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Overcoming language barriers in health care services in the medical tourism context:
Health care companies' perspective

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Master's thesis

Maiju Röysky

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Department of Management Studies
Aalto University
School of Business

Aalto University
School of Business

Aalto University, P.O. BOX 11000, 00076 AALTO
www.aalto.fi

Abstract of master's thesis

Author Maiju Röysky

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Abstract

The primary objective of this study was to understand the role of language in health care services. This study aimed at investigating 1) how language barriers affect health care encounters and how health care companies overcome language barriers in medical encounters and 2) the role of native language in health care services and when native language use is particularly important. The context of this study was medical tourism from Russia to Finland, and the secondary purpose of this study was also to comprehend the global phenomenon of medical tourism. The research problem was studied from Finnish health care companies' perspective.

This study was conducted as a qualitative multiple case study with four case companies: Coxa Hospital for Joint Replacement, Docrates, Hospital Neo and Orton. Case companies were selected among the participants of FinlandCare program. For the study, three different groups working in the Finnish medical tourism sector were interviewed: two industry experts, seven health care professionals and five directors/managers from the case companies. Altogether 13 semi-structured interviews were made for this study and transcriptions of the interviews formed the primary empirical data. Within-case analysis and cross-case analysis were used as data analysis methods in this study.

The findings of this study indicate that language barriers are in many ways problematic in health care services and they may have various negative impacts on a patient. However, in order to be able to communicate and interact in health care encounters with Russian patients, the case companies demonstrated various interventions for overcoming language barriers in health care, ranging from having Russian-speaking personnel (language concordance) and using professional and non-professional interpreters to different creative solutions like written translations and internal grammar books. This study concludes – in line with previous studies mainly from patients' perspective – that patient's native language has an important role in health care services. Based on the findings of this study, native language use is particularly important in the beginning and end of the health care service process, as particularly in those phases patient and health care personnel must be able to communicate effectively. Moreover, language has also an important role in medical tourism and the findings of this study support the previous findings that service language can even affect patient's choice of the service provider.

Keywords Health care services, medical tourism, language barriers, native language use, service encounters, service language, health care companies in Finland, Russian patients

Aalto-yliopisto
Kauppakorkeakoulu

Aalto-yliopisto, PL 11000, 00076 AALTO
www.aalto.fi

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Tiivistelmä

Tämän maisterintutkinnon tutkielman ensisijaisena tavoitteena oli ymmärtää kielen merkitystä terveydenhoitopalveluissa. Tutkimus pyrki selvittämään 1) miten kielelliset esteet vaikuttavat palvelutilanteisiin terveydenhoitopalveluissa ja millaisia keinoja terveydenhoitoalan yrityksillä on kielellisten esteiden ratkaisemiseen sekä 2) millainen on potilaan äidinkielen rooli terveydenhoitopalveluissa ja missä vaiheessa hoitoprosessia äidinkielen käyttö on erityisen tärkeää. Tutkimuksen kontekstina oli terveysmatkailu Venäjältä Suomeen ja tutkimuksen toissijaisena tavoitteena olikin ymmärtää globaalia terveysmatkailun ilmiötä. Tutkimusongelmaa lähestyttiin suomalaisten terveydenhoitoalan yritysten näkökulmasta.

Tutkimus suoritettiin kvalitatiivisena monitapaustutkimuksena, jossa tapauksina toimivat neljä terveydenhoitoalan yritystä: Tekonivelsairaala Coxa, Syöpäsairaala Docrates, Sairaala Neo ja Orton. Case-yritykset valittiin FinlandCare –ohjelman osallistujien joukosta. Tutkimusta varten haastateltiin kolmea eri ryhmää, jotka työskentelevät Suomessa terveysmatkailun sektorilla: kahta terveysmatkailun asiantuntijaa, seitsemää hoitohenkilökunnan edustajaa case-yrityksissä sekä viittä johto- tai päällikkötason henkilöä case-yrityksissä. Tutkimusta varten tehtiin yhteensä 13 puolistrukturoitua haastattelua ja litteroitu haastatteluaineisto muodosti tutkimuksen ensisijaisen empiirisen aineiston. Haastatteluaineiston analyysimetodeina käytettiin yksittäisten tapausten analysointia ja ristikkäisanalyysia.

