Emerging Multinationals: The South African Hospital Industry Overseas

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1. Introduction

The healthcare sector remains relatively unaffected by globalisation compared to other service sectors. Trade and Foreign Direct investment (FDI) in healthcare services constitute a much smaller share of global trade and investment in services, than healthcare spending in total global spending.[1] This is mainly due the 'public good' nature of healthcare services and the consequent large public health sectors in many countries. However, the opening of the economy to trade and investment is affecting health systems worldwide – including those dominated by publicly subsidised and provided healthcare as public sector markets are opening-up to private investors and suppliers. Healthcare provision is thus increasingly fragmented and reorganised across national borders as a global industry. As such it follows in the footsteps of an ever increasing number of industries, which are distributing production and consumption of their products and services globally through trade and FDI.

Trade in services, as defined by the General Agreement on Trade in Services (GATS) under the World Trade Organisation (WTO), can take place in four distinct ways – so-called modes of supply: cross-border supply (mode 1), consumption abroad (mode 2), commercial presence (mode 3), and temporary movement of persons (mode 4). Healthcare services are traded in all modes of supply but commercial presence is currently the dominating mode (Mortensen 2008) and will be the focus here.

A firm establishes commercial presence in a foreign country if it sets-up a representative office, affiliate, or subsidiary in a foreign country either through 'greenfield' investment or through mergers and acquisitions (M&As). In order to qualify as commercial presence the investment must afford control to the parent company. In other words, it must take the form of FDI (equity and non-equity). It is not the investment but the sales of the foreign affiliate that constitute the value of trade generated by commercial presence. FDI in services thus often functions as a vehicle for trade in services.

Multinational Companies (MNCs) operating in the hospital sector are gaining momentum and, as this paper reveals, they are not only from rich developed countries. Healthcare MNCs from the loosely defined category of emerging economies have taken centre stage. As such they are a part of a wider trend identified by market analysts (Accenture 2008; BCG 2006), media (Business Week 2006; Economist 2008), international organisations (UNCTAD 2006) and academic literature (JIM 2007; JIBS 2007), which provide evidence of emerging economy MNCs in industries traditionally dominated by MNCs from developed countries.

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[1] Mortensen (2008) estimates that global trade in health services was worth USD 33 billion in 2005 which equaled 1.3% of total trade in services, while, in 2004, the world spent 10% of GDP on health.

Outreville (2007) argues that very little research has been done on FDI in the healthcare sector and that it is surprisingly difficult to find data on global patterns of investment in the healthcare sector.[2] A body of literature which have been particularly concerned with FDI in healthcare is that on trade in health services (Chanda 2001; Smith 2004; Blouin et al. 2006). A frustration over lack of empirical research on the issue is virtually endemic to this literature. At the same time, Aulakh (2007) notes that the existing literature on emerging MNCs is largely based on anecdotal evidence complemented with deduction and inference from the history of North-South FDI flows (and not South-North flows).

This paper is a response to these and other calls for empirical case studies of the globalisation of the healthcare sector and emerging economy MNCs. Through a case-study of three South African private hospital firms, the focus will be on an understanding of how healthcare services MNCs from an emerging economy, South Africa, has internationalised and how this may impact the home country. The three firms have over the past 5 years established a strong commercial presence overseas and are today the leading global players in the hospital industry. They have internationalised in two distinct ways. First, through the winning of NHS tenders to deliver clinical healthcare services in the UK. Second, through the acquisition of private sector hospitals and healthcare facilities in the UK, Switzerland and United Arab Emirates (UAE).

The first section of the paper provides a conceptual framework for analysing MNC from developing countries investing in developed countries. The second section presents the private hospital sector in South Africa. The third section presents company case studies of the three dominating South African private hospital groups, which have all engaged overseas markets. A fourth and final section analyses and concludes.

2. Developing Country MNCs in Developed Countries – a Conceptual Framework

Dunning (1980, 1981) and Dunning and Narula (1996) have formulated an approach for understanding the determinants of FDI known as the OLI framework. It avers that the extent, geography and industrial composition of FDI undertaken by MNCs is determined by the interaction of three sets of interdependent variables. The first variable concerns a firm's competitive advantages, which are a combination of firm-specific advantages, such as brands, technologies, knowledge or managerial skills, and country-specific advantages, such as abundance of natural resources, low cost structures or a high level of human capital (called 'ownership' specific advantages – the O in OLI). The second variable concerns a firm's ability to identify markets in other countries or regions in which its ownership specific advantages provide a competitive edge vis-à-vis incumbent firms (the 'locational' attractiveness – the L). The third variable concerns the alternative motives a firm can implement to exploit its ownership specific advantages in attractive locations through internalising business activities across borders as opposed to other strategies, such as exporting or licensing (the internalisation advantage – the I). As such, the OLI framework explains the existence of MNCs through their possession of superior resources, i.e. superior

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[2] Outreville's own paper is an excellent example of this. Though he sets out to investigate the extent of FDI in the healthcare services sector, his analysis is primarily based on data and analysis of pharmaceutical MNCs and not healthcare providers, such as hospital firms; confirming the old joke about the economist who looks for her keys, not where she dropped them, but where the light is.

relative to domestic non-MNC competitors, and their ability to transfer these between appropriate markets.

The OLI framework is primarily derived from research on manufacturing sector firms. This has raised a debate on its applicability to the service sector. Services have traditionally been thought to comprise activities which are not easily customised and therefore require face-to-face contact (or at least direct interaction) between provider and consumer. Moreover, they have been characterised by the uno acto principle: because they are intangible and in some cases non-storable, they have to be consumed in situ, simultaneously with their production. This has often been associated with the assumption that services, unlike manufactured goods, are non-tradable. Some studies contend that these inherent differences mean that the internationalisation process of service firms differs from that of manufacturing firms. Consequently, new theories are needed for services (Johansson and Vahlne 1990; Knight 1999; O'Farrell et al. 1999). Others, however, contend that the underlying principles observed in the manufacturing sector are directly applicable to the service sector (Boddewyn et al. 1986; Agarwal and Ramaswami 1993; Katrishen amd Scordis 1998; Javalgi et al. 2003). Here the applicability of the OLI framework will be tested on the internationalisation process of three South African service firms.

Dunning (1993) identifies various (non-exclusive) motives that firms have for engaging in FDI. Market-seeking FDI is undertaken to expand the number of customers by serving new foreign markets. Resource-seeking FDI is designed to access natural resources, agricultural products, low-cost labour, technology, knowledge or managerial, marketing or organisational skills. Efficiency-seeking FDI is engaged to promote an efficient division of labour by concentrating a firm's different activities along the value chain in appropriate countries, e.g. labour intensive production in countries with low labour costs. Strategic asset-seeking FDI is designed to protect, improve or expand existing ownership advantages of the investing firm and/or thwart those of the competitors. Escape FDI is made to escape restrictive legislation and polices by home governments and is obviously concentrated in sectors which are most regulated – especially services. Support FDI has the purpose to support activities of the investing firm, such as the promotion of exports and/or facilitation of imports, marketing and recruitment functions, through sales or branch offices.

