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American Hospital Firms and The Burgeoning Chinese Private Health Market

Synopsis

Globalization of health care services is becoming an alternative or complementary strategy for some U.S. health care organizations due to increased competition, a stagnant health care market, and nationally imposed cost constraints in the U.S. If an ambitious American health care firm decides to globalize its product or service lines, what might be some of the primary strategies it would use to enter an international market? To investigate this question, this paper considers the strategies of two American firms that have entered the Beijing and Shanghai markets in the last year or two.

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ABSTRACT

Globalization of health care services is becoming an alternative or complementary strategy for some U.S. health care organizations due to increased competition, a stagnant health care market, and nationally imposed cost constraints in the U.S. Additionally, entrepreneurial U.S. firms not currently feeling the pinch may see globalization as an opportunity to promote their services in new countries with increasing demand for advanced technological services. If an ambitious American health care firm decides to globalize its product or service lines, what might be some of the primary strategies it would use to enter an international market? To investigate this question, this paper considers the strategies of two American firms that have entered the Beijing and Shanghai markets in the last year or two. Numerous conversations and interviews with executives of these firms have been conducted in an attempt to understand their market entry and early development strategies. These firms' market entry strategies range from "greenfield" operations, where the hospital does little to change its corporate and managerial style from what it uses domestically, to a "glocalization" strategy, where the firm is quite sensitive to fitting into the Chinese culture and being accepted by the Chinese government. The strategic challenges for international hospital organization developments in China are extreme, but the potential rewards from becoming among the leading firms in a large nation with an expanding economy are fantastic. What we learn from the experiences of enterprising American hospital firms in China may well portend the future for international developments by many other American-based health organizations.

American Hospital Firms and the Burgeoning Chinese Private Health Market

This article is about the differing market entry strategies into the Chinese hospital market by two American-based hospital development companies. Both of these companies have executives with similar, extensive backgrounds in the U.S. private hospital industry, and both have international joint venture organizations with Chinese firms that are based in Hong Kong. Both companies are aiming at large, but different, urban areas – Beijing and Shanghai – for market entry, and both have plans to expand to other major urban areas within months. And, both firms expect that their western standard quality care management and customer service will give them a distinct competitive advantage in the market places they enter.

The similarities between these firms are striking. Yet, their market entry and marketing strategies widely differ. The first firm is building an "international hospital" that caters to expatriates from other nations and upper class Chinese. Their hospital model, which is based on the top international hospital in Asia, Bumrungrad Hospital in Bangkok, Thailand (Balfour, Kripalani, Capell and Cohn, 2004), could be located almost anywhere in Asia. Even though the hospital will have western and eastern (i.e., Traditional Chinese Medicine) medicine wings, there is little effort being made to localize the culture and management of their facility. Their intention is to become an international destination hospital in Beijing for all nationalities. The second firm is taking a "glocalization" approach to market entry. Glocalization, which means thinking globally but acting locally, implies an optimal mix of parental control and local initiative. In effect, a glocalization strategy means that local managers will have some freedom to develop their own implementation plans for products, marketing and production that are consistent with local political, economic, legal and cultural demands (Phatak, 1992). The second firm will be opening private units within existing Chinese public hospitals. Marketing of their services will be aimed at the emerging Chinese middle class, while also providing the subtleties of care expected by expatriates and upper class Chinese. Their goal isn't to be the top international hospital in China, but to become a brand name for international quality of care standards throughout China in coming years.

A. Background

The Growth of International Health Services

The health care sector is among the most rapidly growing business sectors in the world economy. The size of the sector is estimated at about US $3 trillion (Health and the International Economy, 2002) in the Organization for Economic Co-operation and Development countries alone and is expected to rise to US $4 trillion by 2005 (Zarilli and Kinnon, 1998: 55). Health and related services have become increasingly tradable due to a variety of economic, social, technological, and global institutional factors, although the sector is also subject to a wide range of tariff and non-tariff protection for health related commodities and inputs across developing countries. In recent years, there has been significant growth in trade and investment opportunities both within the health services sector and in related services, such as health insurance, across developed and developing countries.