Tutkimuksen tulokset osoittavat, että kielelliset esteet ovat monella tapaa ongelmallisia terveydenhoitopalveluissa ja niillä on monia negatiivia vaikutuksia potilaaseen. Tästä syystä case-yrityksillä oli monenlaisia ratkaisuja kielellisten esteiden voittamiseen terveydenhoitotilanteissa: venäjänkielistä henkilöstöä (kielellinen konkordanssi), ammatti- ja ei-ammattimaisia tulkkeja sekä erilaisia luovia ratkaisuja, kuten kirjoitettuja käännöksiä ja sisäisiä sanakirjoja. Tämän tutkimuksen pohjalta voidaan sanoa, että potilaan äidinkielellä on merkittävä rooli terveydenhoitopalveluissa, mikä on linjassa aikaisempien aiheesta tehtyjen tutkimuksien kanssa. Erityisen tärkeää äidinkielen käyttö on terveydenhoitoprosessin alku- ja loppuvaiheissa, sillä näissä vaiheissa on erityisen tärkeää, että potilaan ja terveydenhoitohenkilökunnan välinen kommunikaatio ja interaktio on sujuvaa. Lisäksi tutkimuksen pohjalta voidaan sanoa, että kielellä on merkittävä rooli myös terveysmatkailussa, ja tämä havainto tukee aikaisempia löydöksiä siitä, että palveluntarjoajan mahdollisuus tarjota palveluita potilaan äidinkielellä vaikuttaa jopa potilaan valintaan palveluntarjoajasta.

Avainsanat terveydenhoitopalvelut, terveysmatkailu, kielimuuri, äidinkielen käyttö, palvelutilanne, palvelukieli, terveydenhoitoalan yritykset Suomessa, venäläiset potilaat

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1. INTRODUCTION

Long waiting lists, high cost, lack of resources and better services offered elsewhere; health care sectors around the globe are increasingly facing various challenges. Due to the health care sector problems as well as easy and affordable access to cross-border travel and Internet as advertising and marketing platform, patients around the globe are increasingly seeking health care in other countries than their country of residence (Carrera & Bridges 2006). This phenomenon is called medical tourism (e.g. Carrera & Bridges 2006; Freire 2012; Lunt et. al 2012; Moreira 2013b). Medical tourism is probably the most visible part of the generalized growth of health care globalization and voluntarily patient mobility (Morgan 2010) which can take also other forms than medical tourism.

In recent years medical tourism has become a global high-volume phenomenon partly due to affordable cross-border travel and rapid development of information technologies (Lunt & Carrera 2011). The estimations on global flows of medical tourists and the size of the industry vary a lot, but for example Deloitte (2008) estimates that medical tourism is globally a $60 billion business. However, it must be noted that travelling abroad for health care is not a new phenomenon (Connell 2006; Morgan 2010; Lunt et al. 2012). For decades affluent people have travelled in search of health care services that are more affordable, of better quality or for some reason not done in patient's home country (Morgan 2010).

Also due to medical tourism and other forms of globalization, in the global economy international interactions are increasing and people are spending more time in other countries than their country of residence and learning new languages (Holmqvist 2009). As both people and markets become multilingual, both consumers and companies come across situations in which they have to use other language than their native language. Simultaneously, despite the service language, language and communication are always integral parts of any service encounter at least to some degree (Grönroos 1984; Surprenant & Solomon 1987; Holmqvist 2009). In fact, the importance of effective communication in service encounters in a well-known and researched phenomenon (e.g. Grönroos 1984; Bitner et al. 1997; Holmqvist 2009), but not much attention has been paid on situations in which the communication needs to be carried out in a language other than customer's native language (Holmqvist 2009). Moreover, there are certain services in which using native language seems to be particularly important.

