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The creation of sustainable competitive advantages in internationalizing private Swedish medical firms – a conceptual framework based on two empirical cases

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Abstract

Title

The Creation of Sustainable Competitive Advantages in Internationalizing Private Swedish Medical Service Firms - A Conceptual Framework Based on Two Empirical Cases

Introduction

Although the business for medical services have become increasingly internationalized there is little knowledge about how medical service firms go about this and how they tend to use their individual strengths in the long-term perspective in the international market.

Research Question

How may private Swedish medical service firms build sustainable competitive advantages in the international market?

Methodology

A qualitative case study method with an abductive research approach was chosen and based on a market firm analysis of two empirical cases a conceptual framework was created to answer the research question.

Results

The empirical case firms balance between their available resources and their institutional context. They also poise a focus on internal rational decision-making with how business strategy is formed by external factors. On the basis of these four key concepts the present thesis introduces a conceptual framework to answer the research question.

Conclusion

Strong institutional constraints of the Swedish healthcare system favor the institutional-oriented profile on the home market. On the other hand, the more flexible resource-oriented profile seems to have an easier ticket in the international context.

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1. Introduction

In the last decade, medical service firms have been internationalizing at an increasing pace driven by changing demographics in an aging population needing, willing and financially able to seek knowledge-based, specialized treatment and care. Furthermore, the internationalization of medical services has been made possible by technology advancements and an increasing mobility across borders, both by patients and the providing medical service firms. A general international trend towards more open markets through deregulation and privatization, thus increasing competition, has also been a contributing force behind internationalization in this sector (Orava, 2002).

Since the 1990's Swedish welfare has been gradually deregulated from a near state monopoly, thus slowly shifting towards a more diverse funding and provider system composition (Ekonomifakta, 2013). The healthcare sector, in which medical service firms operate, is a well representative case in this aspect. Traditionally, health care in Sweden has been exclusively publicly financed and provided by public actors. However, in the last decade private medical insurance has nearly quintupled in Sweden (LIF Rapport, 2010). Recent liberalizing legislation of the Swedish healthcare sector, i.e. in primary care, has changed the provider preconditions and opened up for more private initiatives on this level of the system (Konkurrensverket, 2010). The Swedish market for medical services, with increasing deregulation and privatization, is therefore a typical case in the international context. In addition, Swedish health care in general, and medical services in particular are ranked among the highest in the world, both in question of efficiency and quality of care. This gives Swedish medical service firms a resource advantage in the international market (Anell, Glenngård & Merkur, 2012). However, although Swedish medical service firms have obvious potential there are, as far as we know, no published academic papers on how they internationalize and are made long-term competitive abroad. Except for a few contributions there is little international knowledge about how medical service firms internationalize and build sustainable competitive advantages in foreign markets (Orava 2002, Barnes, 2006). Moreover, there seems to be a lack of an adequate conceptual framework to encounter these issues (Lindberg, Styhre & Walter, 2012).

Acting within such a unique industry calls for a special theoretic approach to how medical service firms are made defensibly competitive in the international market. Traditional theories of firm internationalization all include different elements of this phenomenon. For example, it can be seen as the proactive, strategic and systematic action of balancing a firm's resource advantages against the price of entering a foreign market on the one hand, and the possible efficiency gains of doing so on the other (e.g. Dunning, 1980; 1988). Firm internationalization can also be viewed as a behavioural process. This approach describes a constant reactive interaction of experiential knowledge and the commitment of resources to a new market. Through this dynamic relationship it is then proposed that the incremental development of a certain firm's international engagement is driven (e.g. Johanson & Vahlne, 1977; 1990). A third way of explaining how and why firms internationalize is by highlighting its external network embeddedness on different levels as the key driving factor (e.g. Johanson and Mattson, 1988). With the network approach internationalization decision-making is described as being either reactive or proactive or both (ibid; Shama & Blomstermo, 2003).

DiMaggio and Powell (1983) pointed at an alternative view of explaining organization development. Instead of being shaped by individual attributes and motives their new institutional theory seeks cognitive and cultural explanations of social and organizational phenomena. The main proposition of the new institutional theory is that organizations in the same field tend to conform pressured by the prevailing rules, norms and beliefs in the environment (Clemens & Cook, 1999). Carolan (2008) studied these institutional pressures in public education, which in many ways is similar to healthcare. Carolan's main finding was that however different the systems were originally designed they were homogenized over time because of the expectations of the consumers and other organizations of public interest (ibid). However, institutional pressures do not explain obvious dissimilarities in the internationalization patterns of firms within the same institutional context (Orava, 2002). Barney (1991) explains why firms differentiate with the resource-based view. The resource-based view is the foundation of the theory of competitive advantages, which states that the firm who controls a certain value-adding resource has an advantage over its competitors. To maintain this advantage on a longer term the firm is forced to keep the resource hard to imitate and substitute. This explains heterogeneity among firms in the same sector and identical institutional settings (Barney, 1991).

This heterogeneity is most evident in the Swedish healthcare industry with fundamentally dissimilar preconditions on the local and municipal level due to different demographics and geographical conditions as well as differences of financing, access, provider ownership and payment systems (LIF Rapport, 2010). This is what makes the business terms of the healthcare industry in which medical service firms operate unparalleled to any other knowledge-intensive service industry (Morrisey, 2008). It also makes it highly interesting to know how medical service firms are made sustainable competitive in the international market.

1.1 Purpose

Building on other academic research and our own empirical findings our purpose with this thesis is to show how two private Swedish medical service firms have used individual strengths in their respective internationalization processes to compete in the long-term perspective on foreign markets.

1.2 Research Question

How may private Swedish medical service firms build sustainable competitive advantages in the international market?

2. Theoretical Background

To capture the complexity of our research question it is necessary to seek a special theoretical perspective. In search of a suitable perspective we present three major theories of firm internationalization, i.e. the economic approach, the behavioural approach and the network approach as well as institutional theory and the resource-based view. We will later take time to argue for the most suitable perspective once the empirical findings have been introduced. The reason for this is to motivate a theoretic perspective of profound and holistic explanations due to the uniqueness of the particular industry of medical services.

2.1 Firm Internationalization Theory

2.1.1 The Economic Approach: the Eclectic Paradigm

Dunning's (1979) eclectic paradigm or OLI-framework tries to explain why firms choose to engage in international production instead of domestic production or exports in their attempt to serve and supply domestic and international markets. The likeliness of firms to engage in international production depend on the combination and fulfilment of three conditions; ownership, internalization and localization advantages (ibid). Ownership advantages are firm specific assets that in some way are unique to the firm (Dunning, 1992). The assets can be either actually possessed by the firm or acquired. Critical is that the assets are available to the firm on more advantageous terms compared to other firms (ibid). The assets can likewise be both tangible, such as natural resources and capital, and intangible, such as technology and managerial skills (ibid). To fulfil the second condition, internalization, it must be more profitable for the firm to transfer the ownership advantages to the foreign market within the firm instead of selling or leasing them to foreign firms (Dunning, 1979). Location advantages are location specific factors in the foreign market that are immobile but can be used jointly with the firm's ownership advantages (Dunning, 1988). The location advantages therefore deal with the "where" of production (ibid). Location advantages can be a large market, low labor costs or a strong government supporting the industry in a country (ibid).