Home country factors 'pushing' firms to invest in new markets may include a relatively small or saturated domestic market, high transportation costs, unfavourable exchange rates, high-levels of home-market competition and rising production costs. Host country 'pull' factors may include the existence of attractive markets, high barriers to trade, securing access to scarce natural resources (at the expense of competitors), liberalisation and privatisation policies, such as relaxed regulations of inward-FDI, subsidies and the opening of 'public sector' markets to private investors and suppliers (UNCTAD 2006).

FDI from developing-country firms is mostly market- or efficiency-seeking (UNCTAD 2006)[3], while FDI from service providers, such as hospital firms, is dominantly market-seeking (UNCTAD 2004). The geographic orientation of service industries tends to be directed at 'centres of excellence' (Nachum 2000) or 'world cities' (Taylor et al. 2004). Service companies may enter foreign markets using a variety of entry modes. The four most common entry modes are exporting, licensing, joint ventures and wholly owned subsidiaries (Javalgi and Martin 2007). The latter two can take the form of an acquisition (often referred to as mergers and acquisitions – M&As) or a greenfield investment. A joint venture can take the form of a majority owned equity holding, a balanced partnership or a minority partnership (Chang and Rosenzweig 2001).

Dunning (1993) presents a stylised and incremental five-phase model for the internationalisation of firms. Phase 1 represents firm's initial entry into foreign markets which typically will take the form of exporting domestic produced products (or licensing arrangements) with little direct contact to export markets. Phase 2 involves the establishment of sales and marketing subsidiaries (support FDI). Such investment is often a first step to take up other more substantive forms of FDI and thus functions as a learning experience. In phase 3, firms transfer a part or parts of the production value chain to foreign subsidiaries. The end market may be the home market of the parent company, the home market of the subsidiary or any number of other markets. Phase 4 involves increased transfer of higher value added activities to foreign subsidiaries and/or a widening of products produced by foreign subsidiaries. Phase 5 envisages an equal distribution of value-added activities between the parent company and its foreign subsidiaries. It should be noted that in real-life firms may leap-frog phases and/or never 'upgrade' from one phase to another (and may actually 'downgrade' from say phase 3 to 2).

Some studies argue that the nature of services (i.e. inseparability and intangibility) means that service firms generally need to enter a market 'all at once', as exporting is generally not a viable option. Instead FDI is the dominating aspect of service firm's internationalisation process as proximity to customers abroad, either through a subsidiary or through a joint venture, is key (Bryson 2001; Lovelock 1999). Phase 1 and 2 would then be irrelevant. However, as noted by Erramilli (1990), services can be classified as 'hard services' or 'soft services'. In hard services (such as architectural drawings and computer software) production and consumption can be separated and easily exported. The rapid advance of telecommunication technology means that more and more services have become 'hard' over the past years. The effects of this can be witnessed in the growing outsourcing and offshoring of the production of various services. Conversely, soft services are those that can be characterised by the above-mentioned conventional perception of services (such as a haircut and healthcare). Ekeledo and Sivakumar (1998) argue that entry modes do not differ significantly between hard services and manufactured goods; whereas, there are notable differences between hard services and soft services. However, even soft services feature hard services elements and are increasingly becoming compatible with cross-border transferability. Likewise, many soft services can be 'embodied' in people and 'carried' across borders

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[3] Although much focus has been dedicated to resource-seeking investment from not least Chinese MNCs, a survey by UNCTAD show that while 40% of Chinese MNCs stressed resource-seeking motives, this was relatively low compared to market-seeking (85%) (UNCTAD 2006).

(Bhagwati 1984) – so-called mode 4 trade, for example, by doctors that cross borders to deliver healthcare. In this way elements of virtually all types of services can be exported.

The number of developing countries that are spawning MNCs are limited at present. Salehizadeh (2007) lists 15 developing countries which have the necessary economic and political foundations to foster MNCs. All of the countries fall under the loosely defined category of emerging economies. Mathews (2006) argue that MNCs from emerging economies have engaged in FDI at an earlier stage in the home country's economic development process than could be predicted from conventional wisdom. Likewise, the FDI has been spread across a wide range of industries ranging from low- to high-value added manufacturing and service provision. As such, MNCs from developing countries seem to be exhibiting 'accelerated internationalisation' when compared to incumbents. This aspect often provide new and latecomers with the benefit of surprise in creating their global presence (Bonaglia et al. 2007).

Several factors may explain this. Some developing-country governments, for example, actively promote FDI, either through state-owned firms or by providing incentives for private firms, and many developing countries are 'dual economies' with internationally competitive industries existing parallel with poorer performing ones. However, evidence seem to suggest that elements of globalisation, for example through increased competition and opportunities, are driving developing-country firms to engage FDI at an earlier stage and in a perhaps different manner than incumbent MNCs did (UNCTAD 2006).

Outward FDI presents potential benefits and costs to home countries. Positive impacts can be contributed by a combination of two factors: (i) a 'substitution/complimentary effect' on home employment levels and skill composition and (ii) a 'spill-over effect' from foreign affiliates leading to productivity improvements in the parent company and other firms in the home country (Bonaglia et al. 2007). 'Substitution/complimentary effects' related to employment and skill-composition are probably less important in services with limited tradability (such as hospital-related services) as FDI will not entail relocation of labour-intensive production activities abroad and/or increased exports, thus the home country will not experience loss of jobs from redundant factories or job-gains from increased exports.[4]

'Spill-over effects' such as dynamic learning effects on the parent company from operating in overseas markets may be relevant. These can come from the imitation and adoption of techno-logical, managerial or organisational best practises. Such effects may also 'spill-over' to other companies in the home country improving the general level of competitiveness (Ibid). This could translate into broader economic benefits and enhanced competitiveness for the home country by contributing to industrial restructuring and up-grading of value-added activities and higher national income. However, such 'spill-overs' are less likely in mature or low technology-intensive industries (UNCTAD 2006).

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[4] Of course, it can be argued that particularly developing countries have a comparative advantage in mode 4 trade, not least in services. However, mode 4 trade remains limited because of, *inter alia*, restrictive immigration regimes in many countries.