These services are called high involvement services and they include for example medical and financial services (Holmqvist 2009). Empirical research (McDougall & Levesque 2000; Holmqvist 2009; Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013) suggests that consumers consider it essential to use their native language in services that include high financial or physical risk (e.g. medical and financial services) and they find native language less important in less risky service contexts, like during a cafeteria or grocery store visit.

The global medical tourism generates service encounters in which patient and the service provider are not always sharing a common language, which indicates language barriers. Holmqvist (2011) notes that if a customer and a service provider do not share a common language there is possibility for adverse impact on the personal interaction, which is at the core of the service communication and thus, the whole service itself. Language barriers may also have an impact on the outcome of a service encounter (Holmqvist 2011). Besides, particularly in the context of health care services, language barriers have been demonstrated empirically to have various negative consequences on patients (Carrasquillo et al. 1999; Morales et al. 1999; Sarver & Baker 2000; Fernandez 2004; Jacobs et al. 2006). At the same time, Jacobs et al. (2006, p. 111) note that an efficient dialogue between a doctor and a patient is understood to be 'of diagnostic import and therapeutic benefit'.

1.1 Research problem and research gap

The importance of languages in international business context has been recognized already for some time (e.g. Marschan, Welch & Welch 1997; Marcella & Davies 2004; Holmqvist 2009; Holmqvist 2011). There is currently an emerging consensus (e.g. Marschan, Welch & Welch 1997; Jacobs et. Al 2006; Holmqvist 2009; Holmqvist 2011; Holmqvist & Grönroos 2012) within international business and service marketing literature proposing that languages are a key research area in international business and thus, language issues cannot be neglected. However, at the same time many researchers (e.g. Holmqvist and Grönroos 2012) emphasize that there ought to be more research on language influence in service encounters as well as in general the role of language in services.

However, although language is an extensive research area in the field of marketing and services, it has raised relatively little attention in the academic research until recently (as an exception, please see Holmqvist 2009; Holmqvist 2011; Holmqvist & Grönroos 2012;

Holmqvist & Van Vaerenbergh 2013). One explanation for the lack of research in the field of language is that language has traditionally been seen as a sub-field of culture and thus, it has been studied as a part of broader cross-cultural aspects (Hofstede 2005). At the same time researchers (e.g. Holmqvist & Grönroos 2012) argue that languages, language skills as well as difficulties with languages progressively impact how consumers perceive, experience and evaluate different services. Holmqvist and Grönroos (2012) emphasize that language is an increasingly important topic in multinational management and marketing research.

In addition, so far the language research in international business has mainly focused on language and communication *within* a multinational company (MNC). The need for this kind of research is evident as an absence of a common language may cause significant barriers to communication flows within the MNC (Marschan, Welch & Welch 1997). However, there is no extensive research domain focusing on language issues and communication *with* international customers. This is mainly due to the previous studies that have focused on manufacturing companies rather than service companies (Piekkari et al. 2013). Not much attention has been paid on consequences of the consumer and the service provider not sharing the same language (Marcella & Davies 2004). Besides, Holmqvist and Grönroos (2012) also point out that so far the language research in international business has ignored the interactive nature of communication, although it has been found in an empirical research that language has a great influence on how consumers perceive services during face-to-face service encounters (Holmqvist & Grönroos 2012).

Traditionally the service marketing literature has taken a common language between a company and its customers for granted by assuming that the customer and service personnel share the same language (Holmqvist 2011). However, in the globalized world of 21st century this is not the case anymore. If service provider and a customer are lacking a common language, it provides a potential problem for the success of the service encounter (Holmqvist 2011). Nevertheless, Holmqvist (2009) notes that within the field of service marketing, relatively little attention has been paid on consequences of the consumer and the company not sharing a common language. Majority of empirical research of language and communication in service encounters has focused on consumers' perspective and preferences in language (e.g. Holmqvist 2009; Holmqvist 2011). As the service providers' perspective has been lacking, this study approaches language and communication in health care services from the health care companies' perspective.