2.1.2 The Behavioural Approach: the Uppsala Model

In the behavioural approach the Uppsala model is one of the most well-known theories. The model describes the gradual intensification of activities and commitment of firms to foreign markets based on firms increasing market knowledge (Johanson & Vahlne, 1977). According to the model the lack of market knowledge can hinder the internationalization process of firms (ibid). It is claimed that market knowledge is mainly accumulated through actual operations in specific foreign markets. Thus, lack of experience or market knowledge of foreign markets lead to lower commitment to foreign markets. But when experience has been accumulated by firms commitment increases (ibid). The type of knowledge that is most critical in the internationalization process of firms is so called experiential knowledge; knowledge that can not be taught but only learnt through experience from actual operations in the particular foreign

market (ibid). It is experiential knowledge that enables firms to perceive the real opportunities and problems in the foreign market and therefore is crucial in the decision-making process of committing further into the market (ibid).

2.1.3 The Network Approach

The network approach focuses on firms' network relationships with network partners, such as other firms, customers and distributors, to explain the internationalisation behaviour of firms (e.g. Johanson & Mattson, 1988). Accordingly, firms are driven into foreign markets through its network relationships with its network partners (Chetty & Blankenburg Holm, 2000). In their study of entrepreneurial firms Coviello and Munro (1995) found that firms' foreign market selections and decisions to enter foreign markets not only originated from managers strategic decisions, but also from information obtained from network partners. They also found that both more formal networks, such as business networks, and informal networks consisting of friends and family, can be sources of business opportunities (ibid). Johanson and Vahlne (2009) added a network approach to the Uppsala model through emphasizing the importance of network relationships in the market knowledge acquisition in foreign markets. Instead of stressing that firms market knowledge acquisition mainly is driven by firms independent operations in foreign markets as initially stated in the Uppsala model, a new focus on networks as sources of knowledge acquisition was added (ibid). The networks and the foreign market knowledge acquired through them thus was claimed to function as a basis for further commitment to foreign markets (ibid). According to Johanson and Mattson (1988) the extent of a firm's internationalization depends on the firm's ties to foreign networks.

2.2 Institutional Theory

In institutional theory organizational change tends to be less driven by competition and efficiency-seeking among organizations and to a greater extent affected by the influence of the state and professions (DiMaggio & Powell, 1983) In the beginning of their life-cycles organizational fields show signs of diversity in structures and outputs, but once more established, organizational structures, cultures and outputs seem to be driven against conformity. Organizations thus by time become more homogenized (ibid). But organizations not only adapt to

the institutional context they operate within, they also shape the same institutional context affecting other organizations within it (Meyer & Rowan, 1977).

The homogenization among organizations in the same organizational field is driven by the rewards in form of increased legitimacy, resources and chances of organizational survival that organizations obtain from the conformity (Scott, 1987). Legitimacy is a fundamental concept within the new institutionalism and can be described as actions of organizations that are desirable, proper, or appropriate within a social system of norms, values and beliefs (Suchman, 1995). Accordingly, organizations gain legitimacy from institutional relations through conforming to social expectations and obtaining social support for its actions leading to organizational success (Baum & Oliver, 1991).

Organizations operate in institutional environments consisting of regulative, normative and cognitive institutions affecting organizational legitimacy (Scott, 1995). Regulative institutions refer to national laws and rules in the institutional environment that promote or restrict organizational behavior (Kostova & Roth, 2002). Normative institutions include both norms and values. Values reflect the preferred and desired behavior while norms refer to appropriate and correct behavior (Scott, 1995). Or according to Scott (1995; pp 37); "Norms specify how things should be done". Cognitive institutions can be referred to as shared social knowledge that affects how things are categorized and interpreted (Kostova & Roth, 2002). It can be symbols such as words and gestures or shared meanings in a society that influence how people perceive an activity or an object (Scott, 1995).

Every country has a specific institutional profile consisting of certain regulative, normative and cognitive institutions (Kostova & Roth, 2002). But to best explain homogenization among organizations the concept of isomorphism is needed (DiMaggio & Powell, 1983). Isomorphism is "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions" (ibid; pp 149).There are three types of institutional isomorphism or mechanisms that exercise institutional pressure on organizations and impose the

described institutions upon the organizations: coercive, normative and cognitive isomorphism (Scott, 1995).

Coercive isomorphism, the main mechanism for regulative institutions, refers to institutional pressure on organizations by the government and other organizations. The organization can feel forced, persuaded or invited to conform to such pressures (DiMaggio & Powell, 1983.). Normative isomorphism, the main mechanism for normative institutions, originates from professionalization. Formal education and professional networks are therefore important sources of institutional pressure on organizations since they are making knowledge and skills among people in a certain industry more similar (ibid). Mimetic isomorphism, the main mechanism for cognitive institutions, stem from uncertainty in the environment that organizations operate within. To respond to such uncertainty organizations tend to resemble the behaviour of organizations in the industry that are perceived to be successful or legitimate (ibid).

2.3 The Resource-based View

A firm's resources can be viewed in many different ways, but in the sense of the word they include all properties empowering the firm to follow an effective and efficient economic strategy (Daft, 1983). Penrose (1959) argued that the firm consists of 'a collection of productive resources' (Penrose, 1959). These resources may contribute to the firm's competitiveness if it is able to make use of their valuable services. This proposition was later formalized by Wernerfelt (1984) and named the resource-based view.

Prahalad (1990) stated that a firm manager's most important undertaking is the product development process. They also argued that the determinant factor to this process is how well the firm is able to use its core competence. The resource-based view is often looked upon as in part the rational internal decision-making process, and in part the external factors affecting firm strategy, such as present and future rivalry, market configuration and buyer-supplier power structure (Conner, 1991).

Barney (1991) continued to evolve the resource-based view by adding two fundamental assumptions to it, namely that resources are heterogeneously distributed and imperfectly mobile

among firms in the same industry. The contributing factors to these phenomena have been identified as market imperfections, such as the impediment to acquire, imitate and substitute certain resources (Penrose, 1959). The existence of market imperfections explains why differences in resource endowment may exist and persist over time between firms with essentially identical preconditions. This, in turn, allowed for the creation of the theory of competitive advantages (Barney, 1991).

The criteria for turning a certain resource into a competitive advantage are that it holds value and rarity thus creating added short-term value to a specific firm against all others in the same field (ibid). To keep this advantage the resource needs to be kept hard to imitate and substitute (Dierickx & Cool, 1989). When a firm is exclusive in implementing a value-creating strategy in a market and no other firm is able to duplicate the benefits of this strategy it is said to be a sustainable competitive advantage and thus generating above average returns to the particular firm (Barney, 1991).