Potential negative impacts from outward FDI include reduced domestic investment, 'hollowing out' of parts of the economy, loss of jobs, and higher risks and complications from operating abroad. Generally evidence shows a positive correlation between outward FDI and the level of domestic investment thus indicating that outward FDI has a positive impact on the level of domestic investment. As services tend to be less-tradable, 'hollowing out' and loss of jobs are not likely outcomes from outward FDI in services. Higher risks and complications are inherited in the undertaking of overseas investment. Problems related to cultural, social and institutional differences between host and home markets can lead to higher coordination, governance and other transaction costs. Moreover, the more locations a firm establish a presence in, the more complexity it faces in terms of coordination activities which may eventually put a strain on managerial capacity. Also, outward FDI carries specific risks such as exchange-rate fluctuations and political uncertainties. These risks and complications may entail higher costs leading to a decrease the competitiveness of the home country (UNCTAD 2006; Reeb et al. 1998).

The next section presents case studies of three South African private hospital groups. A subsequent analysing and concluding section will assess how the internationalisation process of these groups relate to the above presented 'conventional wisdom' on the internationalisation of firms, particularly in relation to ownership specific advantages, types of FDI and entry modes. As a prelude to the case studies, a brief introduction to the South African private hospital sector is provided.

3. The South African Private Healthcare Sector

Until recently, the South African government saw no role for the private hospital sector in alleviating the country's health crisis despite the fact that the private sector absorbs 60% of all healthcare spending in the country. Government policies directed at the sector have lacked a coherent and comprehensive post-apartheid strategy. At least three factors underpinned this. First, the government has traditionally distrusted the white dominated sector's motives and objectives, which have led government officials to almost exclusively focus on the strengthening of the public sector. Second, internal disagreement between the Department of Health and the Treasury over healthcare financing and the role of the private sector has complicated the development and implementation of coherent policies. Third, the opposition from the entrenched private sector to regulatory reforms has been difficult to overcome. The result has been piecemeal and ineffective regulation of the private sector (McIntyre et al. 2004, 2006).
However, an attitude shift toward the private sector seems to be emerging. In 2005, the Department of Health together with the private sector published a Draft Charter of the Private and Public Sectors of South Africa (Department of Health 2005). A central element is to bring ownership of the private health sector into the realm of Black Economic Empowerment (BEE). This constitutes a departure from previous policy statements and may signal a change in attitude from the government in which private sector interests are defended rather than frown upon (Schneider et al. 2007). One significant factor pointing in this direction is the DoH's plans to extend medical scheme coverage to low-income groups involving public subsidies, which would increase the proportion of the population with access to private healthcare, thereby relieving the stretched public health sector (Still 2007; Wilbury and Claymore 2007).

For the private sector the attitude shift is a double edged sword. It is likely to increase the number of patients in the sector, i.e. the amount of business. Conversely, it has increased the government's effort to regulate the sector to curb cost escalation. Thus, the sector faces current and future regulatory legislation aimed at reducing costs for healthcare funders, which translates into reduced income for providers. At present, the private hospital sector reaction appears to be one of welcoming additional business, while fiercely fighting new regulatory legislation.

Private hospital beds constitute 22% of total hospital beds in South Africa. Beds in private hospitals have grown substantially since 1990, largely paralleling a decrease in the use of public hospitals by insured patients – in 1990, public hospitals made up roughly 20% of benefits paid by medical schemes, by 2006, this had fallen to 1.5% (Council of Medical Schemes 2007). The majority of private hospitals in South Africa can be classified as small, short-stay hospitals, with an average number of beds below 200 and average length of stay of 3 days. Many private hospitals were initially small individual businesses established by doctors. In the late 1980s, the private hospital sector was disintegrated into individual or small independent regional groups. No hospital groups with nationwide coverage existed. However, during 1990s the private hospital market became increasingly consolidated with the emergence of three dominating groups – Netcare, Life Healthcare (formerly Afrox Healthcare or Ahealth) and Mediclinic (hereafter 'the big three') (Matsebula and Willie 2007).

In 1996, the big three had a combined 50.9% share of the market, which by 2006 had grown to 83.8% (in terms of beds). Based on the Herfindahl-Hirschman Index (HHI),[5] the South African national hospital market became a concentrated one around 2002, while the major metropolitan areas became concentrated in 1999. The latter threshold coincides with a clear upward trend break in hospital costs increases (Council of Medical Schemes 2008). The Council of Medical Schemes (2008) argues that the increase is related to change in market power and that the big three are effectively price makers in an oligopolistic market, particularly because the market for medical schemes, the funders of private healthcare, is much less concentrated.

Unsurprisingly, the private hospital sector disagrees. It points to several factors to explain the cost increases: the near 60% depreciation of the South African Rand from 1998 to 2002, regulatory change, general medical costs inflation, change in case-mix and an escalation of in-patient days (HASA 2008). To settle this debate, one may have to consider the views of major market analysts. UBS (2005: 25), for example, states that 'private hospitals have market power owing to their dominant market position'. Citigroup (2007) subtitled a report on the private hospital sector in South Africa 'Investing in an Oligopoly' and according to Rand

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[5] The HHI is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of thirty, thirty, twenty and twenty percent, the HHI is 2600 ($30^2 + 30^2 + 20^2 + 20^2 = 2600$). The HHI takes into account the relative size and distribution of the firms in a market and approaches zero when a market consists of a large number of firms of relatively equal size. The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases. Markets in which the HHI is between 1000 and 1800 points are considered to be moderately concentrated, and those in which the HHI is in excess of 1800 points are considered to be concentrated.

Merchant Bank '[The big three] has historically been characterised by a conscious avoidance of price competition (...) and operated as a cartel (Competition Tribunal 2005: 18-19)'.

The consolidation of the big three has been achieved through a combination of organic growth and acquisition of smaller groups. However, there is little scope for further consolidation through acquisition since the independent hospital sector[6] is fragmented and the Competition Commission uncooperative. Thus, future domestic growth will likely be at the expense of increasingly squeezed independent hospitals, changes in market share among the big three and an emerging and possibly accelerating expansion of the population covered by medical schemes. Additional growth factors may be a continued deterioration of the public sector pushing patients toward private healthcare on a self-pay basis and the mining hospitals[7] (Citigroup 2007).

The barriers to entry for new participants are significant. The sunk costs of establishing or buying hospitals or other healthcare facilities are considerable (currently estimated at around ZAR 1.2 million per bed). This has furthered the concentration of hospital groups in terms of size as well as geographical spread which suggest that a credible competitor requires a national network. Also, the existing contractual relationship between the big three and medical schemes increases the time required for a new entrant to penetrate the market. Likewise, establishing a 'supply chain' of patients through referrals from doctors will demand time. Additionally, a government sanctioned moratorium on new hospital licences works as an effective barrier to market entry for new providers, while the existing providers have been able to transfer licenses between locations. A new trend is that some new licences are being awarded to BEE consortiums. These are currently being offered for sale to or as a basis for joint ventures with the hospital groups. Nonetheless, the current market structures and the barriers to entry are unlikely to change significantly and the South African private hospital sector will most likely remain dominated by the big three (Citigroup 2007; Netcare 2007; Matsebula and Willie 2007).