As the whole language research domain is relatively new, either the role of language in certain services, like health care, has not been researched widely. Many researchers point out that there ought to be more research on language barriers in health care (e.g. Lee et al. 1998; Jacobs et al. 2006; Morales et al. 1999; Jansson 2014), as there are several problems related to patients who do not speak the language of the majority and thus, face language barriers in health care encounters. Jansson (2014, p.203) highlights that 'there is a pressing need for research to address the linguistic complexities of health care interactions'. Moreover, Jacobs et al. (2006) emphasize the three broad areas in the field that would need further research: 1) the way how language barriers affect health and health care, 2) the efficacy of different approaches to overcoming language barriers in health care and 3) the costs of language barriers and efforts to solve them. In relation to Jacobs et al.'s (2006) research propositions, this study focuses on understanding how language barriers affect health care encounters and what kind of interventions do health care companies have for overcoming them.

Language barriers are common in today's international business settings. However, although language barriers have been researched extensively in other international business contexts, for example multinational teams (e.g. Tenzer et al. 2014), have the previous studies lacked research in language barriers with international customers in different kind of services. Simultaneously, many researchers note that language barriers can be problematic in ertain services, like health care (Jansson 2014). For example, Jacobs et al. (2006) highlight that language barriers in health care have many potential adverse impacts for the success of the medical treatment. Language barriers in health care forms a relevant and topical research topic also due to today's globalized world where travelling abroad for medical care is not the only situation in which language barriers in health care encounters may occur, but there are multiple reasons for why patient and health care personnel do not share a common language language. Jansson (2014) notes that so far the main body of research has focused on investigating language issues in health care in the context of immigrant populations in Europe, the United States and Australia.

Neither has the medical tourism field been researched extensively, although medical tourism is a significant global business area. For example Freire (2012) estimates that medical tourism corresponds globally to 4% of all hospital admissions. Many researchers (e.g. Carrera & Bridges 2006; Freire 2012; Wang 2012) note that medical tourism is a little known and not sufficiently studied phenomenon. Also Lunt et al. (2012) notes that although medical tourism

has raised globally high-profile media interest and coverage, there is still lack of sufficient research evidence on the topic, particularly in OECD countries, which are important medical tourism destinations and whose citizens also travel abroad for health care. Wang (2012) states that the majority of research in medical tourism is based on book and literature reviews, and thus there is not much empirical evidence. In other words, there is a lot of written on medical tourism from different perspectives, but the material is hardly ever evidence-based.

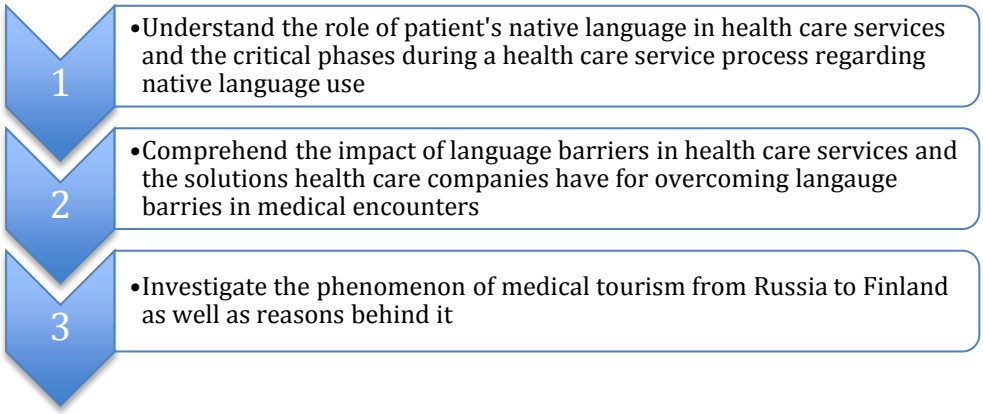
1.2 Research objectives and research questions

This study has three objectives that are collected to the Figure 1 presented below. Primarily, the objective of this study is to understand the role of language in health care services. Moreover, this study also aims at investigating the impact of language barriers in health care services and especially the solutions health care companies have for overcoming them. In general, this study explains how Finnish health care companies take language issues into account when involving themselves to the global medical tourism field.