3. Methodology

3.1 Research Approach

To answer our research question we have chosen the qualitative case study method, which is particularly suitable in the object of building theory out of an empirical phenomenon (Eisenhardt, 1989). Further, we have chosen an abductive research approach, which is significant to the constant exchange between theory and empirical findings in our research process, where we have projected real-life data against a literary background and academic reasoning to unveil and inspire philosophical patterns and new theoretical interpretations (Dubois & Gadde, 2002).

3.2 Sampling procedure

Our purposive sampling is based on our insights in the literature and in relevance to our research question (Merriam, 2009). Private Swedish medical service firms, as defined by Orava (2005) below, are our targeted population.

The goal of qualitative research is to look for variations of a certain phenomenon and not for strict statistic incidence (Eisenhardt, 1989). A scope of all possible research subjects matching the definition above were extracted from a comprehensive list by the Swedish branch organization Swecare (Swecare, 2012). They were in alphabetical order Aleris, Capio, Global Health Partner, Mando and Scandinavian Care. Based on access and convenience sampling after evaluating the quality of information we were able to gather as a step in our pre-analysis of each of the five mentioned firms we selected two out of these, namely Capio and Global Health Partner (Merriam, 2009).

3.3 Description of Research Subjects

Medical service firms are part of the life science industry and the broader healthcare sector in which life science firms operate. The life science industry consists of various sub-industries in the fields of research, development and production of health care products and services. In particular there are three sub-industries within the life science industry; medical care, pharmaceuticals, and other health related industries. Medical services are part of the medical care industry within the broader life science industry (Orava, 2005).

3.3.1 Capio

Capio is a leading medical service company in Europe providing a comprehensive range of medical services within medicine, surgery and psychiatry. Founded in 1994 the company today has around 140 operating units, everything from specialized clinics to large emergency hospitals, in Sweden, Norway, France, Germany and Great Britain. In 2012 the 11000 employees treated 2.9 million patients generating a SEK 12 billion turnover for Capio. Capio acquired Carema Care with 7000 patients from Ambea in 2012 (Capio, 2013).

3.3.2 Global Health Partner

Global Health Partner is a private healthcare company providing specialised care within selected treatment areas and is focusing on Spine surgery and rehabilitation, sports orthopaedics, bariatrics (obesity treatment and surgery), gastro, general surgery, arrhythmia (treatment of heart rhythm

disorders), maternal health care and specialist dentistry. Established in 2006 Global Health Partner today operates 20 clinics in four countries; Sweden, Finland, Denmark and the United Arab Emirates. In 2012 Global Health Partner had around 390 employees and an approximate turnover of SEK 700 million (Global Health Partner, 2013).

3.4 Data Collection

Our initial intention was to perform in-depth interviews with key personnel at the chosen firms. However, denied interview access forced us to dismiss this method of data collection. Pre-analyzing Capio's and Global Health Partner's annual reports of 2012 further we concluded that we were able to perform our research on the basis of these reports instead of interviews (Eisenhardt, 1989). Merriam (2009) describes data collection from documents as a rich and more complete source of information since these documents are less limited by motives and constraints than observations and interviews. The general transparency of the annual reports also made us confident that this source, in fact, would be the most objective one and that it would give us the most accurate answers to our research question.

Different methods of data collection are often complementary to each other and this is referred to as triangulation (Merriam, 2009). In our study triangulation was reached by using both quantitative data and qualitative information from the two firm's annual reports as well as to establish the branch-specific surrounding context of Swedish healthcare and the same for the other countries the two firms had chosen to establish themselves in. This contextual data was also both quantitative and qualitative in its nature and it constituted the institutional setting extracted mainly from supranational statistic materials from the Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO), and the World Bank (OECD 2012; WHO, 2013, World Bank, 2013). Accordingly, all information was taken from secondary sources.

3.5 Research Process

To enhance the authenticity of the study it is important to show all variations in the material (Merriam, 2009). To achieve this there is a need for constant overlap between data collection and analysis (ibid; Eisenhardt, 1989). The abductive approach offers the possibility of doing so. It is, in a sense, the very essence of this approach which serves as an incremental and dynamic exchange between empirical findings and theory (Dubois & Gadde, 2002). Our research process started in theory by collecting and reading literature on firm internationalization, in general, and internationalizing medical service firms in specific. This knowledge was then applied to our selected cases and their markets in a pre-analysis and early assessment of expected results, mainly based on intuition and creative speculation by the authors.

From the pre-analysis of empirical data we went back to a more specific literature review based on practical constraints of our sources, such as the information we were able to find and so forth. With a deeper theoretical understanding we were able to outline a coded protocol with an initial categorization of our collected data of firms and markets. To better understand some relationships we had to both make an additional literature review and a parallel check back into our empirical sources. Based on these new insights we could finish our protocol. The categories of information on markets and firms went through an added analysis process in which we drew matrices which helped us see additional patterns and inter-connections in the material. This gave us supplementary information to categorize and analyze.

In the end we reached saturation through exposure of complete variation in our collected data. This involved a market description of mixed resource and institutional factors in all the health care systems the two firms had chosen to establish themselves in as well as a case comparison of firm attributes. The market material was categorized into four different domains, namely “Health care financing: Public vs private financing”, “Access to healthcare: Primary care role”, “Provider ownership” and “Provider payment”. These concepts were, first of all, defined and then summarized in table 1 as a description of the different markets of each country’s healthcare system. To specify certain market factors there is also a short description of each of the healthcare systems following this section. The firm comparison was separated into eight different categories, namely “Core business concept”, “Model and method”, “Organization and human

resource management", "Care chain characteristics", "Quality assurance", "Reputation and branding", "Financing and ownership" and "Future challenges".

We went on to argue for the most suitable theoretic perspective supported by our empirical findings. Because the choice of theoretic perspective is very much dependent on the empirical cases we chose to present it after the establishment of our findings in the thesis. It is our firm belief that choosing a perspective before describing the special case of the healthcare industry would be jumping to conclusions. Next, the market description and firm comparison went through a synthesized analysis based on our chosen theoretic perspective. This market firm analysis is presented as two separate case analyses in the thesis. These two case analyses were then conceptualized into a model framework, which in turn answered our research question of how the two case firms build sustainable competitive advantages in the international market.

3.6 Quality of Research

The quality of research of a certain study is determined by its reliability and validity. The latter is also categorized into one internal and one external dimension (Merriam, 2009). Internal validity, i.e. the issue of how well the findings match reality, is in part ensured with the inductive reasoning approach, which in its nature is a dynamic mirroring process where empiricism is constantly contested against conceptual theory. Internal validity is also enhanced by our triangulation method, through two investigators and multiple sources of data (ibid).

Reliability is defined as how well a certain study can be reproduced (Merriam, 2009). In qualitative research it is more of a measurement of how dependable the findings are (ibid). For this purpose there is a need for this profound description of methodology. Following this path the present study can certainly be reproduced. Nevertheless, it has to be said that connections to theory can be done in dissimilar ways thus altering some assumptions made and ending up with a different outcome (ibid).

External validity measures how well the findings can be generalized. This is, however, not the object of qualitative research, which instead focuses on describing a phenomenon (Merriam,

2009). The closest we get to generalizations is to show typical variation in the data material. We believe we can ensure typical variation through our thorough analysis of the two cases and their chosen markets. It is then up to the reader to evaluate the generalized inferences of the results.

