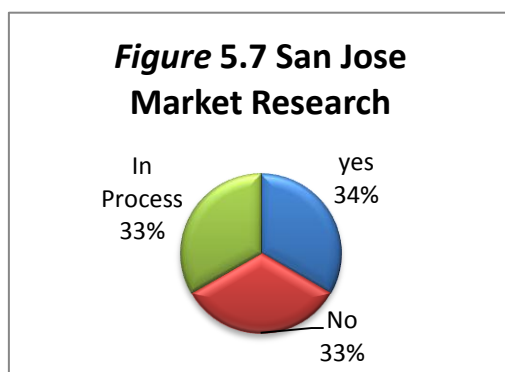


The annual growth of IPs since internationalization has been estimated by Mde1 to be 11%. Mde2 claimed no to have records of this increase, but stated that IPs in the last five years have come from the US, Canada, Curacao and Netherlands Antilles. As for Mde3, they estimate this growth to be between 1-2% annual rates; “between 2004 and 2005 there was a huge increase due to transplants, but because of government regulations, we have to prioritize the local demand of organs. Right now our demand is very low.” Finally, Mde4 did not offer a growth percentage, though, mentioned to have attended more than 1000 IPs so far this year (August, 2012). Interviewee added, “What I can say is that it works by Cycles. There are high



demand seasons and slow seasons. June, July and August will be high for us.”

The case with samples at San Jose was a bit more detailed. For instance, SJ1 described: “If you take 100% of the MT patients, 50% corresponds to cosmetic reasons. Out of this 50% seek cosmetic treatments (80% for dental and 20% medical cosmetics), the remaining 50% visit San Jose because of medical reasons; Orthopedics, General surgery, Gynecology, and Preventive medicine. Therefore, they estimate this annual growth to be about 7%, or about 9,000 IP per year. SJ2 did not disclose the rate, though published that IPs represented more than 15% of the patients they attended every year. SJ3 declared it to be 25%, but did not offer details on it.



Figures 5.7 and 5.8 represent MSOs intention to do research on target markets. Mde1 and Mde4 claimed to have done it using their own resources and methods, While Mde2 and Mde3 has used resources from local medical clusters market research. Meanwhile, JS1 from San Jose, said, “specifically in the USA, we have not performed it but, we collect statistics that are used internationally as Delloite. Obviously, the presence we have in the conferences, seminars, conversations we have with insurance companies and with the entities that are interested in this field are basically the info we have used to design our own strategy.” SJ3 has not perform a market research and SJ2 highlited the support given by PROCOMER in this regard.

All MSOs from both cities mentioned to take into account the degree of cultural affinity with the markets they wanted to explore. While doing market research, MSOs from Medellin said to consider aspects such us language and culture, governmental regulations and trade barriers to access the market, levels of technology, and economic development. Mde2 also consideres the analysis of the health sector status (insurance coverage) and purchasing power. See Figures 5.9 and 5.10.

In San Jose, we can say that the MSOs gave more relevance to culture and language, and government regulations demanded in the market they wanted to reach. Also, JS1 and JS3 consider aspects such as the approval of the same quality healthcare in target market and use of the same standards they follow, are important.

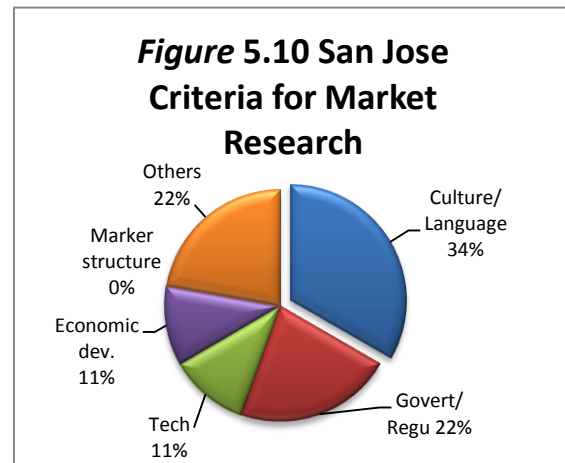
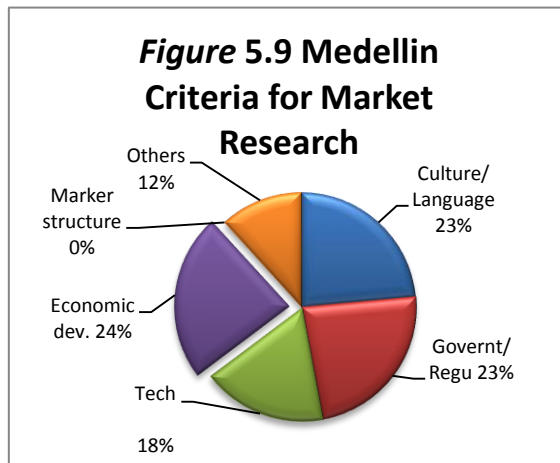
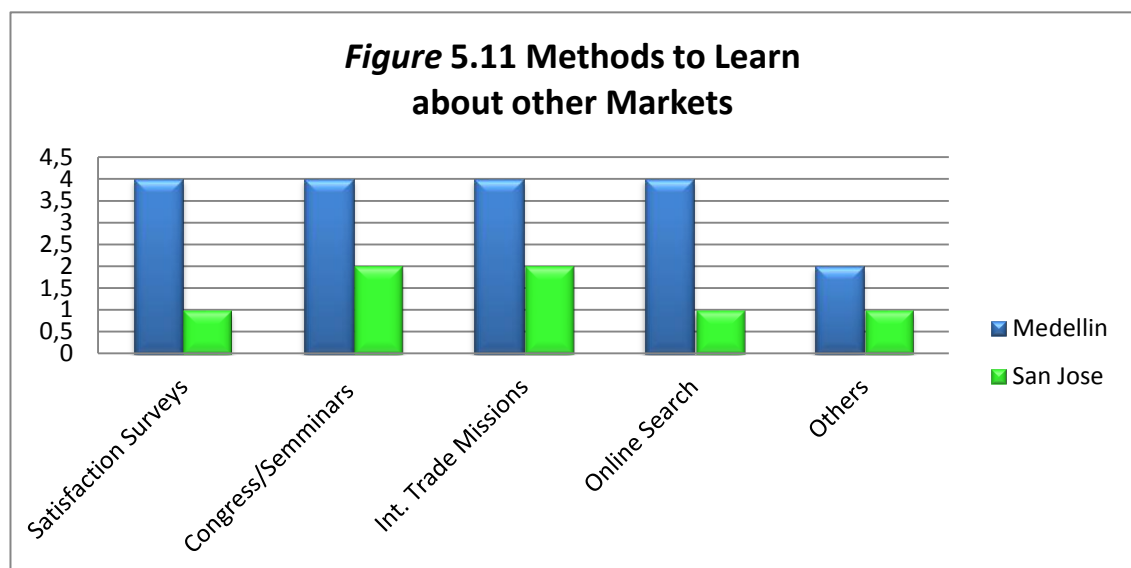