Simultaneously, the secondary objective of this study is to comprehend the phenomenon of medical tourism in the Finnish context, but more specifically medical tourism from Russia to Finland. So far the academic research in Finland on medical tourism has been very limited. At the same time, Russian medical tourists are the biggest group of medical travellers coming to Finland and medical tourism is a growing phenomenon not only globally but also in Finland. Consequently, by understanding the phenomenon better and especially the motives and drivers of Russian medical tourists to travel abroad for health care, Finnish health care companies could meet the demand better and thus, serve the growing foreign patients' segment more appropriately.

This study researches language and language barriers as well as medical tourism from Finnish health care providers' perspective, but previous studies in both service marketing and communication and language literature in health care have mainly taken patients' perspective into account. Moreover, patient perspective is not included due to legal constraints that protect also foreign patients' privacy in Finland and thus, limit the possibility to gather patients' opinions for example in the form of a survey.

Figure 1 ***Research objectives of the study***



The research questions are derived from the research objectives. This study has two main research questions and one sub-question. The sub-question is related to the context of the study: medical tourism from Russia to Finland.

Research questions

1. How do language barriers affect health care encounters and how do health care companies overcome them?
2. How important is patient's native language in health care services and when is the use of patient's native language particularly important?

Sub-question

3. What kind of phenomenon is medical tourism in the Finnish context?

1.3 Definitions of key concepts

Before introducing the previous academic literature on the subject, some key concepts need to be defined in order to clarify the literature.

Medical tourism

The definition by Carrera and Bridges (2006) seems to be the most frequently cited in medical tourism literature. Carrera and Bridges (2006, p. 447) define medical tourism as 'the organized travel outside one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention'. A key aspect in medical tourism is that the patient travels abroad voluntarily, by his/her own volition (Lunt et al.

2012). Thus, a situation in which a patient needs to use health care services in a foreign country due to a sudden illness or an accident, is not defined as medical tourism (Moreira 2013b).

In some contexts health tourism is used as a synonym for medical tourism. Carrera and Bridges (2006, p. 447) define health tourism as "the organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's wellbeing in mind and body". This definition emphasizes the fact that health tourism focuses on wellbeing in mind and body, whereas medical tourism includes a medical intervention like medical examination, surgery or other medical operation. However, this thesis focuses on medical tourism rather than health tourism. The concepts of medical tourism and medical travel are used interchangeably in this thesis. *Medical tourist* is a patient travelling outside one's own health care jurisdiction in search of health care services.

Language

The concept of language can be defined in different ways in different contexts. The Oxford Dictionary (2015) lists six different meanings for language:

a) the system of human communication, either spoken or written, consisting of the use of words and enabling people to express their feelings and thoughts
b) the system of communication used by a certain country, nation or group of people
c) a specific manner or style of speaking or writing
d) the phraseology or vocabulary used by particular profession, domain or other group of people
e) the system of symbols, signs and rules used in writing programs or algorithms
f) the system of signs, symbols and gestures used for expressing feelings and ideas non-verbally

In these six definitions, definitions a) and b) refer to spoken languages like Russia and Finnish. Thus, in this thesis the concept of language is understood like defined in definitions a) and b), and language is seen as a tool for human communication, either spoken or written, that is distinct between different countries, nations or other groups of people. In addition, this thesis focuses mainly on spoken languages, as the focus in this study is on language use in service encounters in which an interaction between the consumer and the service provider

occurs. Therefore, in this thesis written language is not discussed the same extent as spoken language.

Native language

Native language is the first language a person has learnt (Holmqvist 2009). Typically the first language a person has learnt is also the language the speaker masters most proficiently; however, nowadays this not always the case (Holmqvist 2009). It is a common debate within linguistics whether a person can have multiple native languages or not, but the debate is not in the scope of this thesis and thus, will not be discussed.

Language barrier

Language barriers indicate difficulties that two people, who do not share a common language, face when they are trying to communicate with each other. Language barrier can also refer to complete absence of communication between the two people who speak different languages. (Collins Dictionary 2015.)

Interpreting

The Oxford Dictionary (2015) defines interpreting as translating orally or into sign language the words of a person speaking a different language. Interpreting is thus translating that happens orally (Piekkari et al. 2013).