4. Empirical Findings

Using our chosen research approach to answer our research question it is essential to look at the different national contexts in which a certain firm operates as well as the attribute profile that firm carries in order to build sustainable competitive advantages in those markets. Both areas contain elements of both resource and institutional factors affecting the firm in different ways. Our empirical findings are therefore twofold and presented likewise as first of all a *Market Description* of the health care systems of all the individual countries, including Sweden, the two firms have chosen to establish themselves in, and secondly a *Firm Profile Comparison* of the two medical service firms, Capio and Global Health Partner. It is then through cross-examination of the two materials the main analysis has been carried out.

4.1 Market Description

In the market description the healthcare systems of the different countries Capio and Global Health Partner have established themselves in are presented. Each country's system is described by four main categories: health care financing, access to healthcare, provider ownership and provider payment. These four categories constitute the specific industrial environment of healthcare and serve as both incentives and constraints for the business of medical services (LIF Rapport, 2010). First the main categories are defined, and then the table with the four main categories of each country is presented. The table data is collected from reports by the World Health Organization and the Commonwealth Fund. Lastly, to specify certain market factors each country is presented with a short description.

4.1.1 Definitions

4.1.1.1 Health care financing: Public vs private financing

Health care can either be publicly or privately financed. The private financing then can be divided into private out-of-pocket payments made by the patients and private payments made by insurance companies. The share of public financing indicates the state's power to interfere in the medical service field and to what extent the society is considered to be responsible for the medical treatment of its citizens. It has been shown that a higher degree of private out-of-pocket payments decreases patients' access to healthcare (Wendt, 2009).

Because of the relatively large share of public funding in the medical service industry public procurement has a prominent role in this industry. Traditionally low price, and not high quality, has been rewarded in the public procurement procedures taking place within the medical service industry. Since large actors have taken advantage of scale economies they have been able to offer lower prices than small actors. Therefore, large actors have been favored in the public procurement procedures and been better placed to win public medical service contracts than small actors (Bergh, 2012).

4.1.1.2 Access to healthcare: Primary care role

In the medical service sector actors outside the primary care are dependent on if patients need referrals from general practitioners (GP's) in the primary care in order to gain access to hospitals and specialist clinics. In countries where referrals are not needed patients can choose providers more freely and the so-called gate-keeping is weak. On the contrary, in countries where referrals are needed gate-keeping is strong which complicates for patients to access hospitals and specialist clinics (Wendt, 2009). Another factor affecting patients' access to healthcare is whether they need to register with a GP to be able to access the healthcare or if registration is not needed. This can be more or less regulated by the state (Wendt, 2009).

4.1.1.3 Provider ownership

Medical services can either be provided by the public or the private sector where medical services provided by the private sector are characterized by not being directly controlled by the state

(Orava, 2005). Private ownership can either be non-profitbased or profitbased (Commonwealth Fund, 2012).

4.1.1.4 Provider payment

How medical service providers are compensated can be more or less regulated by the government. Global budgets are expenditure budgets that are set by the government to control costs of health care services, and provide medical service firms with incentives to be more efficient in order to earn more money (WHO, 2004). However, case-based and fee-for-service payment systems, where costs are less regulated by the government, strengthen the incentives for medical service firms to see patients and thus earn more money. Hence, case-based and fee-for-service payment systems affect the level of health care provided and patients' access to health care (Wendt, 2009). Another payment system for medical service providers is capitation that reimburses providers for each patient that is assigned to them regardless of whether the patient seeks care or not. Capitation is the payment system that most commonly lead to overuse of referrals (Wranik, 2012). Medical service providers can also be compensated simply by a monthly salary where the control over the payment is the highest (Wendt, 2009). Generally, capitation and salary based payment systems, where costs are more regulated by the government, weaken the incentives for medical service providers to see patients and earn money (Wendt, 2009). Finally, in pay-for-performance (P4P) payment systems reimbursement of medical service providers is linked to the quality and efficiency instead of the quantity of the provided services. This payment system has the potential to strengthen the economic incentives for medical service providers that focus on providing high-quality medical services (Glickman & Peterson, 2009).

4.1.2 Healthcare Systems

Table 1. A market description of the different healthcare systems the two empirical case firms, Capio and Global Health Partner, have chosen to establish themselves in.

	Health care financing: public vs private (in %)		**Access to healthcare: Primary care role**		**Provider ownership**		**Provider payment**	
Healthcare system	Public	Private	Registration with GP required	Gate-keeping	Primary care	Hospitals	Primary care	Hospitals
Denmark	85.2	14.8	Yes	Yes	Private	Almost all public	Mix capitation/ FFS	Global budgets + case-based payment
Finland	74.8	25.2	Automatically within own municipality	Yes	Mainly public	Almost all public	Mix salary/capitation/FFS	Salary
France	76.7	23.3	Not mandatory, but incentives to register	Not in general, but incentives for referral	Private	Mostly public and private non-profitbased	Mix FFS/P4P	Mainly case-based payment
Germany	75.9	24.1	No	Not in general but in some cases	Private	50% public 33% private non-profitbased 17% private profitbased	FFS	Global budgets + case-based payment

	Health care financing: public vs private (in %)		Access to healthcare: Primary care role		Provider ownership		Provider payment	
Healthcare system	Public	Private	Registration with GP required	Gate-keeping	Primary care	Hospitals	Primary care	Hospitals
Norway	85.6	14.4	Yes	Yes	Private	Almost all public	Mix capitation/FFS	Global budgets + case-based payment
Sweden	80.9	19.1	Yes	Not in general, but incentives for referral	Mixed	Almost all public	Mix capitation/FFS /P4P	Global budgets + case based payment
United Arab Emirates	74.4	25.6	N/A	N/A	Mostly public	N/A	N/A	N/A
United Kingdom	82.7	17.3	Yes	Yes	Mainly private	Mostly public, some private	Mix capitation/FFS /P4P	Mainly case-based payment

4.1.2.1 The Swedish Healthcare System

While most hospitals in Sweden are publicly owned the provider ownership in the primary care sector is more diverse (Table 1). The privatization of primary care can mainly be explained by the deregulation of the sector that has been in progress since the 1990's. The deregulation has resulted in mandatory medical service provider choice for patients and freedom of establishment for private providers. In 2012 around one-third of the primary care practices were privately owned (The Commonwealth Fund, 2012). Generally, deregulation has led to the establishment of more actors in the Swedish market for medical services increasing competition and quality of the provided services (Konkurrensverket, 2010).

However, although increased privatization, medical services in Sweden are still characterized by a profound public involvement considering the funding of the industry. Around 81 per cent of the Swedish health care is publicly financed (table 1). Privately financed health care is mostly made up of out-of-pocket payments representing 17 per cent of total health care financing. Private health insurance, accounting for only two per cent of total health care funding, is an increasing share of funding (WHO, 2013).