The General Agreement on Trade in Services Treaty (also known as, GATS) characterizes services as being traded via four modes of supply: 1) consumption abroad, 2) commercial presence, 3) movement of persons, and 4) cross-border supply. Of these, commercial presence will be the primary subject of this paper. However, one should note that the other modes of supply do have growing health industry applications. For example, consumption abroad – or the movement of patients to receive treatment in foreign markets – is growing quickly, especially among neighboring countries and within regional trading

blocks (Chandra, 2002; Freeman and Frank, 1995). The movement of health personnel, including doctors, nurses, paramedics, technicians, consultants, and health management personnel, has been discouraged by host countries, but is a growing phenomenon as health workers continue to seek better wages and working conditions (Zarilli and Kinnon 1998). Finally, the cross-border supply of health services reflects the growth in telemedicine and cross-border delivery of medical samples and diagnosis. For example, Mathur (2001) discusses the potential of information technology for revolutionizing health care design and delivery by influencing wide-ranging aspects of health care, from the development of new medicines based on biotechnology to distance supervision of patients and the transfer of medical information to the health care insurance companies and health care administration.

The emergence of international health service delivery is being driven by a number of developments. First, the cross-border training and movement of health professionals has made high quality health care available in most nations of the world. Second, advanced quality of telecommunications has allowed physicians to consult on procedures that are happening in real time thousands of miles away. Third, the increasing availability of high speed transportation has made it such that a 24 hour or less air flight will get you half the way around the world. Fourth, the concept of overseas hospitals should be attractive to governments, employers, insurance companies and HMOs in the U.S. and other western nations who carry the primary burden of rising costs of medical care.

An emerging commercial presence in the health sector has grown in importance because of the increasingly liberal attitude of countries toward foreign direct investment and towards collaboration with foreign companies in the form of joint ventures, alliances, and management tie-ups. Developing countries, in particular, are becoming increasingly aware that they must learn to capitalize on their advantage of low-cost skilled human resources in the global market. This advantage is particularly important in the labor-intensive field of medical care. Those countries that have a ready supply of well-trained health workers, language and cultural proficiency, good government and a need for foreign investment in their healthcare system (there are many such countries) are taking a proactive posture in persuading foreign governments and corporations to shift their medical care services to their shores. One high-quality, medium-size foreign hospital could bring an investment of tens of millions of dollars per year (Jain, 2003).

International Health Strategic Management

The rapid development of international health trade provides unprecedented opportunities for firms to enter emerging private foreign markets. This situation calls for the development of an international health strategic management perspective that will provide a cognitive and conceptual framework to managers who are considering international health developments. There are a variety of strategic management theories that have application in international markets (Thomas, Pollock, and Gorman, 1999). Three perspectives that build on each other and seem to fit best with international health strategic management include: core competencies, national sources of competitive advantage, and networking. To the best of our knowledge, there is nothing in the literature that focuses on international strategic management in health service industries. As such, this paper provides a starting point for such an endeavor.

First, core competencies are the outcome of collective learning in a firm. In order to conduct a comprehensive strategic analysis, managers must evaluate their competencies and competition at the firm, industry, and national levels (Prahalad and Hamel, 1990). These competencies serve as the “dominant logic” for how managers conceptualize their business and make critical resource allocation decisions. Firms that successfully identify and cultivate their core competencies can use them to obtain a sustainable competitive advantage against their rivals. A core competence is therefore a knowledge base or set of skills that is general enough to be applied in a variety of settings, results in a clearly defined benefit to the consumer, and is difficult, if not impossible, for other firms to replicate.