Service encounter & health care encounter

The concept of service encounter is used to describe an interaction in a service between two parties: a consumer and a service provider (Surprenant & Solomon 1987). Not all services require an equal amount of interaction (Holmqvist 2009). However, for example in health care services the effective interaction between the customer and service provider is paramount (e.g. Holmqvist 2009). *Health care encounter* can be defined as a service encounter in which health care service takes place.

Health care service

The World Health Organization WHO (2015) defines *health services* in the following: 'Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. -- Health services are the most visible functions of any health system, both to users and the general public'.

1.4 Limitations and structure of the study

As all empirical research, also this study has its limitations. The limitations of this study are twofold and mainly relate to the previous literature used in the literature review as well as to the methodological choices of the study. Regarding the nature of academic literature on the field, the previous literature on language issues in health care services has mainly focused on Spanish-speaking patients in primary care or emergency department settings in the North American context (e.g. Carrasquillo et al. 1999; Morales et al. 1999; Rivadeneyra et al. 2000; Sarver & Baker 2000; Lee et al. 2002; Fagan et al. 2003; Fernandez et al. 2004; Jacobs et al. 2006).). However, this study is concentrating on medical tourism in the Finnish context and particularly Russian medical tourists in Finland. In addition, also the scope of the study represents one limitation: this study is mainly focusing on medical tourism in the Finnish context, although the phenomenon of medical tourism is unquestionably global.

There are also limitations that arise from the methodological choices of the study. First of all, although some researchers (e.g. Eisenhardt 1989; Yin 2003) emphasize that the results of a multiple case study can be somewhat generalized and are at least more generalizable than a single case study, but still even results of a multiple case study cannot always be generalized to a larger population as such. However, the findings of this study can be generalized to health care companies of comparable size and feature in Finland receiving Russian medical tourists. On the other hand, the main purpose of a case study is not to generate generalizable results, but to gain rich data on the phenomenon under study (Yin 2003). The scope of this study is somewhat narrow focusing only on four case companies.

Some limitations may also arise from using semi-structured interviews as the primary data collection method. Semi-structured interviews can be seen as a relatively complex data gathering method, as the responses of semi-structured interviews are not totally systematic or standardized (Patton 1987). A more detailed analysis of the limitations of this study can be found in the Conclusions of this thesis.

Structure of the study

The remainder of this thesis is organized as follows. The next chapter – chapter two – provides a background for the empirical part by describing the previous academic literature

on 1) the phenomenon of medical tourism, 2) the role of language and communication in services and 3) language and communication in health care. The chapter also presents the theoretical framework. Research methodology, including evaluation of research methodology and limitations, will be presented in chapter three. The empirical findings are provided in the chapter four, and discussion stemming from the empirical findings in the chapter five. Chapter six includes a conclusion for this thesis as well as managerial implications and suggestions for further research. The references can be found in chapter seven.

2. LITERATURE REVIEW

In this chapter I will introduce the previous academic literature written on the topic. Since the research area is relatively new, the theoretical background for my study is based on three different research areas: 1) Medical tourism, 2) The role of language and communication in services, and 3) Language and communication in health care. These research areas are somewhat separate and they are introduced in this literature review independently, but finally merged in the theoretical framework. However, before going into the three different research areas, health care as an international service industry is briefly discussed (part 2.1).

Consequently, this literature review is consisting of five different parts. The three main parts (2.2, 2.3 and 2.4) are each focusing on a different research area mentioned above. The final part of this literature review (2.5) will connect the three independent research streams coherently, and lastly present the theoretical framework.

2.1 Starting point: Health care sector as an internationalizing service industry

Currently service businesses create a major component of the global business. Services are the most rapidly growing sector of world trade and services have already overtaken the growth of goods (Czinkota & Ronkainen 2010, p. 490). Health care sector is predominantly a service industry and health care services are tradable, global commodities (Lunt et al. 2012). As the trading opportunities in many other sectors are already saturated, shifts the focus increasingly on international trade in services, including health care services (Lunt et al. 2012).