4.1.2.2 The Norwegian Healthcare System

With one of the highest total expenditure on health per capita in the world Norway seems an attractive country establishing medical service firms within (WHO, 2013). Further, Norway has top-level gross national income per capita on the global level and among the highest shares of public funding of health in the OECD countries (World Bank, 2013, OECD, 2012). Hence, the Norwegian market can be held to possess high potential for business firms in general, and it is a stable environment for medical service firms in particular.

4.1.2.3 The French Healthcare System

While public expenditure on health is on moderate level in France compared to other OECD countries the relatively high importance of private insurance in the country stands out on the European level (OECD, 2012, WHO, 2013). In France almost 15 per cent of the total financing of health care is made up by private insurance (WHO, 2013).

Gate-keeping in France is very weak facilitating for actors outside the primary care to attract patients since these can access hospitals and specialist clinics without initial contact with primary care. Case-based payment is the prevalent payment system for hospital operators in France thus differing from the otherwise most commonly used payment system of global budgets in the OECD countries (Table 1).

4.1.2.4 The German Healthcare System

Germany has many similarities with France considering the importance of private health insurance and the features of the gate-keeping system. Germany, in a European context, relies to a relatively high degree on private insurance as a source of funding of medical services; private

insurance making up around ten per cent of total expenditure on health (WHO, 2013). Germany has a weak gate-keeping system with low barriers for patients to access hospitals and specialist clinics. Further, Germany has a high degree of privately owned hospitals in European terms with around 50 per cent private ownership. In Germany fee-for-service payment is the prevalent payment system in the primary care sector (Table 1).

4.1.2.5 The British Healthcare System

The U.K is similar to Norway regarding the role of public financing and has a relatively high public expenditure on health in comparison with other OECD countries (OECD, 2012). In the U.K case-based payment system is the prevalent payment system for hospitals (Table 1).

4.1.2.6 The Finish Healthcare System

Finland has the highest degree of total private funding and the highest degree of funding from private health insurance in the Nordic countries (WHO, 2013).

4.1.2.6 The Danish Healthcare System

With among the highest per capita total expenditure on health in the OECD countries Denmark appears to be an attractive place for medical service firms in general to establish operations within (OECD, 2012). Denmark has the second highest private health insurance funding in the Nordic countries (WHO, 2013).

4.1.2.8 The United Arab Emirates Healthcare System

The United Arab Emirates creates general incentives for business firms to establish operations within the country by being one of the top ten countries in the world considering gross national income per capita (World Bank, 2013).

In the United Arab Emirates funding from private health insurance companies is relatively high; as a comparison such financing is three times more common than in any Nordic country (WHO, 2013).

4.2 Firm Profile Comparison

The following is categorized and descriptively analyzed data material extracted from the two company cases' annual reports of 2012. The data is categorized into eight different aspects to reflect the complete variation in the empirical material.

4.2.1 Core Business Concept

Capio's core business concept is that of generic Swedish health care, both in model and method. Accordingly, their strategic fit of expansion and internationalization is very much based on the Swedish system. As Sveneric Svensson, head of Capio's business area France puts it: "Through the (Swedish) organization model we are able to create systematic improvements, both in quality and productivity" (Capio, 2012; pp 15). With the power of a big actor Capio has the possibility to create volumes for economies of scale which enables it to offer a lower price. This, in turn, helps Capio to win large procurement contracts both at home and on the international market.

Global Health Partner's (GHP) corresponding strategy is, instead, that of focusing on certain niches to fill in gaps of specialized operations in the system. This is essentially – and particularly compared to the case of Capio – more driven by the laws of supply and demand, which in turn opens for improved opportunities for financing, i.e. the customer seeking this kind of specialized care is also willing to pay for it.

The base of GHP's different activities is to fully cover a few diagnostic areas with concentrated and tailored sub-specialist competence at focused business area centers. The idea is to create virtues of cost effectiveness as well as quality benefits for the patient. Marianne Dicander Alexandersson states: "Our focus on specialist care is our strength giving us the ability to remain competitive within our business area" (Global Health Partner, 2012; pp 4).

4.2.2 Model and Method

Capio's mission to "care, alleviate and comfort" and the core values of care, compassion and quality are set out as the foundation of their business model. It implies that Capio is grounded on soft values and norms developed and applied in an organizational context.

GHP on the other hand relies on a totally different set of core values. The new CEO of GHP, Dicander Alexandersson, even states that "We are not into caring and tending; the medical service we provide is production and can be measured as such" (Global Health Partner, 2012; pp 3). Patient treatment and care are, of course, acknowledged and addressed by GHP, but turned into harder key performance indicators through quantification. These numbers are then seen as a measurement of customer trust and firm legitimacy. In GHP's annual report of 2012 domains of efficiency and accessibility are put above patient treatment and care as key drivers of qualitative medical services, both for the individual patient and society as a whole.

Capio ensures its quality-centred organizational method in a four-legged model of modern medicine, good information, kind treatment and finally nice environment and adequate equipment. On these four legs Capio's intention is to fire an ongoing process of development within the organization. This is consolidated into the motto of "Quality Drives Productivity". The continuous organizational improvement process is to be driven by staff initiatives and facilitated through company routines, training programmes and internal recruitment. The object is to build a high level of medical competence inside the organization in order to reach the goal of "improving life quality for every individual patient" (Capio, 2012; pp 2).

GHP's motto is "Quality through Specialization" which, at first, sounds almost the same as Capio's. However, a deeper analysis of GHP's definition of quality is that it is drawing towards a synonym of efficiency, which is problematized below. In this context the semantic usage of quality as efficiency implies a closer focus on internal factors within the company as a well-run medical firm. This also has implications on GHP's model, which in analogue to the internal perspective, is based on business strategy rather than fundamental values: "…combining a small company's flexibility and closeness to the customer with the muscles of a large company" (Global Health Partner, 2012; pp 5). The strategy cornerstones to GHP's business model are except for the mentioned "quality through specialization" also a geographical Nordic focus, a decentralized organization and internal/external networking through the partnership model and collaboration respectively. In this model the patient, and not the organization, is seen as the motor and combining factor to all four cornerstones.

In Capio's model the patient is, instead, the outcome of the organizational process to improve quality of life. The latter can be seen as more of a bottom-up and holistic approach, compared to GHP's somewhat top-down and highly specialized approach, which focuses more on internal strengths than external opportunities.

4.2.3 Organization and Human Resource Management

Capio's model and method rely on the strengths of the organization and above all the people working in it. Accordingly, the company is putting a major focus on HRM issues and collective participation. These entities are also a central part of Capio's branding as well as the continuous value enhancing knowledge process and quality assurance work within the organization.

At GHP personnel is seen as a valuable asset among others and it is up to the company to attract the best competence. The decentralized organization is complemented by headquarter techno-staff and management able to support and somewhat coordinate the disperse operations in the loosely connected network of individual specialized clinics. Value-enhancing efforts and initiatives by GHP personnel are encouraged, but there seem to be a lack of an outspoken strategy for this.

4.2.4 Care Chain Characteristics

Capio has operations on all different levels of the Swedish healthcare system, i.e. primary, hospital and specialist care, except for university hospitals. The company is, however, indirectly involved even on this level by actively promoting, financing and in other ways supporting the medical academy and scientific projects closely related to day-to-day patient work within the organization as well as other interesting initiatives.