Second, to move into international markets, health managers need to understand their firms' capabilities in relation to a globally competitive environment. Part of this process should be an evaluation of how market experience in a firm's homeland might provide competitive advantage in a foreign market (Porter, 1990). Sources of competitive advantage in a foreign market can include the natural resources and cultural advantages available to firms located in different countries: lax regulatory environment, direct entry by foreign competitors in local markets, and, the low cost of labor in many developing nations. Alternatively, health managers need to recognize that strong domestic competition in the U.S. can provide their firms with a competitive advantage in a foreign market. For example, strong domestic rivals push each other to innovate and improve the quality and characteristics of their products and services in ways that upgrade the competitive advantages of domestic firms. In addition, domestic competition often forces firms to expand into foreign markets if they wish to continue to grow and reap any scale advantages that may accompany increases in size.

Third, it is extremely difficult for a single health firm to develop internally all of the skills and knowledge necessary to compete effectively abroad. As a result, globally competitive health firms are typically involved in alliances and cooperative joint ventures with current and potential competitors, both locally and in the host nation. Firms use networks strategically by forming alliances, joint ventures and the like that allow them to develop new skills, enter new markets, and leverage current skills (Powell, 1990). Although networks of relationships can offer a number of advantages, they also possess some limitations. Networks open up opportunities for interaction, but they also constrain the options and behaviors of network members. If the organization's environment were to suddenly change, the restrictions of a firm's current network might not allow it to adapt along with the changing environment. Networks can also result in significant costs associated with establishing the relationship and attempting to guarantee that one partner is not able to take advantage of the other (Kaluzny, Zuckerman and Rickets, 1995).

It is important to note that international health strategies come with caveats. U.S. health care organizations, in particular, will encounter some barriers that organizations in other industries may not encounter as international strategies are implemented. In most other countries, health care is believed to be a fundamental need and right, and governments ensure equal access to health services for all people. This social welfare state orientation leads government to play a strong role in the delivery of health care services. For example, governments don't just oversee but are involved in the management of different delivery and reimbursement mechanisms. Also, governments can be directly involved in financing health care and setting overall fee schedules for physicians and annual budgets for hospitals. Developing strong governmental relations, as well as understanding reimbursement policies, are crucial for the successful implementation and management of organizational strategies.

Other hurdles which will temper the development of international health strategies include: 1) Regulation - For example, in the U.S., citizens are generally precluded from obtaining healthcare anywhere they want without paying a substantial amount above their monthly insurance premium. 2). Licensure - A licensed health practitioner in one nation may not have legal permission to offer care in another. Even if they do, the liability risks might make providing such care economically risky, creating a substantial disincentive to practice medicine across national lines. 3). Information - There are no international standards in healthcare nomenclature, making it difficult to share data. 4). Culture - For example, in many cultures, a patient's immediate family members will not just accompany the patient to a hospital, but will stay with him or her, handling such chores a cooking, bathing and laundry. One can imagine that this cultural convention suggests a much different approach to hospital design as well as communication channels between health professionals and patients.

The Chinese Hospital System

The Chinese government is looking for joint venture clinics and hospitals with foreign firms to help with the long-term development and advancement of China's healthcare system (Wood, 2004). Exclusively foreign-invested medical institutions are still denied access to the Chinese market. Joint ventures can set their own prices for medical services, are exempt from business tax for the first three years operation, and their self-made drugs are exempt from value-added tax for the same period. Since all hospitals participating in the medical insurance system must be state-owned, private clinics including joint ventures may receive only self-funded patients.

The demand for international caliber healthcare in China has been best reflected in the growth of international standard clinics and outpatient facilities operated by foreign-invested enterprises. Since the first Sino-foreign hospital was founded in 1989, almost 200 joint venture or cooperative venture hospitals or clinics of various types have been established in China. However, 50% of these clinics and hospitals have investment of less than US $2 million, and only about 10% have funding of more than $10 million. Most are clinics without in-patient beds, and less than 20% of the hospitals have more than 200 beds (cite needed). They are currently regulated as for-profit healthcare service providers.

Although China's health system is classified by most as having developing world conditions, it is quickly evolving. China's hospital system provides care to 1.3 billion citizens under a system of national health insurance which is funded primarily by the government, but with some contributions from its citizens through a self-pay mechanism for those individuals not covered by the national insurance plans. Currently, there are 3 national health insurance plans in China, but they only cover relatively few (approximately 15% of the population citizens.