In sum, the high market share of the big three combined with the high level of unemployment and poverty which exclude the black majority from access to private healthcare (and quality healthcare on the whole) have increasingly limited possible growth opportunities in the South African market. Venturing into related activities in the domestic healthcare market and seeking out international markets represent two subsequent growth strategies of the industry. The following section presents each of big three's domestic and international activities in turn.

3.1 The Case Studies

Netcare

Network Healthcare Holding Limited (Netcare) is organised as an investment holding company listed on the Johannesburg Stock Exchange (JSE) and operates through its

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[6] The independent sector refers to the private hospitals which are not part of one of the big three groups.

[7] The mining industry operates its own hospitals. In 2006, there were 42 mining hospitals with a combined 1470 beds. Some of these are available for non-mining employees and are as such in competition with the 'regular' private hospitals.

subsidiaries private hospital networks in South Africa and United Kingdom. Additionally, Netcare has a hospital in Botswana, which it considers as in integral part of its South African activities.

In South Africa: Netcare was founded in 1994 and listed on the JSE in 1996 with six hospitals. Since 1996 several other small and independent hospital groups in South Africa were acquired, notably Clinic Group and Excel Medical. During 2001 Netcare acquired Medicross, a managed health provider network of 75 medical and dental centres across South Africa. In January 2006 Medicross acquired Prime Cure Holdings, a provider of primary care services with a further 25 centres. On 1 October 2007, Netcare acquired the remaining 56.25% of Community Hospital Group (CHG), a majority black owned entity operating five hospitals in South Africa with 682 registered beds (Netcare 2007).

Today, Netcare runs the largest hospital group in the South Africa consisting of 56 hospitals with 9,546 registered beds, which sees more than 1 million admissions per year. It operates 86 pharmacies and the largest private emergency service, Netcare 911, with 7.5 million members and a fleet of 264 vehicles, three helicopters and two fixed-wing air ambulances transporting 175,600 patients per year. Through the primary care networks, Medicross and Primecure, a combined 3.5 million patients are treated per year. The group has a 50% interest in Ampath, a nation-wide administration and logistical service entity servicing 290 pathology depots and laboratories, and employs 18,877 people in South Africa.

Netcare's yearly revenues from the South African operation reached ZAR 8,869 million (GBP 635 million) in 2007, a 14.9% increase on 2006. Operating profit was up 13.6% to ZAR 1,406 million (GBP 101 million) whilst the operating profit margin fell slightly to 15.9% in 2007 from 16% in 2006.

Overseas: The principle overseas market for Netcare's international activities is the UK. The decision to enter the UK market followed a substantial increase in expenditure on healthcare in the UK. This had always been comparatively low but increased spending on the NHS has been a key policy aim for the Labour government which came to power in 1997. Thus, while in 1997 the UK government spent 5.4% of GDP on the NHS, government healthcare expenditure for 2007/08 is estimated to be 7.8% of GDP. Government funding of the NHS accounts for 85% of total spending in the UK; the remaining 15% is accounted for by private health insurance and by self-pay spending. Total healthcare spending amounts to 9.4% of GDP (Wanless et al. 2007). This is, however, still below that of Germany, France and the US, which in 2005 were spending 10.7%, 11.1% and 15.3%, respectively (OECD 2007). In nominal terms, total healthcare spending in the UK stand at around GBP 113.5 billion in 2007/08. Of this, GBP 95.5 billion represents government spending on the NHS while an estimated GBP 17 billion is spent on private sector healthcare (Wanless et al. op. cit.).

The introduction, in 2000, of the private healthcare sector as providers of public services was meant to provide additional capacity to the NHS. The healthcare sector, however, was constrained by a lack of health professionals and, consequently, additional private sector capacity came at the expense of public sector capacity as personnel simply switched from the NHS to the private sector. Consequently, the DoH then introduced what it called a new sector in healthcare provision in the UK: new surgical and diagnostic units, which were be set-up and

run by private sector operators and staffed with overseas personnel. Two models were proposed:

- Clinical teams: where staff are made available to supplement clinical capacity in existing NHS provider organisations, both to support existing services and to help staff new NHS-managed developments (especially new diagnostic and treatment centres)

- International establishment: where independent health service providers set up and run healthcare units in the UK (they plan, finance, staff and operate the services for the NHS as a public purchaser) (Department of Health 2002).

In this way, additional capacity was to be injected into the NHS through import of health services from overseas. On implementation, the first model, clinical teams, consisted of a pilot scheme of 17 short-term, low volume contracts involving the treatment of about 10.000 patients. No further tenders were announced. The second model was implemented in the guise of Independent Sector Treatment Centres (ISTCs)[8] and in a first wave of contracts announced in September 2003, seven providers were appointed to manage 29 ISTCs in England. The contracts had a combined value of GBP 1.7 billion over five years. The first wave favoured overseas based companies, with only one incumbent to be awarded contracts. In this way, the DoH used ISTCs as a means to 'shake-up' the NHS and incumbent private providers by introducing foreign competition (Laing and Buisson 2007).

At the outset it was projected that 15% of total NHS procedures would be conducted by private operators in 2008 as a result of an ambitious second wave of contracts. This wave was initially planed to comprise 27 contracts with a combined value of GBP 3.75 billion over five years. However, only nine contracts have been confirmed, 11 have been cancelled and seven contracts await confirmation from the government (as of 1 April 2008). As a result only about 5% of NHS procedures are currently conducted by private sector operators. The scaling back of the second wave contracts has questioned the future involvement of the private sector in the NHS as it may dampen the private sector's willingness to enter into costly bidding processes in the future. At any rate, it is clear that past projections which foresaw that NHS patients would make-up nearly 50% of private sector patients, while private patients would fall by around 15% as NHS waiting-lists were reduced by reform, has been replaced by a reality in which only about 10% of patients in the private sector come from the NHS, while the number of private patients is growing (Timmins 2007, 2008).

Traditionally, private healthcare in the UK has lived in the shadow of free public healthcare, largely through supplying solutions to real or perceived problems in the NHS. As a result, much of the private sector provision is for routine procedures, which are likely to have longer waiting lists in the NHS. The private sector has also developed niche markets, such as cosmetic surgery, abortion services and fertility treatment, which are either limited or unavailable in the NHS. In 2006, the demand for private medical insurance (PMI) increased

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[8] UK-based providers were accepted but the majority of medical staff had to be 'additional', i.e. from overseas.

for the first time in five years following a gradual downward trend since 2001. The number of subscribers grew by 1.6% to 3.6 million subscribers. With dependents, this means that 7.4 million people in the UK were covered by some form of PMI, corresponding to a total penetration of 12.2% (Laing and Buisson 2007).