GHP have chosen to focus solely on specialist care at standalone clinics connected in a partnership-based network of knowledge exchange with other company clinics around the same diagnostic area. There is also an extensive external collaboration on GHP's part to provide a complete and sustainable care chain for the patients being treated at the different business areas. To spell it out, GHP does not control the whole care chain and is forced to networking from

outside-in the rest of the health care system. Accordingly, GHP is also more dependent on direct contact with and information to the patient about their existence to come around the lock-in effect of the Swedish gate-keeping system.

In contrast, it is part of Capio's strategy of accessibility and enhanced quality to cover all levels and thus being able to control the entire care chain. In consistence with the Swedish system, in general, the idea is to relieve and control the flow to hospital and specialist care units. This is meant to save money and increase quality, both on the societal and individual level.

4.2.5 Quality Assurance

In the Capio model quality improvement is the major outcome of all organizational development work. It is described as improvement of patient safety and satisfaction as well as upgrading staff competence. This indicates both an external and an internal view of the results Capio wants to achieve with its quality assurance work. However, since staff competence at Capio is very much measured in how well the whole care chain functions this dimension of Capios quality improvement also draws towards external factors. Hence, Capio's motto of "Quality for Productivity" could be defined as "business as usual within the Capio organization creates opportunities for more business".

GHP's motto of "Quality for Efficiency" implies a more internally-focused perspective of how well resources and capabilities are gathered, allocated and deployed in order to make business as smooth and effective as possible. This view is also supported by how GHP handles staff competence improvement through recruitment and acquisition rather than in an intra-organizational knowledge upgrading process built on a standardized model of their own. The fact that quality assurance work is not totally integrated into GHP's model leads one to believe that GHP deals with these issues more as a consequence of normative branch pressure rather than on direct incentives of activity improvement.

4.2.6 Reputation and Branding

In Sweden private care is in itself an object of extensive questioning and debate. This could be much due to the fact that Swedish health care still is by 81 per cent publicly financed, which raises disputes and a prevailing suspicion about how the issue of profits should be handled (Weibull, Oscarsson & Bergström, 2012). This is, of course, something for both Capio and GHP to work against and in consistence with their different models and strategies they have dissimilar ways of dealing with this matter.

Capio communicates that a good reputation is essential to attract patients. Since listing is mandatory in Swedish primary care it is easy to understand why Capio works hard on keeping a well-reputed brand name. In this, Capio enhances its similarities to public actors as well as its convergence to the over-all Swedish health care system.

GHP's branding strategy is the opposite of Capio's as it is profiling itself as the outsider to the customer. The idea is that a differentiated brand with a strong resource base will appeal directly to the patient and attract the ones willing to raise their out-of-pocket stakes. Considering this, and GHP's dependence on its external networking, it is obvious how concerned GHP is with branch branding as well as employer branding. Keeping a good reputation among its partners makes it easier to recruit the best competence. It is also the prerequisite to be prioritized by insurance companies and progressive county health care governments shifting towards a qualitative-evaluated case based procurement process of specialist medical services.

4.2.7 Financing and Ownership

Capio is by 90 percent publicly financed, which reflects its unanimity to the Swedish health care system as a whole. GHP's financing comes from a 50/50 split between public and private funding. This, of course, makes GHP more dependent on the direct contact with the patient as the paying customer in order to have ongoing business.

On the other hand, GHP is less bound to procurement procedures, which put certain external demands on the various activities within the firm as well as economic constraints due to competition essentially based on price.

The Swedish procurement procedure is very much part of Capio's reality, which is visible in the company model and market strategy. The holistic and bottom-up approach and focus on increasing productivity through economies of scale are all activities in line with a bid-winning best-practice medicine to the lowest price.

As for ownership structure GHP is a limited company – Capio is not – listed on the Stockholm Stock Exchange, NASDAQ/OMX. This makes GHP responsible not only to stakeholders like the Swedish healthcare system and the patients but also to its shareholders, thus perhaps more profit-oriented than Capio needs to be. However, the two companies are both private and private business depends on financial surplus to be kept alive in the longer run.

4.2.8 Future Challenges

Capio identifies its biggest challenge as its internationalization process. Differences between healthcare systems in the countries Capio operates in have already imposed certain strenuousness on the organization and its model. Capio's CEO, Thomas Berglund, states: "Because of different reasons there is a variety of how modern medicine is being practiced in different countries. This certainly affects the outcome and our work very much" (Capio, 2012; pp 8).

GHP's biggest challenge is, in turn, to fit in on the home market. As explained above GHP's business model is not directly compatible to the Swedish healthcare system as a whole. Being a private provider acting only in the area of specialist care makes GHP's operation more vulnerable in the Swedish institutional setting than that of a public provider or even Capio's for that matter. As Dicander Alexandersson puts it: "The healthcare market has been characterized by a tough climate of pressured pricing and also a harsh political debate on welfare profit… (we wish for) more focus on the question of fact, namely what kind of health care Sweden wants and how this could be accomplished" (Global Health Partner, 2012; pp 3). GHP's strategy to fit in is to focus its past somewhat sprawling business areas, both geographically and activity wise. The idea is to be as strong as can be within a few different diagnostic care chains.

5. Analysis

5.1 The Choice of Theoretic Perspective

Health care is by definition shaped by both an abstract organizational system and a more concrete materialistic component (Lindberg, Styhre & Walter, 2012). Supported by our empirical findings the healthcare sector combined with the life science industry of our present-day society in which medical service firms operate is a highly complex setting to do business in. Moreover, there are fundamental dissimilarities in different countries' healthcare systems even within the European Union.

Thus, in order to fully understand the comprehensive picture of our research question of how Swedish medical service firms may build sustainable competitive advantages in the international market it is essential to understand all circumstances and factors influencing this issue. Traditional internationalization theories, i.e. the economic, the behavioural and the network approach, contribute with certain elements to the comprehensiveness of our studied phenomena. However, these major internationalization theories are criticized for only being descriptive (Andersen, 1993) and hard to apply in a broader context (Knight & Cavusgil, 2004). Each one them alone fail to show the entire picture of and mechanisms behind our studied phenomenon, which will be discussed below.

Dunning's eclectic paradigm is a host country outward FDI framework focusing on opportunities in the host country market and not on the ones in the home country market. In other words, all the OLI variables are analyzed from the host country perspective (Rugman, 2010). Looking to our empirical findings we see that Private Swedish medical service firms, instead, use their respective home market advantages to compete internationally. This implies that Dunning's eclectic paradigm is not applicable on how these firms go about competing in the international market.

The incremental view of the Uppsala model might describe this process better. However, it fails to explain how the contemporary knowledge-intensive service firm obtains information about new markets. Nowadays, local legal and financial information is transparent and easily accessed. In-depth analysis can to a greater extent be purchased from international consultancy firms thus

facilitating for firms to gain information about foreign markets. The easier and faster access of knowledge about international markets has also been facilitated by the rapid development of information technology (Hollensen, 2004). The process of slow and gradual building up of in-house knowledge presented in the Uppsala model has therefore become out of date. The changing knowledge gaining process about foreign markets is of particular importance in how Private Swedish medical service firms build competitive advantages in the highly regulated health care systems in the different countries presented in our market description.