Healthcare expenditures are especially low in the rural areas of China. Per capita healthcare expenditure per year is US $45 in China. In comparison, per capita healthcare expenditure per year is US $2,908 in Japan (highest amount in Asia), and US $4,737 in the U.S. (Final Briefiing, 2003). Life expectancy differences are: China is 62.8 years, Japan is 73.5 years (highest in Asia), and the U.S. is 77 years (By The Numbers, 2003).

Seventy percent, or 900 million, of China's 1.3 billion people live in rural areas. This 70% only uses about 20% of China's healthcare resources (Chen, 2003). The urban population of China, in comparison, has broad access to healthcare, both in the quantity of hospitals and clinics available and the quality of health services that are offered. Recent studies have suggested that there are more than 23 million 'affluent' households in China where affluence is defined as sufficient income to allow discretionary spending power. In 2000, 8.4% of urban households met these criteria (Executive Summary, 1999). It is also noted that affluent households spend four times as much on healthcare as non-affluent households (Executive Summary, 2001).

The number of hospitals in China and their distribution is very difficult to assess. The definition of a hospital is not clearly delineated in government documents and often sub-acute and extended care facilities, nursing homes, etcetera are included as "hospitals." Of some reliability is the number of large-bed facilities which may with some confidence be considered as acute care facilities. The official count of hospitals in China, as of 2002, is 17,148. A major role for hospitals in China is provision of primary care. Of the 17,148 official hospitals, only 8,849 are classified as acute care facilities. The breakdown in acute care facilities is: 'A' Hospitals (over 500 beds), 977, 'B' Hospitals (250-500 beds), 5,198, and 'C' Hospitals (less than 250 beds), 2,674 (Ministry of Health, 2003).

The physical plants of China's hospitals vary in their quality and appearance, with large urban hospitals built in the last 25 years appearing, in many respects, to be equivalent to those found in Western countries. However, even in these facilities, the level of maintenance is strikingly poor with inadequate hygiene, dirty floors and walls, torn and shabby furniture and inadequate toilets and restrooms. Equipment is often the latest generation, international brands, but it is often poorly maintained and calibrated. Typically, the large urban centers have very few upper tier hospitals with reasonable standards. The other urban hospitals and most of the rural hospitals are wholly inadequate by international standards. Further, Chinese hospitals have rudimentary management systems. Most managers are non-professional and physician managers with little, if any, business training and experience. Typically, organizations do not have organization charts, and joint management/medical staff committees and board governance is non-existent. Many hospitals do not have a chief financial officer and do not utilize cost-center budgeting, have no reimbursement or accounts receivable functions and have minimal IT support of financial functions (Wood, 2004).

In May 2000, the Ministry of Health announced that China would establish new health care service management in an effort to make high-quality basic medical care available to all Chinese. Competition between hospitals is being introduced to improve the distribution, efficiency and quality of services. Patients now have to pay a user fee to attend a hospital, and they can choose which hospital to attend. The Ministry of Health also announced that medical service organizations would be divided into for-profit and not-for-profit units and that patients would be able choose their hospitals on their own. Not-for-profit providers still predominate in China. They receive preferential tax policies and must adhere to government guidelines on prices. Alternatively, for-profit hospitals are allowed to set their own prices and they pay taxes.

B. Research and Methods

In return for providing strategic and proprietary information on their activities for use in this article, the lead author promised the organizations that their identities would remain confidential. Firms that are in the market entry stage are generally very private about their strategies and do not want their intentions publicized. The summary information provided herein comes from a series of interviews, phone conversations and document exchanges between the lead author and each of these case study organizations over the last two years.

The second author of this article, due to his former position of CEO of Beijing United Hospital and current position as Managing Director of ChinaCare Group (Beijing) and due to the proprietary nature of the information provided by the case organizations, was not involved in information exchange with either of the case study hospitals and has never talked to representatives from either organization. The second author's primary role in this article has been to critique the plans of the two case organizations. His comments regarding both firms' market entry strategies are interspersed throughout the following text.