The PMI segment accounted for 63% of the private sector's revenue in 2006. Self-pay patients added 18% of revenue, NHS another 14.5% while foreign patients contributed with 4.5% (Laing and Buisson 2007). Payer concentration is high with the top three PMI payers accounting for 72% of all PMI payments. This means that providers are price takers rather than price makers in a highly competitive market. After a period of high growth in the late 1980s, PMI membership has remained stable since. Yet, private hospital revenue growth has been around 7% pa in recent years. This is partly explained by a steady growth of self-pay patients, partly by private sector involvement in the NHS. The private healthcare market is expected to grow as PMI coverage increases, driven both by an ageing population demanding more care and medical advances allowing new treatment forms (Netcare various). Moreover, the UK lags other OECD countries in private healthcare expenditure (at 1.2% of GDP against the average of 3%) even compared with other countries featuring comprehensive public provision (OECD 2007).

The private hospital sector is dominated by five major national providers: General Healthcare Group (GHG), Spire Healthcare, Nuffield Hospitals, Ramsay Healthcare UK and HCA International, with a combined market-share of nearly 80% measured in beds. Of the five groups, three are foreign controlled. In May 2006, General Healthcare (GHG), was acquisitioned by a consortium led by Netcare (see below) and in September 2007, Australia's largest private hospital group, Ramsay Healthcare, acquired Capio UK (Capio UK was previously owned by Swedish group Capio). In August 2007, the third largest group, Spire Healthcare (then BUPA hospitals) was acquired by the UK-based private equity group Cinven for GBP 1.44 billion in close competition with foreign investors. HCA International is a subsidiary of the US major healthcare supplier HCA. Nuffield is organised as a not-for-profit group of independent hospitals. The recent foreign acquisitions are somewhat ironic given that, as Pollock (2005) argues, the strengthening of the private sector role in the NHS was partly aimed at giving UK-owned companies a competitive edge in an emerging global healthcare market.

Netcare has engaged both of the two market segments referred to above. In 2001, it established Netcare UK to win tenders from the NHS to provide clinical services in the UK. The first contracts Netcare won were four 'clinical teams' contracts. These included 929 cataract operations performed in Morecombe Bay; around 12,000 ear, nose and throat procedures in London; 338 hip and knee joint replacements in Southport; and 1000 orthopaedic operations in Portsmouth. All procedures were conducted in NHS facilities by South African personnel. Overall, a total of around 200 South Africans participated in travelling to the UK on a rotational basis (Netcare various).

When the NHS stopped tendering 'clinical teams' contracts and started the tendering of contracts for ISTC centres, Netcare UK was awarded two such contracts. In 2003 Netcare UK was contracted to operate a mobile ophthalmic chain using mobile theatres to provide some 45,000 procedures throughout England over a five-year period, employing around 30 staff. A second ISTC centre was opened in Manchester in 2005 to fulfil a five-year contract for some

45,000 procedures. In 2007, Netcare UK opened two primary care NHS Walk-in-centres; one in Leeds and one in London, which will each treat around 50,000 patients per year. It also opened the first NHS ISTC centre in Scotland (in Stracathro). In 2006, total revenue from Netcare's NHS contracts was ZAR 273 million (USD 21.3 million), up from ZAR 181 million (USD 14.1 million) in 2005 (Netcare various).

In May 2006, Netcare led a consortium to acquire General Healthcare Group (GHG) for a total of GBP 2.2 billion from BC Partners, a UK-based private equity firm. Netcare acquired a controlling stake of 52.6% (which has subsequently declined to 50.1% as management have taken-up their allotted stake). Its investment in GHG involved an equity contribution of GBP 219 million and the injection of Netcare UK valued at GBP 20 million. The other consortium partners are Apax Partners Worldwide (31.7%), London and Regional Properties (7.4%), Brockton Capital (3%) and management (7.4%). As a consequence of the acquisition, Netcare UK was merged with Amicus Healthcare, GHG's NHS service arm, but has kept the Netcare UK brand.

GHG owns BMI Healthcare the largest private hospital provider in the UK. BMI has 48 hospitals with 2,600 beds, 152 operating theatres and 37 pharmacies. BMI admits 230,000 patients and attend 892,000 outpatients per year. The majority of surgeries are provided to patients with private medical insurance, while life-style procedures (such as plastic surgery) are provided to self-paying patients. In December 2007, GHG acquired nine hospitals with a total 346 beds from Nuffield Hospitals for GBP 140 million. These have been merged with BMI increasing the number of beds it operates with 14%. The acquisition brings GHG's share of the UK private hospital market to 28.5% (in beds) making it the largest private healthcare provider in the UK.

In 2006/2007, Netcare's UK business contributed 52.3% and 53.9% to revenue and operating profits, respectively to the company's overall result. The UK operation employed a staff of 8,850. The revenue from the UK business was ZAR 9.7 billion (GBP 689 million). Operating profit was ZAR 1.6 billion (GBP 116 million) and the annual profit margin was 16.9%.

Life Healthcare

Life Healthcare Group ('Life') consists of six subsidiaries. Five of these operate in South Africa, while one – Partnership Health Group UK - is a joint venture with London-listed Care UK, providing services to NHS patients in the UK. The group is owned by the BEE group Bidco (see below).

In South Africa: Life was originally known as Afrox Healthcare (or Ahealth) and its stepping stone into health sector was the acquisition by African Oxygen Limited (Afrox) of and 85% stake in Ammed, a group of four hospitals. The acquisition was followed by several others and when the healthcare arm of Afrox merged with the PresMed Group to form Ahealth in 1999, it had a 9.4% share of the private hospital market (in beds). Together with PresMed's 7.3% share, the merger established Ahealth as one of the Big Three.

In 2003, Afrox announced the sale of its 69% shareholding in Ahealth to Bidco, a Black Economic Empowerment consortium and Mediclinic. The acquisition was cancelled by the

Competition Commission of South Africa when it emerged that a second leg of the transaction would have resulted in Mediclinic acquiring hospitals representing some 2500 beds from Ahealth. The transaction would have removed Ahealth as a significant competitor and propelled Mediclinic to a market dominating position. An alternative acquisition proposal, which excluded Mediclinic,[9] was approved by the Competition Commission 15 month after the first was filed. The approval was subject to conditions designed to ensure that the sale of Ahealth would not compromise the level of competition. Thus, cross-holdings between Bidco and any other hospital group was forbidden. Likewise, future sale of shares in Bidco or Ahealth to Mediclinic, Netcare or Rand Merchant Bank,[10] was restricted (Crotty 2005).

In terms of the new acquisition, Bidco acquired a 100% of Ahealth in 2005 for ZAR 3.5 billion, which was subsequently delisted from the Johannesburg Stock Exchange. Bidco consisted of the BEE group BEECo (comprising Brimestone Investments and the Mvelaphanda Group in equal shares) with a 50.2% stake, Afrox with a 20.1% share, Old Mutual Life Insurance and Rand Merchant Bank each with 10.1%, Ahealth Management with a 5% share and the Industrial Development Corporation with a 4.5% share. After the transaction Ahealth was renamed Life Healthcare. In 2006, Afrox sold its 20.1% stake to the other Bidco partners.