Our modern-day information business culture is well covered by the complement of network theory. But, instead, this perspective lacks an in-depth explanation of how relationships initially are created when not existing (Andersson, 2002). In the particular case of private Swedish medical service firms that traditionally have been nationally oriented with only a few links to the international market there is a need for a thorough understanding of both how relationships are created and how to handle the issue of when they are essentially non-existent. Supported by our empirical findings the private Swedish medical service firm is more dependent on the system as a whole than individual relationships when building its competitive advantages in the international market. This is not explained by the network theory.

Oliver (1997) introduced a model combining institutional theory with a resource-based view to describe how a certain firm creates sustainable competitive advantages. In this model a firm's resource capital is defined as assets, competences and architectural capacity adding value to the firm and its institutional capital as contextual factors enhancing the optimal use of the above mentioned. The author concludes that the continuous success of the firm depends on how well it balances its resources and capabilities with the entire social context. Based on the complexity of our empirical findings and the nature of the medical service industry, as a combination of the welfare state and the life sciences, institutional theory complemented by the resource-based view captures our research question better than any of the traditional theories of internationalization we have looked at. Therefore, it will serve as our theoretic perspective.

5.2 Market Firm Analysis

The two empirical case firms tend to use different strategies for long-term survival in the international market. They are also diversely affected by their environment in how they take advantage of opportunities and are hindered by constraints. We now present a synthesized analysis of each of the two case firm's characteristics in relation to their individual new markets of establishment.

5.2.1 The Case of Capio

Capio has chosen to comply with the generic Swedish healthcare system in their model and method. They transfer this concept to new markets serving as a strategic asset and giving the company an edge against its competitors. Capio's bottom-up and holistic approach combined with low costs due to economies of scale work well in most European countries, where there seem to be a perceived notion of a standardized healthcare system. This is why Capio seeks large contracts of procurement covering many levels of the care chain and is successful in landing these contracts all over Europe.

Capio's way of differentiating in the international market is to bring the 'Swedish health care model' abroad. As described above this has given the company success in the procurement procedures of all the countries it has chosen to establish itself in.

Capio's model and method derive from the continuous organizational development process within the firm as well as imitation of other actors in the business. It is also very much influenced by the preconceived conception of what health care should provide and stand for in the individual country markets. Hence, the company has to deal with normative and cognitive pressures both from inside and outside the organization. Furthermore, as a big actor and primarily publically financed in all countries it has established itself in Capio is displayed to different pressures on state level. For example, it is forced to deal with different kinds of regulative pressures to be successful in the procurement processes.

In controlling many levels of the care chain Capio has the opportunity to surpass the lock-in effect of a gate-keeping system. For example, in countries with strong gate-keeping, such as in Sweden and Norway, it is a true advantage to operate on different levels of the care chain which facilitates the flow of patients. Further on, Capio's size in itself and the fact that it resembles the generic Swedish healthcare system could imply somewhat of a market disturbance, at least against smaller actors competing in the same field.

5.2.2 The Case of Global Health Partner

Global Health Partner is gaining its legitimacy as a provider of private healthcare through recruiting, maintaining and transferring its specialist competence as its strategic asset. Both nationally and internationally, it collects this knowledge at its diagnostic-specific units, which creates a certain amount of cost efficiency. However, GHP's operations are still mainly profiled as specialized and high-qualitative isolated medical treatments and less as a low cost alternative. Furthermore, in order to survive GHP is more dependent on gaining industrial-specific legitimacy through networking with other actors in the market, both providers and sources of funding.

As an outsider on the home market Global Health Partner's strategy is to actively distinguish itself from the generic Swedish healthcare system and to be a better complement to it within certain diagnostic niches. As a collection of specialist units GHP seeks to fill in gaps not covered by the health care systems in the countries it operates in. This, in turn, enables the opportunity to attract customers less sensitive to price and more focused on quality and efficiency.

GHP is more exposed to the cognitive and normative pressures on the home market than Capio. These external pressures of what health care should and should not be are more apparent on the outsider firm profile. Further on, with a larger ratio of private funding GHP is more exposed to pressures from private stakeholders. For example, GHP is supported in countries where private funding plays a major role in the financing of medical services. The high degree of private financing, especially from private health insurance, in Finland and Denmark compared to other Nordic countries can facilitate the building of competitive advantages in those countries. Similarly, GHP is supported in the United Arab Emirates; a country where private health

insurance is three times more common than in any Nordic country. Still, GHP is by 50 per cent publically financed and accordingly needs to comply with a certain amount of state level regulative pressure similar to Capio. At last, GHP needs to comply with the demands of its shareholders, which is a unique situation in Swedish healthcare.

Since GHP is not operating on different levels of the care chain it is dependent on networking, both in the provision and the financing areas. For example, GHP is actively working on creating close relationships with large insurance companies in the countries it is operating in to attract private funding.

GHP's way of displacing the free market forces lies in their specialized operations. Specialization creates a supply disorder since this type of high-qualitative treatment care is hard to imitate by other firms in the business. Profiling itself as a better alternative GHP is targeting patients willing to pay more for quality and efficiency.

5.3 Building a Conceptual Framework

Concluded from the market firm analysis Capio is a larger and more diverse organization drawing towards generalized health care operations on many different levels of the system. We label Capio's profile as "institutional-oriented" as it in many ways directly reflects the generic Swedish healthcare system as a whole. GHP, instead, we label as "resource-oriented", being a smaller, network-based and knowledge-intensive specialized firm focusing on one to a few diagnoses at disperse specialist units. In turn, this profile does not resemble the Swedish healthcare system as a whole. This profile is more of an outsider relying on its own strengths rather than external opportunities in the surrounding context. Although, no one of the two case firms are exclusively institutional- or resource-oriented it is most evidently that Capio is more institutional-oriented than GHP and vice versa in every category of our empirical findings.

Analyzing the two cases' operative strategies we have also found evidence of a balance between an internal focus on the one hand, and an external focus on the other. The internal focus refers to the rational intra-firm decision-making process and the external focus is the sum of surrounding

contextual factors affecting firm strategy, such as competition, market structure and state regulation (Conner, 1991). Neither one of the two case firms have an all internal or an all external focus. However, in our empirical findings Capio showed a marginal tendency towards an external focus, whereas GHP mainly represented an internal focus.

A cross-examination of the two conceptual pairs of institutional versus resource orientation and internal versus external focus completed by the rest of our chosen theoretic perspective and supported by our market firm analysis give us a chart of four domains, namely "strive for legitimacy" in the institutional-oriented/internal domain; "wish to differentiate" in the resource-oriented/internal domain; "institutional pressures" in the institutional-oriented/external focus domain; and "market imperfections" in the resource-oriented/external focus domain. "Strive for legitimacy" is the firm's intentional actions to fit in within a certain system (Suchman, 1995). A firm's "wish to differentiate" is how it consciously separates itself from other firms to gain advantages against them (Barney, 1991). "Institutional pressures" denote the mechanisms behind a constant homogenizing process on different levels affecting all firms within the same industry (DiMaggio & Powell, 1983). "Market imperfections" or market failures are entities perturbing the free market forces, such as barriers to acquire, imitate and substitute certain resources (Penrose, 1959). The firm who controls a certain imperfection gains advantages over its competitors (Barney, 1991).