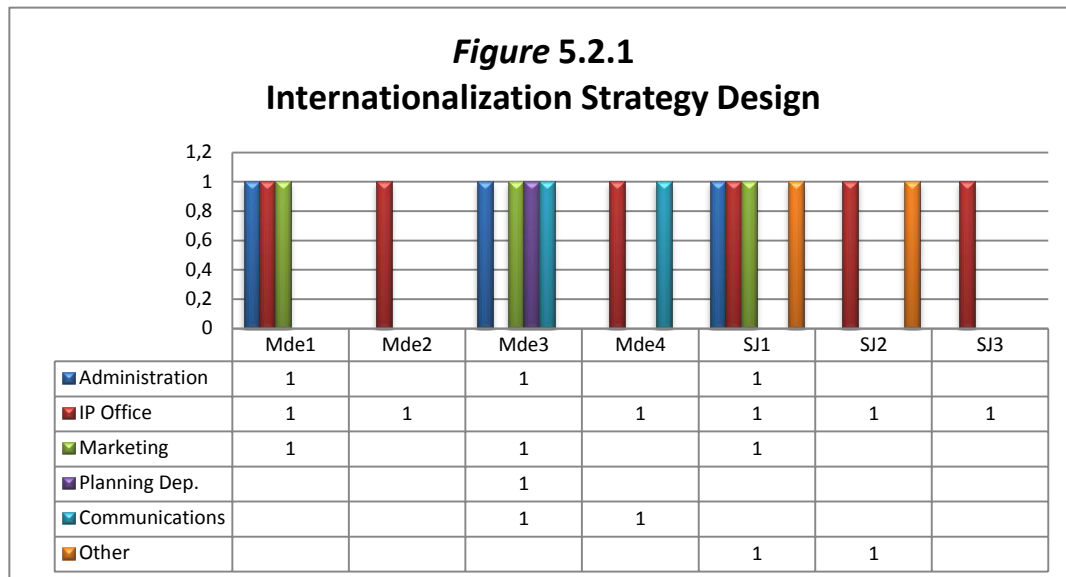
Figure 5.11 presents four of the most useful methods MSOs use to learn about other markets. Other methods included hospitals' experiences and case studies, getting updated on healthcare reforms, market trends, and general connections and alliances they have abroad.



## 5.2 Internationalization Strategy

Internationalization design for some of the organizations was a joint effort between different units. For instance, as in Figure 5.2.1, samples Mde1 and SJ1 needed about four components to design and approve a proposal. Mde1 uses three and SJ2 two. Interestingly,

SJ2, as a member of an international hospital chain, they require this design to work similarly than the headquarters in the US. While Mde2 and SJ3 work independently in the internationalization strategy.



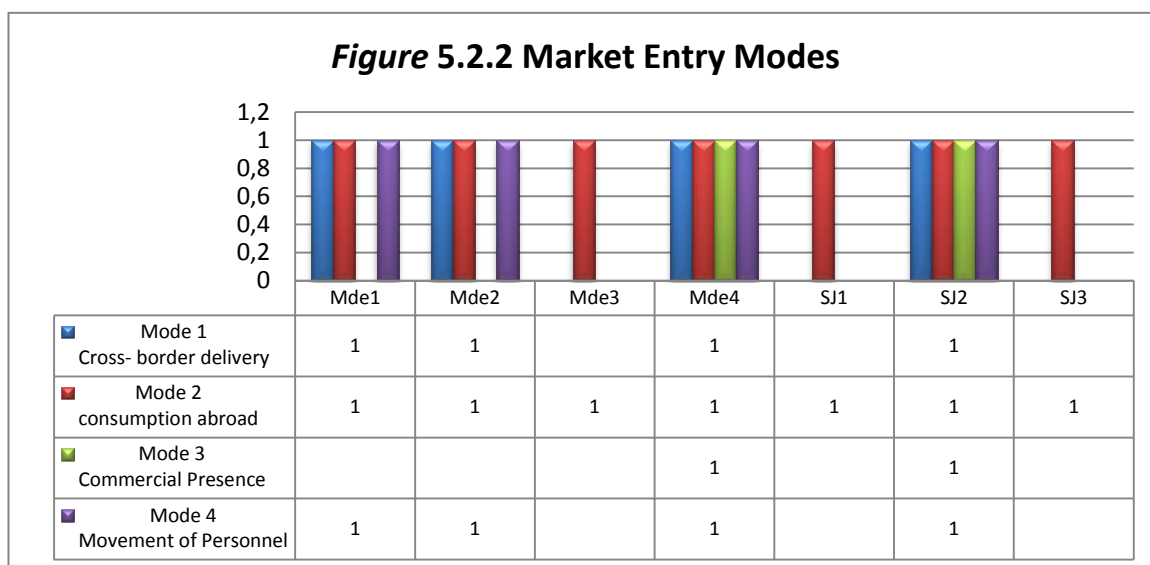
MSOs did not share the actual strategy design or a map. However, a summary of the main aspects they included in their plan is presented in Table 5.1.