Today, Life operates 62 hospitals and same day surgical centres with a combined 7300 beds spread throughout South Africa (including one hospital in Botswana). This makes the group the second biggest private hospital operator in the country. In addition to its core business of operating hospitals, Life has continued a traditional Ahealth strategy of focusing on five additional businesses:

- Life Esidimeni - provides long-term care to chronically ill patients through its 24 facilities with 9,100 beds.

- Life Rehabilitation - offers acute physical and cognitive rehabilitation for patients disabled by stroke, brain or spinal trauma, and other disabling injuries at four rehabilitation units.

- Life Occupational Health - provides contracted, on-site, occupational and primary healthcare services to over 120,000 employees of large employer groups (commerce, industry, prisons and the mines) at over 180 costumer owned clinics.

- Life Pharmacy Management Services - manage 45 hospital pharmacies.

- Life Doctor Solutions - provides doctors and specialists with IT systems and business support to help with practice management.

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[9] Mediclinic was paid ZAR 50 million to walk away from the deal and ZAR 23 million in transaction fees by Bidco (Khuzwayo 2005)

[10] Rand Merchant Bank owns a controlling share of Discovery Health, a leading medical insurance provider.

As Life is not publicly listed, financial information is treated as confidential and is thus unavailable. However, according to the Mvelaphanda Group (2007), Life continues to perform well ahead of the medium-term forecasts prepared at the time of the buy-out from Afrox (see above) and the Group's share in Life has increased its value from ZAR 812 million at 30 June 2006 to ZAR 1,502 million at 30 June 2007, an increase of ZAR 690 million. Moreover, according to Citigroup (2007) operating margins which have traditionally lagged the competitors have caught up in recent years.

Overseas: Like Netcare, Life (then Ahealth) used the NHS contracts as a vehicle for internationalisation. In 2003, it established Care UK Afrox (later renamed Partnership Health Group – PHG) a joint venture in equal shares with Care UK, a leading operator of nursing and residential homes in the UK. In 2005, PHG began the operation of two NHS ISTC centres (one in Barlborough to perform some 22,000 orthopaedic procedures over a five-year period and another in Plymouth to perform 16,500 orthopaedic procedures worth GBP 56 million over a five-year period). In 2006, PHG began the operation of an additional two ISTCs (one in Maidstone to perform 55,600 various procedures, including chemotherapy, minor surgery and endoscopy, over a five-year period and another in North East London to perform 55,000 orthopaedics, urology, minor surgery, ophthalmology, oral, ear, nose and throat procedures). All contracts are for a five-year period. In 2006, PHG's operating revenue was GBP 32 million, operating profit was GBP 2.9 million and the operating profit margin was 9%. In 2005, the same values were GBP 25 million, GBP 0.9 million and 3.6%, respectively (Laing and Buisson 2007).

The overseas activities of Life are negligible relative to its South African activities. Unlike Netcare, Life has not used its NHS contracts as a stepping stone to further involvement in the UK private hospital market. The Group was rumoured to have been in the final round of bidding for Capio UK, which was sold to Australia's Ramsay Healthcare in 2007 (Fortson 2007). Management of Life Healthcare maintain that overseas expansion remains a priority and that the group is searching the market for acquisition opportunities (Mvelaphanda 2007)

Mediclinic

The Mediclinic Group consists of the parent company and a number of subsidiaries, two of which – Mediclinic Middle East and Mediclinic Luxembourg - operate in United Arab Emirates and Switzerland, respectively. Mediclinic is listed on the Johannesburg Stock Exchange. Remgro Limited, a South African investment holding company, is the majority and controlling shareholder with a 43.4% share.

In South Africa: Mediclinic was founded by the Rembrandt Group, then a South African tobacco and industrial conglomerate (now Remgro Limited), in 1983 with the establishment of Panorama Medi-Clinic in Cape Town and the acquisition of Leeuwendal and Medipark, two small private hospitals in Cape Town. This was followed by the acquisition of the then largest private hospital in the country, the Sandton Clinic in Johannesburg. In 1986, Mediclinic, now owning 7 hospitals with 1500 beds, listed on the Johannesburg Stock Exchange. In 1995 the takeover of MediCor Group added another 1100 beds to the Mediclinic Group. Next the Hydromed and Hospiplan Groups were acquired. In 2002 Mediclinic expanded further through the acquisition of the Curamed group of private hospitals in Pretoria, in association with the black empowerment group Mvelaphanda. In 2005 Mediclinic

acquired Wits Donald Gordon Medical Centre and Legae Private Hospital in the Tshwane region. The Protector Group was acquired in 2006 adding three hospitals.

Today, Medi-Clinic operates 50 hospitals throughout South Africa (including three in Namibia) with 6,845 registered beds. With 16 hospitals the Western Cape province (with Cape Town) remains the stronghold of the group. However, recent acquisitions of hospitals in Gauteng province (with Johannesburg and Pretoria) have given the Group an important presence with 11 hospitals in the wealthiest region of South Africa. The Group has a 51% stake in a joint venture, Phodiclinics, with Phodiso, a black economic empowerment partner, which has been licensed to build a 140 bed hospital in Cape Town and a 70 bed hospital in Scottburgh, Kwazulu-Natal. Mediclinic projects that the number of beds in the group will increase by about 500 beds before 2010 resulting from the building of new hospitals and expansion of existing ones.

In addition to the core business, Mediclinic runs an emergency service network, ER24, with over 110 response vehicles. ER24, additionally, contracts with independent ambulance and aero service providers to secure national coverage. ER24 was originally run as a joint venture between Life and Mediclinic but became a fully owned subsidiary of the group in 2005. Mediclinic has traditionally focused on the top-end market and has, unlike Netcare and Life, not pursued the primary care market.

Mediclinic's yearly revenue for its South African operations reached ZAR 5,364 million (USD 740 million) in 2007, a 13.6% increase on 2006. Operating profit was up 29.1% to ZAR 1006 million (USD 139 million) and the operating profit margin increased to 18.8% in 2007 from 16.5% in 2006.

Overseas: Unlike Netcare and Life, Mediclinic has not entered the UK market. Instead it has grown internationally by investing in UEA and Switzerland.