The lead author communicated, at the beginning of his association with both organizations, that he would eventually write a summary piece of this nature and that he would construct his own analysis and critiques of each organization's strategies. A draft of this article was delivered to both organizations for comments, corrections and changes prior to publication. Note that the lead author has felt no pressure from either organization to alter or not report the information that was divulged in the interviews and the documents provided by the organizations. Conversations with 'China International Partnership Hospital' (CIPH, an alias name for this article) started in September 2002 and have been as recent as April 2004. Conversations with 'International Hospital in China' (IHC, an alias name for this article) initiated in February 2003 and have been as recent as January 2004).

C. Case Studies

China International Partnership Hospital

China International Partnership Hospital (CIPH – an alias) was initiated as a U.S. corporation in 2002 and is the principal firm in CIPH International (alias), a joint venture organization based in Hong Kong. Like all other international hospitals in China, CIPH focuses on providing high quality and state-of-the-art medical services and technologies. However, CIPH differentiates itself from other international hospitals by targeting middle class Chinese citizens, focusing on being the high quality provider of just one service – maternity care, and by not starting greenfield hospital operations in China, but opening up their own private "VIP" units within existing hospitals.

CIPH's focus on state-of-the-art service allows them to market services to the wealthiest Chinese and expatriate populations. Clinical quality of care is managed at CIPH through a clinical training contract with a top medical school on the east coast of the U.S. According to the CEO of CIPH, the University entered into an exclusive contract (7 initial years, plus 5 years renewable), non-compete contract in China with CIPH. However, the authors believe that this University has arrangements with other western health facilities in China. It isn't clear how CIPH's contract with the University might differ from other contractual relations by the University in China.

CIPH also focuses on having an immediate cash flow without having high capital risk and risk of liability. This strategy is operational zed by starting with smaller, profitable projects and then developing market share. For example, CIPH opens small units (11-13 beds) within Chinese women's and children's hospitals. After contracting a partnership, CIPH opens its own floor within the hospital, housing private rooms and VIP services, and then expanding its units to other floors of the hospital as demand increase. This development strategy has less risk of failure and capital loss, while providing a quality brand for the partnering Chinese hospital. As a result, consumers are less likely to see CIPH as a profiteering international hospital, and more likely to see it as a Chinese hospital with high quality Western services. This culturally sensitive approach to international hospital development is supported by Chinese government officials, also.

CIPH's focus is on maternity care, although they expect to move into other services in coming years. CIPH estimates that there are about 600,000 babies born annually to middle class Chinese, at present, and that this number will increase to about 1,200,000 babies in three to five years as the Chinese middle class grows. CIPH's goal is to capture 1 to 2% of births to middle class Chinese in the next couple of years, and 5% of these births in five years. According to the CEO of CIPH, there are three primary reasons why they chose to focus on high quality obstetrical care as a strategy. These reasons include:

1. Chinese women have a tradition of being their families' gatekeepers to health care services. CIPH will offer other hospital-based services in coming years, and they expect women who have given birth in one of their obstetrical units to come back to use other services at CIPH.

2. There is vast opportunity for Western-based obstetrical services in China. Due to the one child family policy in China, Chinese are willing to expend considerable costs to assure the best standards of care for birthing. Also, obstetrical care services in China are about "20 years behind Western standards." Obstetric units in Chinese hospitals generally hold four to eight patients, with a shared bathroom or a bathroom down the hall. The hallway is dark and families wait outside in small waiting areas, and it often takes hours for families to hear about the childbirth outcome.

3. Compared to other service lines, Chinese obstetrical physicians and mid-wives are quite well trained. Introductory training of Chinese health professionals for CIPH can be done in a one or two

months at the U.S. medical university that CIPH is contracted with. In comparison, cardiology or oncology training of Chinese physicians would be substantially longer and more complex.