The balance between "strive for legitimacy" and "wish to differentiate", we have chosen to label as "internal governance". Internal governance refers to activities commanded by the firm itself, i.e. strategic issues driven by rational decision-making by the firm management. In their strategic choices we see that our two case firms balance between different kinds of legitimacy issues on the one hand and how they are forced to differentiate to be competitive on the other.

The balance between, "institutional pressures" and "market imperfections", we have labeled "external response". External response represents the contextual factors surrounding the firm over which it has little to no control. This can be pressures on firm, branch or state level as well as certain market failures disturbing equal business terms in this sector. Depending on the

individual firm profile the external response might either favor or hinder a certain firm in building advantages against others.

It is then how a certain firm profile matches its individual strengths into a balance of "internal governance" and "external response" that our two case firms, Capio and Global Health Partner, build sustainable competitive advantages in the international market.

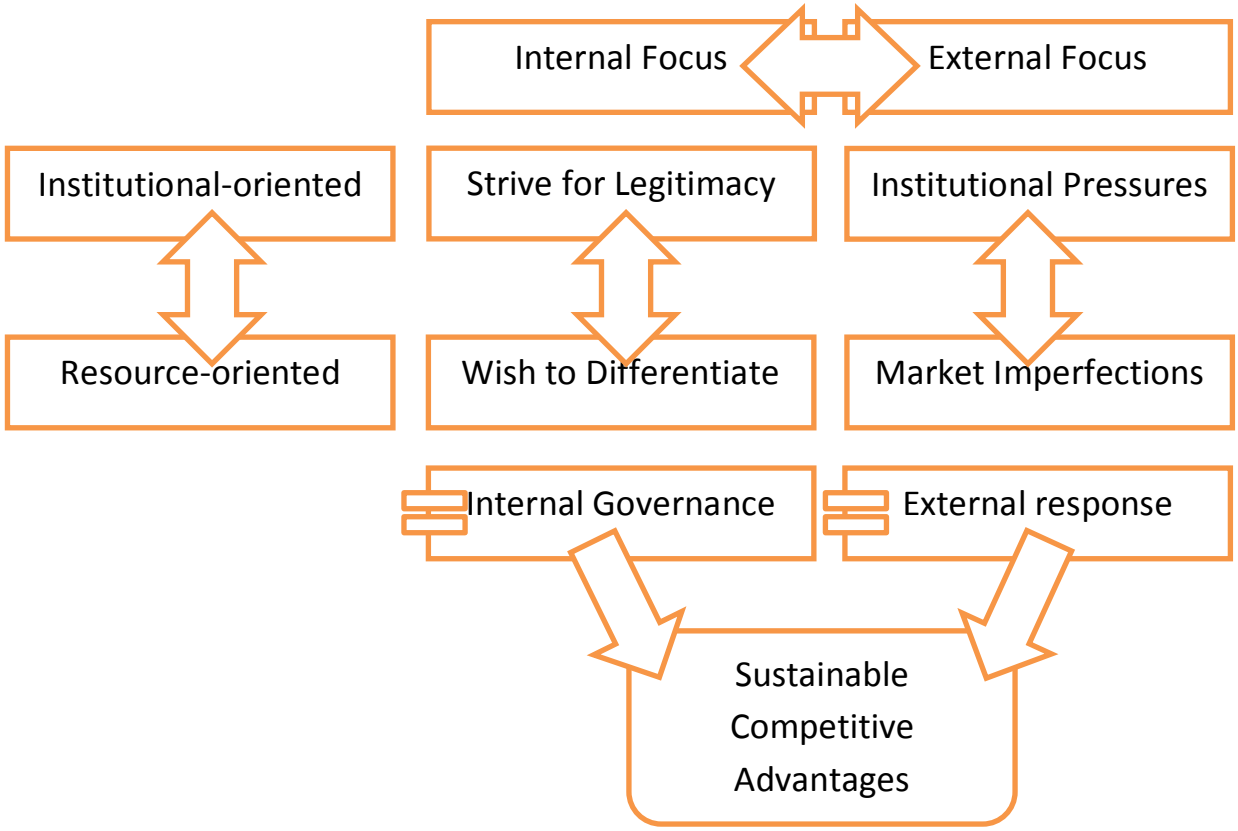

Figure 1 The conceptual framework model of how private Swedish medical firms build sustainable competitive advantages in the international market.

6. Conclusion

Our two case firms, Capio and Global Health Partner, balance between their institutional context and their available resources. They are a combination of the organization of the modern welfare state and the advancements in techno-science, specifically the life sciences. These firms also

poise the rational internal decision-making process, i.e. internal focus, on the one hand, and external strategy shaping factors, i.e. external focus, on the other. Through cross-examination of these four key concepts we have created a four domain model chart in “strive for legitimacy”; “wish to differentiate”; “institutional pressures”; and “market imperfections”. The balance between the first two we chose to call “internal governance” and the one between the latter two we labeled “external response”. Finally, in our model it is in balance of the internal governance and the external response the two case firms create their sustainable competitive advantages in foreign markets.

Capio with its close resemblance to the generic Swedish healthcare system as a whole has clear advantages, nationally as well as internationally, both in the internal and the external institutional-oriented domains. However, as much as its ”Swedishness” is Capio's main advantage it may also be a burden in the international market. This negative impact is visible both within the organization and in the external communication with the customer and different governments as well as in relation to other healthcare actors and financiers. Being too Swedish can be accompanied with a certain degree of discrimination and a liability of outsidership.

A general high share of public financing of healthcare in Europe, and in nearly all our investigated markets support Capio in building competitive advantages in these markets. In its size Capio is able to create economies of scale to win procurement contracts based on price. Notwithstanding, this raises the question if quality might be suffering in this process. In a large organization it may be hard to keep an even high-leveled deliverance and optimal efficiency in every process. This implies that the institutional-oriented profile is less flexible than the resource-oriented.

Global Health Partner on the other hand tends to use its resource-oriented strengths to compete both on the home market and in the international setting. Because of its strong wish to differentiate in the home market GHP has to withstand a more extensive outside pressure into what is seen as the general custom of Swedish health care. It is clear that the Swedish system is not quite ready for the type of competitive profile GHP is representing and its future is very much dependent on public opinion and political decisions to come. However, in many other markets

GHP seems to have better prerequisites for success. Thus, by the use of Swedish medical knowledge as its main asset GHP might have an easier ticket in building sustainable competitive advantages in the international market.

We hope that our created conceptual framework will contribute to the general theory-building as well as the day-to-day operating activity of how private Swedish medical service firms stay competitive in foreign markets. Accordingly, we call for further research and practical use of the present model.

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