The UEA healthcare market is characterised by a wealthy population and a shortage of hospital beds. The gap is estimated at more than 5000 throughout UEA. At present, UEA has about 9,200 beds of which 2,300 (25%) are in the private sector. Public services are free for nationals, while fee-based but subsidised for expatriates, who comprise around 80% of the population. Because of the high prevalence of expatriates in the work force, only 1% of the population fall into the above 65 age group. With 40% of the national population in the below 15 age group and a population growth rate exceeding 6%, projected demand for hospital beds is estimated to grow by 180% from 2006 till 2025. To meet demand and reduce out-of-country treatment costs (reimbursed by the government for nationals), the government has a stated aim and policy to encourage private healthcare; consequently, private healthcare spending is increasing and accounts for more than 50% of total spending. Moreover, developments such as the Dubai Healthcare City (DHCC) have been successful in attracting foreign investment and expertise (Citigroup 2007; Hediger et al. 2007).

In March 2007, Mediclinic's acquisition of Emirates Healthcare became unconditional (it had been announced in April 2006). Ultimately, the group obtained a controlling stake of 50% plus one share, with board and management control through the subsidiary Mediclinic Middle

East for an amount of USD53.1 million (ZAR 384,2 million) from the Varkey Group. Other shareholders include General Electric Group with a 6.59% share and the Varkey Group with a 43.41% share. Emirates Healthcare owns and operates the 120-bed Welcare Hospital, one ambulatory surgery centre and two clinics – all in Dubai. It has commenced with the construction of the first hospital in DHCC, City Hospital with 210 beds. Further, it has the right to develop an additional hospital in DHCC and three clinics of which two opened during 2007. This will make Emirates Healthcare the largest private healthcare provider in Dubai (Mediclinic 2007a).

The transaction came too late to appear on the groups 2007 accounts. However, had the acquisition taken place a year before, the Group's revenue would have increased by ZAR 409 million (7.6%) and operating profit by ZAR 28 million (2.8%). Mediclinic sees the investment as an ideal platform to prosper from not only the emerging UEA private healthcare market but also to enter other markets in the region (Mediclinic 2007a).

In August 2007, Mediclinic announced the acquisition of Hirslanden, a private hospital group in Switzerland, by the fully owned subsidiary Mediclinic Luxembourg from BC partners, a UK-based private equity group for an amount of ZAR 17.3 billion (USD 2.4 billion).

The Swiss healthcare system is based on compulsory social insurance governed by the market and administered by competing private insurance funds. It thus differs from the two dominant European systems: the national health system (as in the UK and Scandinavia) and public insurance system (France and Germany). Every resident of Switzerland is required to buy a basic health insurance. In 2005, such mandatory health insurance covered a third of total health spending, while a further near-third was funded by self-paying patients. The rest was financed by the government (17%), by other social insurance schemes (8%) and by voluntary private health insurance (9%) (Kocher and Oggier 2007). The Swiss health system scores high on factors such as coverage, quality, accessibility and user satisfaction (OECD 2006). It is, however, expensive. With 11.6% of GDP spent on health in 2005, compared with 9% in the OECD as a whole, Switzerland is second to the US (15.3%) in healthcare spending among OECD countries (OECD 2007).

Administration of the healthcare delivery system is highly decentralised. Cantons (regions) are responsible for the provision of health services. This means, inter alia, that each canton operates public hospitals and implement overall hospital planning through the use of hospital lists. These lists define which categories or facilities of a particular hospital (public or private) are eligible for reimbursements from the mandatory health insurance schemes. There are currently two alternative methods of listing practises among cantons. The first alternative operates with a list A and a list B. List A includes hospitals that may claim reimbursement from the mandatory health insurance schemes and are entitled to cantonal support for funding of running costs. List B includes hospitals that may claim reimbursement from mandatory health insurance schemes but are not entitled to receive cantonal support. The second alternative operates with an integral list which entitles all hospitals (on the list) to the same benefits.

Cantons have significant leeway when choosing which hospitals to list as there are no specific criteria for inclusion. Likewise, being on a list establishes no right to inclusion in future lists.

Cantons generally list private hospitals on the basis of two overall considerations. First, a canton may choose to include private providers to contribute to the overall hospital care for mandatory insured patients. Second, a canton can choose to have certain specialised services provided by private hospitals (such as heart surgery). The mandatory health insurance scheme covers all curative treatments and diagnosis in the event of illness, accident or maternity. Patients have free choice of listed hospitals (i.e. any of the public cantonal hospitals or possibly some private hospitals) within the canton of residence and will be placed in shared wards. Voluntary insurance is available for an additional premium above the mandatory insurance premium. Such insurance can cover special hotel-like services (such as accommodation in private or semi-private rooms) in listed hospitals or treatment in unlisted private hospitals.

Private and public hospitals compete for patients with both mandatory and voluntary insurance. Public hospitals have an 80% share of the overall market (by admissions), an 88% share of the mandatory insurance market and a 57% share of the voluntary insurance market. This leaves 20% of the overall market, 12% of the mandatory market and 43% of the voluntary insurance market to the private hospitals (Mediclinic 2007b). Private hospitals, for-profit or non-for-profit, represents about one fifth of overall hospital beds and generally provide simple surgical procedures, day-care and elective surgery. However, a few hospitals offer highly specialised care (OECD 2006). The private hospital sector is dominated by two major groups, Hirslanden and Swiss Leading Hospitals, with a combined 50% of the market.

The Hirslanden Group is the largest private hospital group in Switzerland. It has a national market share of close to 30% in the private healthcare sector and a market share of more than 40% in the cantons of which its hospitals are located. Hirslanden comprises 13 hospitals with 1,275 beds, 78 operating theatres and more than 3,600 full-time equivalent staff. It provides admitting rights to 1400 doctors and managed 66,732 in-patient admissions in 2006. The group operates state-of-the-art equipment and infrastructure and owns all its own properties, providing a portfolio of prime real estate in the key cities of Switzerland valued at CHF 877 (ZAR 4.8 billion) in 2006 (including equipment). In 2006, it reported revenue of CHF 907 million (ZAR 4.9 billion) and operating profits of CHF 147 million (ZAR 798 million) - an operating profit margin of 16.2% (Mediclinic 2007b).

The acquisition of Hirslanden means that 48% of Mediclinic’s total revenue and 44% of operating profit are derived from the Swiss market. Hirslanden has 15% of the group’s total number of beds, employs 21% of total staff and operates 20% of the group’s hospitals, reflecting the fact that revenue per bed is higher in Switzerland than in South Africa.

Hirslanden competes with private and public hospitals offering services to both compulsory and complementary insured patients. However, the focus is on the higher margin complementary insured patients resulting in a high ratio of private and semi-private days to total days. The Group enjoys high national market shares of specialised and complex procedures. It, for example, has a 25% national share in heart surgery and 20% in cardiac procedures (Mediclinic 2007b). This is in line with Mediclinic’s South African strategy to target the high-end market.

Mediclinic sees the investment as vital to its strategy to diversify geographically within its core business of hospital care and to transform itself into an international hospital company. In South Africa, Mediclinic enjoys a reputation of being highly adept of extracting efficiencies from hospitals, something it expect to replicate at Hirslanden through a culture of 'cross-pollination' between its domestic and international operations. Mediclinic also sees opportunities for growth in the Swiss market through acquisitions of additional hospitals. Likewise, the acquisition is regarded as a stepping-stone for further expansion into other European markets.