CIPH's focus on the middle class Chinese market is supported in the pricing structure of its maternity services. Currently, CIPH charges from US $2,500 to $3,500 per delivery. These prices are about one half to one third the costs of childbirth at other international hospitals. For example, Beijing United (a 50 bed maternity hospital in Beijing) caters to the expatriate market and charges US $8,000 for a natural childbirth and up to US $12,000 for a complicated childbirth.

Currently, CIPH has a small maternity unit (13 beds) operating in a leading Shanghai hospital, is about to open another unit in a Guangzhou hospital, and has plans to open three smaller units within existing hospitals in three large Chinese cities in the next six months. There are other high quality international hospital obstetrical units in Beijing and Shanghai, but not in any of the cities where CIPH will soon be starting operations. Note that the Shanghai-based obstetrical unit, which opened in October 2002, generates high revenue per month and will soon expand capacity to handle increasing demand for service. The expansion of the unit was delayed for months due to the SARS crisis in spring 2003, but construction will soon begin on an additional 30 beds.

According to the CEO, CIPH will continue to differentiate itself from competitors in the long term by: 1) providing well known brand name recognition in urban China, 2) partnering with well established Chinese hospital partners, and 3) further developing Western-based management systems, including advanced health IT for medical records and clinical care protocols.

International Hospital in China

Established in 2001, International Hospital of China (IHC – an alias) is a Hong Kong Corporation with offices in the U.S. state and Beijing. IHC is owned by IHC Intl, which manages two international clinics: two in New York and one each in Chicago, Atlanta and San Diego. These clinics integrate Eastern and Western medicines. IHC's corporate vision is to develop the first healthcare network capable of delivering "U.S. standard" medical care in leading economic and trade centers throughout China. This capability includes providing leading technology solutions and global resources to healthcare professionals.

IHC has aggressive growth plans for building full service hospitals and referring clinics in Beijing first, and other major Chinese metropolitan areas in coming years. IHC's facilities will provide primary, secondary, and tertiary care services through partnerships with Chinese joint venture hospitals and clinics. IHC will own controlling interest in each joint venture hospital and supporting clinic. Each hospital will operate 250 beds and have Eastern and Western primary care clinical services. Secondary services will be provided through a variety of sources – from sophisticated preventative and diagnostic services to surgical and interventional procedures.

IHC will develop Centers of Excellence (COE) in each IHC hospital by meeting the standards of the top U.S. teaching hospitals. For example, one IHC hospital will be a cardiovascular COE, another orthopedic COE, and so on. Additionally, U.S. healthcare partners will provide remote consultations, provide on-site rotational services, teach Continuing Medical Education (CME) course for Chinese physicians, and provide training opportunities for Chinese physicians in the U.S. IHC has partnership arrangements with nationally renowned teaching hospitals in the U.S. to administer CME courses.

IHC will "target cash-paying customers such as expatriates, tourists, and high-income patients." Based on market studies, IHC believes there are about 4.92 million Chinese citizens in their target market. Note that 4.92 million is much larger than other marketing surveys have indicated for high-end health service market

users. Target customers will pay U.S. market rates on an upfront fee-for-service basis. Qualified customers (such as multi-national corporations) will pay an annual network access fee to use an IHC facility. According to IHC, "ninety-five percent of payments will occur in advance of the treatment, thus there will be very little need for a billing and collection operation, and virtually no bad debt." However, there is no precedent for such a high volume of out-of-pocket pay in China. Other western hospital firms rely on insurers payments to cover the costs of care for expatriates and tourists.

The management team of IHC is well rounded and has excellent experience in the hospital industry. The executive team includes managers who have been serving the healthcare industry for over 30 years in the U.S. and for over 15 years in Asia. Their combination of hospital operational expertise and healthcare technology expertise are "unsurpassed by any competitor," as stated in their business plan, and should be seen by future investors as a competitive advantage of IHC. In particular, the management team of IHC has expertise in hospital construction, health system development, customization of health information technologies and international business. Although the leaders of the management team are new to the development of hospitals in international markets, and, in particular, the Chinese private health market, their perseverance, financial wherewithal and other resources may be enough to bring them success in the China.