*Table 5.1 Main Aspects in Internationalization*

MSOs	Main Aspects of Internationalization
Mde1	<ul style="list-style-type: none"> <li>• <b>Goal 1.</b> Patient correct identification</li> <li>• <b>Goal 2.</b> Improving effective communication</li> <li>• <b>Goal 3.</b> Improving the safety of high-alert medications</li> <li>• <b>Goal 4.</b> Ensure correct site surgery, with the correct procedure and to the right patient</li> <li>• <b>Goal 5.</b> Reducing the risk of infections inside the organization</li> <li>• <b>Goal 6.</b> Reducing the risk of falls</li> </ul>
Mde2	<ul style="list-style-type: none"> <li>• <b>Administrative Strategic line:</b> Agreements with foreign insurers, handling billing, visits, receiving documents, creation of strategic alliances with third parties, and functions necessarily involved with the patient and family.</li> <li>• <b>Infrastructure strategic Line:</b> making changes in structure and staff. Comfortable facilities and medical equipment.</li> <li>• <b>Assistance Strategic line:</b> Generate internationalization culture. Having trained nurses to care for foreign patients.</li> <li>• <b>Medical Strategic line:</b> Trained doctors, not only in surgical and medical procedures, but also, in patient care.</li> <li>• <b>Touristic Strategic line:</b> Prepare to provide touristic information and brochures to the patient. Contacts embassies, the procedures and the necessary paperwork to be submitted in immigration and required in each country.</li> </ul>
Mde3	<ul style="list-style-type: none"> <li>• Hospital Strategic Directions are 8:</li> <li>• Increase economic performance by improving continuous highly complex processes with</li> </ul>

	<p>differentiated and innovative qualities.</p> <ul style="list-style-type: none"> <li>• Achieve higher standards of quality, patient-centered and continuous improvement.</li> <li>• Consolidate an integrated information system to support the activities clinical, technical, management and research and teaching.</li> <li>• Strengthen the position of the institution.</li> <li>• Facilitate the development of employees and ensure the permanence administrative staff to build competitive advantages.</li> <li>• Responding to the commitment of the institution to attend patients with low resources and related audiences.</li> <li>• Optimize resources to generate higher returns.</li> <li>• Penetrate new markets to grow and increase revenue.</li> </ul>
<b>Mde4</b>	<ul style="list-style-type: none"> <li>• Providing the patient and their guests the best experience.</li> <li>• Medical References: Doctors are classified according to their specialty and certification.</li> <li>• Develop a "data bank." An information system on the broader aspects for service delivery. <ul style="list-style-type: none"> <li>■ National and international insurers we are in agreement with</li> <li>■ Doctors involved with specialty, subspecialty, academic titles, languages they speak, etc.</li> <li>■ National and international institutions that support the service delivery.</li> <li>■ Places to stay in the city.</li> </ul> </li> </ul> <p>In this way one could achieve a conglomerate that could be presented to the DIAN, Proexport and Foreign Trade Ministry, etc.</p> <ul style="list-style-type: none"> <li>• Second medical options</li> <li>• Special agreements</li> <li>• Track new legislation</li> <li>• Training in all areas</li> <li>• Adaptation of companies export services</li> <li>• Represent the company</li> <li>• International Toll Free line</li> <li>• Website</li> <li>• Committee for IPs</li> </ul>
<b>JS1</b>	<ul style="list-style-type: none"> <li>• What we do is following historical goals and projections we have and we measured the overall process. Remember that internationalization is part of the whole production process of the institution and as such it is measured at the end of the whole evolution process.</li> </ul>
<b>JS2</b>	<ul style="list-style-type: none"> <li>• There are still challenges in terms of improving patient care. For instance, in the medium term, healthcare professionals in this MSO would like to greet international patients inside the airport to facilitate the transition through immigration and customs</li> <li>• Relationship between the private and public sector officials must indeed be permanent.</li> <li>• The core working idea within this hospital is to maintain all continuous quality improvement processes active, to identify opportunities for improvement, and to provide, from the private sector, everything necessary for the country's reputation to grow and benefit us all.</li> <li>• All these actions count with the supervision and approval of other subsidiaries following the chain pattern.</li> </ul>
<b>JS3</b>	<ul style="list-style-type: none"> <li>• It is more like a market adaptation process.</li> </ul>

The group was also asked to explain the entry modes or channels they use to enter other markets. Figure 5.2.2 gives an account of the results. Only two of the samples claimed to have used the four of them<sup>45</sup>. For instance, Mde4 has already a representative office in Miami, Florida. In the second case, SJ2, this MOS is a subsidiary of an already internationalized company.