4. Analysis and Conclusion

The three South African hospital groups described here are among the most successful in the world. Their domestic operations are world class, both in terms of quality and economic performance, and their global presence, at least in the case of Netcare and Mediclinic, dwarfs hospital groups from other countries – even those based in the US. Of course, the vast size of the US market means that the largest US hospital group dwarfs hospital groups from any other country. Netcare, for example, is smaller than any of the 10 largest US hospital groups in terms of revenue (while only two US groups manage more hospitals). The differences in accumulated revenue partly explain why the three hospital groups have not entered the US market – the largest in the World. It would entail to large initial investments. Another reason includes the fact that the US market is highly competitive with market power tilting in favour of funders rather than providers.

The focus of this paper is on an understanding of how healthcare services MNCs for an emerging economy, South Africa, has internationalised and how this may impact the home country. Generally, South Africa has seen a growing number of their firms becoming MNCs since the end of apartheid in 1994. The UNCTAD 'Top 100 TNCs from developing countries' ranked 10 South African MNCs in 2005, while none were ranked in 1994.[11] The South African MNCs have focused mainly on the African region, where they may have a locational advantage. However, the country has spurred MNCs of global significance such as Anglo American (the world's second largest mining company) and SABMiller (SAB is short for South African Breweries which in 2002 merged with Miller to form the world's second largest brewery). In 2004, 9 of the top 15 and 4 of the top 5 South African MNCs were service providers (UNCTAD 2006).

This indicates that South African firms can derive 'ownership' advantages from the South African market, which makes them competitive in other markets. Economic and trade sanctions because of apartheid in 1980s led to diversification and conglomeration in South Africa. Companies were banned from exporting capital and were thus forced to buy domestic companies instead which came cheap as foreign competition was virtually absent. Life and Mediclinic were both born in this way. Life as a part of Afrox and Mediclinic as a part of Rembrandt. Whereas Rembrandt (now Remgro) has maintained its controlling shareholding of Mediclinic and actively supported its internationalisation process, Afrox decided to offload Life (then Ahealth) just as its internationalisation process had begun. The tumult surrounding the sale of Life probably disadvantaged the group relative to Mediclinic and Netcare, which,

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[11] In 1994, UNCTAD only ranked the top 50 TNCs from developing countries. The 2005 top 100 list ranked 5 South African MNCs among the first 50.

while Life was finding its feet in South Africa, expanded overseas to the extend that they today derive around 50% of revenue from overseas markets.

The South African hospital market seems to have provided the groups with a number of non-location specific ownership advantages. Netcare boosts that it has succeeded in transferring the 'Netcare DNA' to its UK subsidiaries and consequently has improved the performance of these. Likewise, Mediclinic is providing managerial support (in form of seconded personnel) to its subsidiary in the UAE and expect to replicate its expertise in extracting efficiencies from hospitals to its Swiss operations, while Life's main contribution to its UK joint venture has been provision of medical and managerial personnel.

Several factors underpin this. First, the market is highly profitable providing the groups with a solid capital base for expansion. Second, the sheer size and diversity of the market relative to other markets, which tend to be both smaller and less diverted (at least outside the US), have provided the groups with superior managerial skills and knowledge on how to efficiently run private hospital chains. Thirdly, the consolidation of the South African market has provided the groups with experience in integrating new and existing business activities. Finally, the South African market has remained protected from global competition which has provided the three groups with a stabile environment in which to develop and hone their skills in close competition with each other in a market they dominate. The latter suggest that protectionism or rather the domination it allows may be crucial to MNCs from emerging economies.

For all of the big three groups the motive for expanding overseas has been to exploit new markets – market seeking FDI. The South African media has speculated that the groups are 'escaping' the South African market to avoid the new regulation initiatives by investing in other markets – escape FDI – but since the markets they have entered (with the possible exemption of the UAE) are more heavily regulated than the South African, this seems unlikely. Furthermore, the South African market remains extremely attractive. Push factors do exist but they are associated with the saturated nature of the South African market which is relatively small and with limited growth possibilities. Likewise, pull factors, such as attractive markets which have been welcoming foreign participation through relaxed regulation and opening up of public sector markets to private operators, have been strong.

The three groups have followed different paths in their internationalisation process. Mediclinic has as the only group entered two different markets following an 'all at once' approach as predicted by one string of theory to be the only entry mode for service companies. Life entered the UK through a joint venture with a local partner; a typical entry mode for emerging market firms. Netcare entered the UK market not 'all at once' but gradually. The group's initial entry was to establish Netcare UK, which functioned as a sales subsidiary for obtaining and manage NHS clinical teams contracts. In other words, Netcare UK initially functioned as a vehicle for mode 4 exports and a stepping stone and leaning experience for Netcare's deeper involvement in the UK market with the later acquisition of GHG. As such, the case studies presented here suggest that service companies too can internationalise by a variety of paths and do not necessarily need to do it 'all at once'.

The case of the South African hospital industry clearly shows that globalisation presents opportunities for developing country firms that are beyond low-value production and extends

to high-value service provision. However, as shown above, the ability to compete globally seems to rely on a set of ownership advantages which are developed in a 'protected' and concentrated market. In the case of the hospital industry, this implies that success in the global market as associated with having a large and dominating private healthcare sector at home. The literature on international trade in health services as referred to in the introduction is particularly concerned with this aspect in relation to developing countries. It generally argues that trade in health services creates or reproduces 'two-tier' healthcare systems – a privately funded for the affluent few and a publicly funded for the poor majority – and as such risk exacerbating existing inequalities within developing country health systems.

However, the concern is with inward FDI. Outward FDI in health services is seen as having minimal interest to developing countries (e.g. Woodward 2005) and it is argued that FDI will most likely flow from developed saturated markets to new profitable opportunities away from these (e.g. Smith 2004; Chanda 2001). It, thus, fail to capture (or predict) the actual trend of FDI flows involving the emergence of hospital MNCs from developing countries. Mortensen (2008) shows that where it involves developing countries, FDI in health services primarily flows from non-OECD countries to other non-OECD countries or to OECD countries. Another trend which this literature fails to capture is the opening of public sector activities for private sector providers and the opportunities this has created for developing country providers.

Of course this does not mean the concerns of the literature in relation to the impact on health systems in developing countries are irrelevant. Instead it implicates that concern should be with how outward FDI impact home countries. In the South African case, it is quite possible that the global success of the private hospital sector is empowering an already entrenched and dominate sector in the fight against government regulations aimed at easing health system inequalities. This, and how outward FDI from developing countries in general is affecting the home countries, appear to be an area that is rich for future research.

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