Other key competitive advantages of IHC include:

1. Patient-Focused Healthcare Solutions. Hospitals will be designed to focus on patient's physical and mental health to limit administrative duties for health professionals so they can concentrate on patient care.

2. Combination of Eastern and Western Medicine. IHC believes that traditional Chinese medicine (TCM) and Western medicine can complement each other, thereby empowering patients to control, alleviate, and prevent many chronic conditions.

3. U.S. Hospital Partnerships. IHC has the means to access the most recent clinical information and cutting-edge procedures, treatments, and technology. IHC has established relationships with over 200 of the major teaching hospitals and academic medical centers in the country.

4. U.S. and International Healthcare Standards. According to IHC, all of "their hospitals will be designed and operated according to U.S. codes and standards." However, the authors note that there is no way to operate on US codes and standards in China. China doesn't have the infrastructure to allow implementation of US codes and standards and won't have the necessary infrastructure for years to come. Also, the idea of having similar strategies running for multiple organizations on centralized administration will be a new concept within the Chinese health system, and management of such will take a large investment.

5. Technology Solutions. IHC has tremendous experience in Health Information Systems including partnerships with PeopleSoft, Lawson, SAP, HBOC, Oracle and over sixty healthcare organizations. IHC is confident that their "electronic solutions, developed in conjunction with leading U.S. technology partners, will have tremendous resale value throughout China." However, the authors note that the transfer of western-based health IT solutions is very difficult in China. All western IT systems have to rewritten in pinyin or Chinese characters, and the financial systems have to be adapted to Chinese accounting system to meet the claims of IHC's management. Further, the IHC's financial systems will have to be approved by the Chinese government before they would have any resale value.

6. Supply Chain Solutions. IHC has significant experience with creating new directions for healthcare supply chain models and logistical transportation practices. IHC's fully integrated supply chain solutions – developed in collaboration with materials managers, nurses, physicians, vendors, and technology partners – address the complexities inherent in the procurement process, reduce costs, and increase organizational efficiency.

D. Conclusion

Most all nations in the world have a private segment in their national health systems, and most of these private segments are increasing in size as international trade policies open up markets and consumers begin to demand health care in accordance with international standards. It can be argued that U.S. hospital firms have a distinct advantage over hospital firms from other nations in these emerging private markets. U.S. hospital firms have tremendous managerial experience in competitive markets, and they understand the necessity for providing the highest quality and technological care to gain hospital market share. Furthermore, the hospital industry in the U.S. has pockets of opportunity, but in the whole it is a mature industry with heightened competition for smaller profit margins. Heightened profits in foreign hospital markets have become alluring enough in recent years to attract some American-based firms to put forward the tremendous investment of time, energy and capital to move into overseas market developments.

As shown by the two enterprising firms discussed in this paper, there is no one model for entering an overseas hospital market, or at least, not the Chinese hospital market. Although the case study firms are quite similar in managerial experience, competencies, and structure (in terms of partnership development), their market entry strategies contrast. IHC is attempting to build an international hospital system in the Beijing area. Their system is designed to serve expatriates and the wealthiest Chinese as is symbolized by their choice of location for their first hospital: next to the 2008 Beijing Olympics village. This hospital is being built in Beijing because the demand for Western-based private hospital services may be the greatest in Beijing of all foreign markets. Alternatively, CIPH is building private units within existing public hospitals in China. CIPH's strategy is to develop market penetration and name brand recognition by middle and upper class Chinese. They will do this by focusing on Western-based maternity care services, a service line which is of critical interest in China due to their one child policy. CIPH isn't really building an "international" hospital like IHC; they are bringing Western techniques and standards into China's existing hospital system

The efforts of these firms over the next few years will be watched and scrutinized by many. Because their marketing strategies are so different and the markets in China are so huge, it is possible that both firms will not compete head-to-head and will thrive. Yet, it is also possible that one of these strategies will win out over the other. As the Chinese economy quickly expands and Chinese citizens, in turn, begin to appreciate and seek health care services that meet international standards, there is tremendous profit potential for the winners of the race into the burgeoning private health markets in China.

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