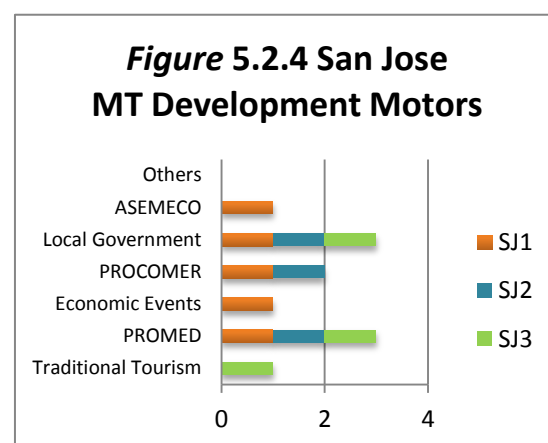
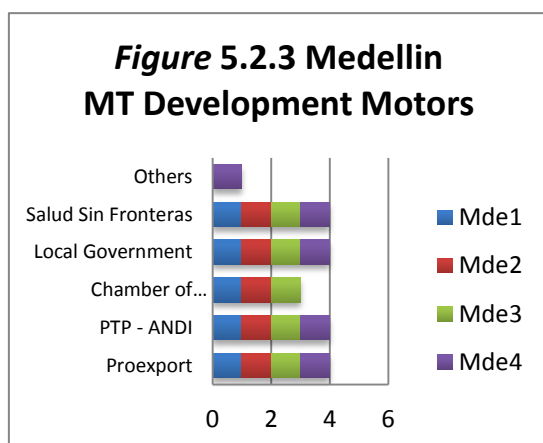
Another important aspect to find out in this research was getting information about FDI. The inquiry demanded information about possible foreign entities that could own wholly or partially the MSO as possible investments that these had abroad. Regarding this question, Mde1, Mde2, Mde3 and JS1 said not to be related to any particular foreign agent. However, in cases like Mde2, this MSO was originally based and founded by a set of shareholders. Likewise, Mde4 has a shareholder system that includes different social reasons, medical and commercial distributed around the city. SJ2 as it was explained in the entry modes description and figure 5.2.2, this MSO is one of eight such centers in Latin America owned by an international hospital corporation. “It represents the most fully corporatized and commodified Costa Rican medical tourist facility.” With an entire administrative division devoted to overcoming insurance paperwork and problems. It also seeks to integrate post-operative care via a wing of “hospital hotel” apartments for patients requiring long term assistance. This is

<sup>45</sup> Please refer to table 2.1 for more info.

considered as Greenfield MSO and wholly owned subsidiary. Other subsidiaries are located in Brazil and Mexico.

On the other hand, strategic alliances and partnerships with different institutions abroad have been important to the sample group. These are channels of knowledge transfer and allies to further international recognition. SJ1 holds a partnership with Jackson Memorial Hospital, Junta de Beneficencia de Guayaquil, Ecuador, Tulane University in New Orleans and some others connections with local institutions in Costa Rica. SJ2 used to hold a partnership with Baylor University Medical Center in Dallas, delivering interns and medicine students to practice and learn from the Costa Rican specialists while learning Spanish. SJ3 is also linked to Hospital Hotel la Catolica, PROMED and some international insurers.

In Medellin, Mde1 is connected to the Jackson Memorial Hospital as well as SJ1, and two more medicine universities abroad, Pittsburgh and Barcelona Clinic. Mde2 has different agreements with local EPSs, and international insurances like Axa Assistance, Vanbreda, Metlife, Asist Card, ABS Red Assist. Mde3 highlighted connections to physicians abroad, and Mde4 has alliances with Grupo Imas, Universal Assistance Bupa, Cigna International, Axa Asistencia Colombia, Coris S.A and Milenium International.



Both cities have had different motors to develop MT. Sample MSOs from Medellin count on different government programs designed to increase the sector productivity. Cluster organizations have also supported internationalization initiatives by promoting a medical services portfolio internationally, not as individual MSOs but as MT destination city. See figure 5.2.3.

Conversely, MSOs from San Jose have a national approach as it was said before. The majority of them are located in the Central Valley, San Jose, and therefore, their dynamic works more as a cluster in permanent correspondance to national expectations. See Figure 5.2.4.

Finally, when talking about the role of Facilitators in their internationalization process, Mde2 and SJ3 consider Facilitators as very supportive during this process. They help MSOs to reach patients from unexpected latitudes. MT facilitators have many connections and referrals. Contrary to this opinion, Mde3 and Mde4 have had negative experiences while using Facilitators, “Some of them can seriously harm the MSO image and that is why we prefer to do the process ourselves.” SJ1 as well believes that facilitators will advertise where they think is more convenient in terms of revenues and not really caring about the whole process IPs undergo. No answers were obtained from SJ2 and Mde1.

## Discussion

### 6.1 Hypotheses

Taking into account all the information that was collected during interviews and various sources (qualitative and quantitative); we now discuss the validity of our three hypotheses. The Uppsala Model of internationalization will be then compared to the internationalization process followed by our MSO samples from Medellin and San Jose.

#### *6.1.1 Choice of Geographical Locations:*

H1: Medical services organizations from Latin-American countries are likely to internationalize to neighbor markets given the principle of ‘psychic distance’ described by Johanson & Valhne (1977, 2009).

The Uppsala Model 1977, says that once companies develop in their own market, they gain experience and increase enough capacity to explore other possibilities and commitment decisions abroad. Theory indicates that organizations will begin to internationalize first to neighbor countries given the ‘psychic distance’ principle or cultural affinity. In this sense, when we compare these statements to the sample group experiences, we can find common patterns. First, all samples but one from both cities claimed to have a world class infrastructure. Internal and external forces move them to increase capacity and making important decisions.

Drivers such as professionals’ recognition, number of procedures available in each organization, and in general terms an increase in the foreign market demand for medical services denote local market knowledge. Contrary to regular manufacture companies,<sup>46</sup> opportunities were first identified in the local market. IPs from a national Diaspora in the case of Medellin and from neighbor countries like Panama, Venezuela and the Caribbean Islands show this city as a close and affordable alternative for MT. Likewise, in the case of San Jose, first IPs came from Guatemala, Nicaragua, Panama and the US. As it was explained,

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<sup>46</sup> This theory was first applied to Manufacture.



Costa Rica has international background in its gens, many multinationals settled down in this country, and therefore foreigners needed competitive medical services assistance.

All MSOs from both cities mentioned to take into account the degree of cultural affinity with the markets they wanted to explore; language, culture, governmental regulations, trade barriers to access the market, levels of technology, and economic development were analysed by MSOs while designing their internationalization strategy. Although most organizations do not have an account on bilingualism levels, and approximations in this regard show that San Jose has a much better English performance than Medellin, this last is doing great efforts to increase these levels supported by the national government and developing different bilingual programs.

We can say that most of our sample of MSOs from these two Latin-American cities internationalized first in neighbor markets thanks to cultural affinity. However, giving the size of the sample it is still premature to make a generalization as H1.

#### ***6.1.2 Entry Mode and Internationalization Strategy Choice:***

H2: Medical services organizations in Latin-American countries will start their internationalization following a step-by-step process as suggested by the Uppsala Model.

On the other hand, analysis demonstrated that at least two of the MSOs samples, one from each city, have given the first step to that internationalization. Mde4 has a representative office in Florida, while JS2 is already part of an international hospital corporation. Organizations are officially exporting services by using at least two of the Market Entry Modes described by GATS and adapted to the MT industry. Internationalization strategy design in some MSOs is a transversal exercise developed by different components in the organization. Initiatives and projects are presented to local and national governments in order to obtain resources and foster the exports and productivity of the sector.

Hypothesis 2 is valid for the cases of SJ2 and Mde4 which already had commercial presence abroad. Nonetheless, more research is necessary to determine an actual step-by step process.

#### ***6.1.3. Foreign Venturing Motivation:***

H3: Medical services organizations from Latin American countries are likely to be driven by relationships to enhance reputation and knowledge when entering foreign markets.

Theory says that firms are autonomous to decide whether to increase or decrease its levels of commitment to one or more relationships within a network. Aspects such as speed, intensity, and efficiency of the learning process, creating knowledge, and trust building are concepts of intellectual and social capital. In this sense, the sample group proved to have a great deal of strategic alliances with hospitals, universities, insurance companies, etc., abroad. These are great sources of knowledge transfer and a way to learn about how others internationalize and operate. All MSOs participated in trade missions, international congresses, and some advertise their services in MT or commercial magazines. Also, reputation was an issue of major concern for the MSO sample in both cities. This is why some of them were very careful when hiring third parties to bring IPs to their organization. I

It is true that this sample of MSOs has made efforts to connect with recognized institutions in the MT sector in order to enhance reputation and attract IPs. However, there is not enough data to demonstrate that H3 is valid.

## **Conclusion**

Data collected and interviews from these seven MSOs allowed us to find some common patterns between the Uppsala Model and the internationalization process of each organization. However, given the size of the sample it is difficult to make generalizations that can fully validate our three hypotheses regarding the MT sector in Latin-American. Further research should be conducted including more variables and a greater number of organizations in the region.

In general terms there is not a clear internationalization process in each MSO per se. Internationalization in all cases seems to be a response to internal and external forces. In Medellin, two of the samples started their internationalization process in the year 2000 and the other two in 2005. Interestingly, Salud Sin Fronteras was founded around 1998 and the Medical and Dental Services Cluster in 2005. These two institutions have promoted organizations initiatives, developing internationalization strategies, promoting and advising organizations on how to internationalize. Meanwhile, in San Jose, although sample MSOs claimed to have internationalized at a different pace and year, it was not until recently that they could formally joined as a medical cluster. PROMED was founded in 2008 and clearly states different ways in which they support and assist MSOs internationalization.

On the other hand, analysis showed the lack of accuracy in data collection methods performed by the MSO sample. General statistics of the sector were difficult to obtain in both cities. First, MSOs are very reserved and jealous with the information they share. Second, not all organizations are counted, only those that belong to a cluster. And finally, some MSOs still do not have clear the difference between who is a Medical Tourist and a foreign patient. Therefore, it is not possible to determine an increase or decrease in the annual MT performance. MT industry should generate standards and indicators that could guarantee a unified performance. The same criteria should be applied in all MSOs in Latin-America.

Even though, the Latin-American region is not as advanced in terms of MT processes as in Asia and other regions, we still have a great potential in the sector that can certainly increase thanks to FTAs. Colombia and Costa Rica have FTA with the US. Right now, Colombia is also negotiating an agreement with Costa Rica as well. Both countries, Colombia and Costa Rica can join efforts to compete regionally using their competitive advantages

Finally, the key factors that have led this sample of MSOs to success are a combination of providing the best healthcare experience, willingness to improve and achieving international standards, joining forces with local industries and internationally recognized entities, strategic location, positive country image, bilingualism, and excellent use of advertizing material and campaigns.

## References

- America Economia. (2012). Clinicas y Hospitales Ranking 2012. Retrieved from <http://rankings.americaeconomia.com/2012/clinicas-y-hospitales/ranking.php> Accessed on: 10-03-2012.
- Barboza, L. (2012). Un Negocio que Rebosa de Salud. Revista Estrategia & Negocios. REtieved from: <http://www.estrategiaynegocios.net>. Accessed on: 10-19-2012.
- Bardey, D. & Castaño, R. (2007). La regulación de tarifas en el sector salud en Colombia. *Revista de economía Institucional*, 9(17), Segundo Semestre. Pp. 347-357.
- BBVA. 2012. Trade in services: East Asian and Latin American Experiences. Retrieved from: [http://www.bbvaresearch.com/KETD/fbin/mult/WP\\_1204\\_tcm348-312641.pdf](http://www.bbvaresearch.com/KETD/fbin/mult/WP_1204_tcm348-312641.pdf). Accessed on: 05-05-2012
- Bolis, M. (2001). El Turismo de Salud en América Latina y el Caribe de Habla Inglesa. *Organizacion Panamericana de la Salud*, 19-23.
- Brenes, C. (2012). Negocios. Turismo Medico con Buena Salud. *El Financiero*. Retrieved from: [http://www.elfinancierocr.com/negocios/turismo-medica-buena-salud\\_0\\_191980835.html](http://www.elfinancierocr.com/negocios/turismo-medica-buena-salud_0_191980835.html) Accessed on: 11-20-2012
- Carneiro, J. & Ferreira, J. (2008). Challenging the Uppsala Internationalization Model : a Contingent Approach to the Internationalization of Services. *Brazilian Administration Review*, 5(2), 85-103.
- CIA (2012). South America. Colombia. Economy Overview. Retrieved from: <https://www.cia.gov/library/publications/the-world-factbook/geos/co.html> Accessed on: 06-19-2012
- CIMA. (2010). Pacientes Internacionales. Retrieved from: <http://www.hospitalsanjose.net/guia-paciente-pacientes-internac.html> Accessed on: 10-05-2012
- Chetty, S. (2011). Geographical Proximity and Inter-firm Collaboration:. The Role of Knowledge Access and Knowledge Acquisition. *Journal of General Management*, 36(4), 71-87.
- Clinica Las Vegas. (2012). Paciente Internacional. Retrieved from: <http://www.clinicalasvegas.com/pacientes-y-visitantes/Paciente Internacional>. Accessed on: 12-10-2012.
- Cloninger, P. (2000). *The influence of service characteristics on internationalization: extending the eclectic paradigm*. Unpublished PhD Dissertation. Robinson College of

Business, Georgia State University, Atlanta, Georgia.

CONPES (2010). Políticas de Transformación Productiva: Un Modelo de Desarrollo Sectorial para Colombia. *Consejo Nacional de Política Económica y social Republica de Colombia Departamento Nacional de Planeación*. Bogotá D.C.

Cortez, N. (2008). Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Healthcare. *Indiana Law Journal*. 83(71). Pp. 70-132.

Coviello, N & Munro, M. (1997) Network Relationships and the Internationalization Process of Small Software Service Firms. *International Business Review*, 6(4). Pp.361-386.

Dangond, E. (2009). Exportación de servicios: otra Forma de Diversificar Mercados. *Camara de Comercio de Bogota*.

Datamonitor (2011). Country Analysis Report. Colombia. In-depth PESTLE insights. *Datamonitor*. P.1-80.

Deloitte (2008). Medical Tourism. Consumers in Search of Value. *Deloitte Center for Health Solutions*.

Ehrbeck, T., Guevara, C., and Mango, P. (2008). Mapping the Market for Medical Travel. *The McKiensey Quarterly*, Health Care May. Pp. 1-11.

Enderwick, P. & Nagar, Swati. (2011). The competitive challenge of emerging markets: the case of medical tourism. *International Journal of Emerging Markets*, 6(4), 329-350.

FOSYGA. (2012). Que es el FOSYGA? Retrieved from: <http://www.fosyga.gov.co/AcercaDelFOSYGA/Qu%C3%A9eselFOSYGA/tabid/103/Default.aspx> Accessed on: 10-14-2012

Garavito, L. (2007). Oportunidades que Plantea el TLC al Sector Salud “Potencial Exportador del Sector Salud”. 5. El Escenario Global. 2019: *Colombia País Saludable*. Propuesta Sectorial. 79-88.

Giraldo, J. and Gómez, C. (2001) Modelo de programa de gestión internacional para la exportación de servicios de salud en la promotora medica las Américas. Universidad Pontificia Bolivariana. Facultad de Administración de Empresas. Especialización en Negocios Internacionales. Medellín. Pp. 1-95.

Grupo Empresarial Las Americas Promotora Medica. (2010). Internacional. Retrieved from: <http://www.lasamericas.com.co/site/oficina-internacional>. Accessed on: 10-09-2012.

Herrick, D. (2007). Medical Tourism: Global competition in healthcare. Retrieved from <http://www.ncpa.org/pub/304> Accessed on 05-06-2012

HIS Global (2012). Country Intelligence: Report Costa Rica.

- Holden, C. (2003). Actors and Motives in the Internationalization of Health Businesses. *Business and Politics*, 5(3), 287-302.
- Hospital Clinica Biblica. (2011). International Patients. Retrieved from: <http://www.hcbinternational.com/web/> Accessed on: 10-02-2012.
- Horowitz, M., Rosensweig, J., Jones, C. (2007). Medical Tourism: Globalization of the Healthcare Marketplace. *MedeGenMed*, 9(4), 1-33.
- Hurtado, M. (1998). The What, How and Why of Health Tourism. Report Prepared for the Panamerican Health Organization. Programa de Políticas Públicas y Salud, División de Salud y Desarrollo Humano, OPS/OMS, Washington, D. C.
- IQnet. (2012). Certifications. Retrieved from <http://www.iqnet-certification.com/index.php?liv1=3&liv2=63> Accessed on: 09-12-2012.
- ISQua. (2012) Who we are? Retrieved from <http://www.isqua.org/who-we-are/who-we-are> Accessed on: 10-23-2012.
- Javalgi, R. & Martin, C. (2007). Internationalization of services: identifying the building-blocks for future research. *Journal of Services Marketing*, 21(6), 391-397.
- JCI (2012). Home. JCI Accreditation and Certification. Colombia. Retrieved from: <http://www.jointcommissioninternational.org/JCI-Accredited-Organizations/> Accessed on: 06-12-2012.
- JHMI (2012). Home. John Hopkins Medicine International. International Collaboration. Fundacion Santa Fe de Bogota. Retrieved from: [http://www.hopkinsmedicine.org/international/international\\_affiliations/collaborations/fundacion\\_santafe\\_de\\_bogota](http://www.hopkinsmedicine.org/international/international_affiliations/collaborations/fundacion_santafe_de_bogota) Accessed on: 06-14-1012.
- Johanson, J., & Vahlne, J.-E. (2009). The Uppsala internationalization process model revisited: From liability of foreignness to liability of outsidership. *Journal of International Business Studies*, 40(9), 1411-1431.
- Johanson, J., & Vahlne, J.-E. E. (1977). The Internationalization Process of the Firm-A Model of Knowledge Development and Increasing Foreign Market Commitments. *International Business*, 8(1), 23-32.
- Jurado, C. & Estupinan, G. (2010). Turismo de Salud. Sector Clase Mundial. *ANDI*.
- Khan, M. (2010). Medical Tourism: Outsourcing of Helathcare. *International CHRIE Conference-Refereed Track*. Paper 23. ScholarWorks@UMass Amherst. 1-8
- Medellin Health City. (2010). Medellin-Colombia. Your Healthcare Destination. Brouchure.

- MEDICIMA. (2011). Successful Re-accreditation by the Joint Commission International (JCI). 5th ed. November.
- Minicomercio (2009). Desarrollando Sectores de Clase Mundial en Colombia. Informe Final Sector Turismo de Salud. *McKinsey & Company* 2008.
- Outreville, J. (2007). Foreign direct investment in the health care sector and most-favored locations in developing countries. *The European Journal of Health and Economic*, 8(4), 305-312.
- Perez, S. (2009). Código del Buen Gobierno y Ética. Departamento de comunicaciones del Hospital San Universitario San Vicente de Paul.
- Petrou, A. (2008). Internationalization of Bank Firms from Emerging Countries: A Comparative Study. *Cyprus International Institute of Management*. p.1-41
- Pluta-Olearnik, M. (2011). Internationalization of the Service Sector - Marketing Approach. *Folia Oeconomica Stetinensia*, 10(1).
- Porter, M. (1998). The Competitive Advantage of Nations, The Free Press, New York, NY.
- Primo-Braga, C. (1996). The Impact of the Internationalization of Services on Developing Countries. *Finance & Development*, (March), 34-37.
- Proexport (2012a). Directorio Clínicas. Hospital Pablo Tobón Uribe. Retrieved from <http://www.proexport.com.co/salud-colombia/industria-salud-colombia/directorio-clinicas/el-hospital-con-alma-pablo-tobon-uribe>. Accessed on: 09-10-2012.
- Proexport (2012b). Directorio Clínicas. Hospital Universitario San Vicente Fundación. Retrieved from <http://www.proexport.com.co/salud-colombia/industria-salud-colombia/directorio-clinicas/san-vicente-fundacion>. Accessed on: 25-09-2012.
- Productos de Colombia. (2010). Plan Vallejo. Retrieved from [http://www.productosdecolombia.com/main/guia/Plan\\_vallejo.asp](http://www.productosdecolombia.com/main/guia/Plan_vallejo.asp) Accessed on: 09-12-2012.
- PROMED (2012). Institutional Summary. Retrieved from <http://www.promedcostarica.com/> Accessed on: 10-03-2012.
- Pronacomer (2008). Documento Estratégico. Cluster de la Salud: Propuesta para la creación de un parque de investigación y ciencias médicas, y comunidades planificadas de retirados en Costa Rica.



- PTP. (2012) Que es el Programa de Transformacion Productiva? Retrieved from <http://www.ptp.com.co/contenido/contenido.aspx?catID=607&conID=1> Accessed on: 09-27-2012.
- Ranking Web. (2012). Ranking Web of Hospitals. Latin America. Retrieved from [http://hospitals.webometrics.info/en/Latin\\_America](http://hospitals.webometrics.info/en/Latin_America) Accessed on: 09-14-2012.
- Rodas, L. (2012, October 17). Caso de éxito. Enseñanzas para el sector turismo de salud. Hospital Pablo Tabón Uribe. Lecture presented at Seminario de Oportunidades del TLC con Estados Unidos para el Sector Servicios. Medellín.
- Rugman, A. & C. Brain (2003). Multinational enterprises are regional, not global. *Multinational Business Review* 11(1), 3-12.
- Salud Sin Fronteras. (2011). Portafolio de Servicios. Brochure.
- Sartori, G. & Morlino, L.(1994). *La comparación en las ciencias sociales*. Madrid. Alianza Editorial, 1994.
- Schramm, W. (1971). *Notes on Case Studies of Instructional Media Projects*. Working paper for the Academy for Educational Development , Washington, DC.
- Stephano, R. & Ho, V. (2008). The Rise of Global Healthcare from Latin America. *Global Healthcare Magazine*. September 9. Retrieved from:<http://www.globalhealthcaremagazine.com/detail.php?Req=160&issue=7> Accessed on: 10-19-2012.
- Stephano, R. (2009). The Role of Facilitators. Best Practices, Their Role and Importance for Medellín. Medical Tourism Association.
- Taleghani, M., Chirani, E., & Shaabani, A. (2011). Health tourism, tourist satisfaction and motivation. *Interdisciplinary Journal of Contemporary Research Business*, 3(4), 546-556.
- Tattara, G. (2010). Medical Tourism and Domestic Population Health. Department of Economics, University of Venice. 2(WP):34
- Trujillo, M., Rodriguez, D., Guzman, A. & Becerra, A. (2006) *Perspectivas Teóricas Sobre Internacionalización de Empresas*. Documento de Investigación No. 30. Universidad del Rosario. Bogotá, Colombia. Pp. 1-38.
- UNCTAD (2002). Trade in services and development implications. Commission on Trade in Goods and Services, and Commodities. 7th Session.
- Warf, B. (2010). Do you know the way to San Jose? Medical Tourism in Costa Rica. *Journal of Latin American Geography*. Department of Geography University of Kansas.

- Welch, L.S. & R. Luostarinen (1988). Internationalization: Evolution of a concept. *Journal of General Management*, 14(2), 44-55.
- WHO. (2009). Health Cluster Guide. What is health? Retrieved from [http://www.who.int/topics/health\\_services/es/](http://www.who.int/topics/health_services/es/) Accessed on: 09-13-12
- Woodman, J. (2010). The Top Ten Medical Travel Destinations. *International Living Magazine*. Retrieved from: <http://internationalliving.com/2010/06/the-top-10-medical-travel-destinations/> Accessed on: 06-12-2012.
- WTO (2012). GATS Training Module: Chapter 7. Preparing Requests and Offers. 7.2 Identifying Relevant Trading Partners, Sectors and Modes. Retrieved from: [http://www.wto.org/english/tratop\\_e/serv\\_e/cbt\\_course\\_e/c7s2p1\\_e.htm](http://www.wto.org/english/tratop_e/serv_e/cbt_course_e/c7s2p1_e.htm) Accessed on: 06-14-2012.
- Yin, R. (2003). *Case Study Research: Design and Methods*. Sage Publications Inc.

## Appendix A

### Description of Uppsala model statements

State Aspects	
Market Knowledge (Uppsala Model 1977)	Market commitment (Uppsala Model 1977)
<b>General Knowledge:</b> General knowledge of the organization and the different units and functions, it facilitates horizontal growth <sup>47</sup> and the knowledge operations are transferable.	<b>Amount of Resources:</b> “It is close to the size of the investment in the market (including investment in marketing, organization, personnel, and other areas)” (p.27).
<b>Market-Specific Knowledge:</b> “Knowledge about characteristics of the specific national market (business climate, cultural patterns, structure of the market system, and, most importantly, characteristics of the individual customer firms and their personnel)” (p.28). It is gained mainly through experience in the market” (p.28).	<b>Degree of Commitment:</b> “The more specialized the resources are to the specific market the greater is the degree of commitment” (p.27).
Knowledge Opportunities (Uppsala Model 2009)	Network position (Uppsala Model 2009)
Opportunities to increase market knowledge. Needs, skills, strategies, and networks connected to the firm represent channels of knowledge.	Internationalization initiative emerges within a network once the firm has positioned in the local market and benefits from the learning, trust and commitment building of partners.
Change Aspects	
Commitment Decisions (Uppsala Model 1977)	Current Business Activities (Uppsala Model 1977)
<b>Economic effect:</b> “is associated primarily with increases in the scale of operations on the market” (p.29).  <b>Uncertainty effect:</b> “concerns the market uncertainty, that is the decision-makers' perceived lack of ability to estimate the present and future market and market-influencing factors” (p.29). This can be significantly reduced by frequent interactions and integration with the target market “communication with customers, establishment of new service activities or, in the extreme case, the	<ul style="list-style-type: none"> <li>○ “The more complicated and the more differentiated the product is, the larger the total commitment as a consequence of current activities will come to be,” (p.28) this can be called a competitive advantage.</li> <li>○ The firm current activities are what constitute its main source of experience. Within every activity performed in the organization, there is experience implied; it can be whether by hiring personnel with a specific background or gained</li> </ul>

<sup>47</sup> The establishment of similar type of business in a different set of markets (Ibid).

take-over of customers” (p.30).	<p>through persons with experience by consulting.</p> <ul style="list-style-type: none"> <li>○ The gap between the firm and the market can also be filled out by facilitators. They interpret, transmit and connect both ends.</li> <li>○ Production is dependent on the general business climate and can only be assessed by the overall performance of the business.</li> <li>○ Hiring new personnel might bring some constraints specially at the beginning. It is recommended then to hire a sales manager with experience in the market or buying portion of assets in the target market.</li> </ul>
<b>Relationships Commitment Decisions (Uppsala Model 2009)</b>	<b>Learning, Creating, and Trust-Building (Uppsala Model 2009)</b>
In this way, the firm is autonomous to decide whether to increase or decrease its levels of commitment to one or more relationships within the network.	The speed, intensity, and efficiency of the learning process, creating knowledge, and trust building; these are concepts of intellectual and social capital.

Based on (Johanson & Vahlne, 1977, 1990, 2009)

## **Appendix B**

### **List of Interviewees**

Acosta-Rúa, A. Personal Communication (October 5, 2012)

Cardenas, C. Personal Communication (September 04, 2012)

Castillo, M. Personal Communication (September 04, 2012)

Cook, B. Personal Communication (September 04, 2012)

Cortés-Rodríguez, J. Personal Communication (August 20, 2012)

Giraldo, F. Personal Communication (July 26, 2012)

Gómez, C. Personal Communication (July 26, 2012)

Moreno J. Personal Communication (October 20 2012)

Perdomo, C. Personal Communication (September 04, 2012)

Ramirez, S. Personal Communication (September 21, 2012)

Rojas-Carmona, L. Personal Communication (September 04, 2012)

Sanchez-Velez, C. Personal Communication (July 13, 2012)

Stephano, R. M. Personal Communication (September 04, 2012)

Uribe, J. Personal Communication (September 04, 2012)

Wachong-Solis, L. Personal Communication (October 3, 2012)