Medical tourism is an emerging phenomenon in the health care industry globally (Deloitte 2008). Traditionally health care has been seen as a local industry due to its labor insensitivity, but nowadays also the health care sector has globalized just like many other service sectors (Connell 2006). Hospitals in many places around the globe are increasingly treating foreign patients not only due to growing immigration, business and leisure travel but also increasing medical tourism.

Medical tourism is also export of health care services. All domestic service expenditures that are funded from abroad by foreign citizens represent service export (Czinkota & Ronkainen 2010, p. 508). Consequently, export of health care services means providing health services to foreign patients, as the cash flow is directed to the receiving country, which makes it export (Nordic Healthcare Group 2010).

Moreira (2013a) has categorized international health care customers into four different groups: 1) long-term residents in foreign countries, including retirees, 2) temporary visitors spending holidays abroad, 3) outsourced patients with access to health care services abroad due to arrangements and agreements between financial intermediaries and 4) patients who travel abroad to purchase health care services on out-of-pocket basis. Medical tourists belong typically to the fourth group, but they can also belong to the third group, as in medical tourism people travel abroad for health care voluntarily. According to Moreira (2013b), in the past international patients have been tourists or business travellers having an accident or falling suddenly ill during their trips, but nowadays international hospitals are increasingly reaching for patients who are seeking for treatments themselves voluntarily. Consequently, Moreira (2013b) notes that the international health care community is gradually shifting away from the 'accidental patients' approach towards the 'gained patients' approach.

All in all, the internationalization of health care sector can take different forms. However, medical tourism is probably the most tangible and visible part of general globalization of the health care industry (Morgan 2010). The global phenomenon of medical tourism is discussed next in more detail.

2.2 Medical tourism

This part of the literature review introduces the global phenomenon of medical tourism. Due to long waiting lists, high cost of health care in home country as well as easy and affordable access to travel, patients around globe are increasingly seeking health care in other countries than their country of residence (Carrera and Bridges 2006). Consequently, medical tourism has become a globally significant and constantly growing global industry (Keinänen et al. 2012). Carrera and Bridges (2006, p. 447) have created the most frequently cited definition of medical tourism and they define *medical tourism* as

The organized travel outside one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention.

In other words, medical tourists are patients who travel outside their own country of residence and the main motive for the travel abroad is seeking treatment for their health problem in the form of some kind of medical intervention (Keinänen et al. 2012). A key aspect in medical tourism is that the patient travels abroad voluntarily, by his/her own volition (Lunt et al. 2012). Thus, a situation in which a patient needs to use health care services in a foreign country due to a sudden illness or an accident, is not medical tourism (Moreira 2013b).

Connell (2006) and Freire (2012) note that medical tourism is a niche in the tourism industry, as it includes the general characteristics of tourism: a short-term stay abroad. However, in medical tourism the main motivator to travel abroad is medical rather than touristic (Freire 2012). Connell (2006, p. 1094) emphasizes that medical travellers are not only patients but simultaneously also 'holidaymakers in a more conventional sense'. Many researchers note that conventional tourism is a by-product of medical tourism and it has benefited travel industry considerably (e.g. Connell 2006).

This thesis focuses on medical tourism rather than health tourism. In some contexts *health tourism* and *health care tourism* and are used as synonyms for medical tourism. However, majority of researchers make a distinction between health tourism and medical tourism. For example, Freire (2012), Carrera and Bridges (2006) and Connell (2006) distinguish *health tourism* and *medical tourism*. Carrera and Bridges (2006) note that there is lack of clarity regarding the definitions of medical tourism and health tourism, but the concepts are related. Connell (2006) emphasizes that it is more practical to distinguish health tourism and medical tourism, as the concepts have different characteristics. Carrera and Bridges (2006, p. 447) define *health tourism* as

The organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's wellbeing in mind and body.

The definition of health tourism by Carrera and Bridges (2006) emphasizes the fact that health tourism focuses on wellbeing in mind and body, whereas medical tourism includes a medical intervention like medical examination, surgery or other medical operation. Freire (2012)

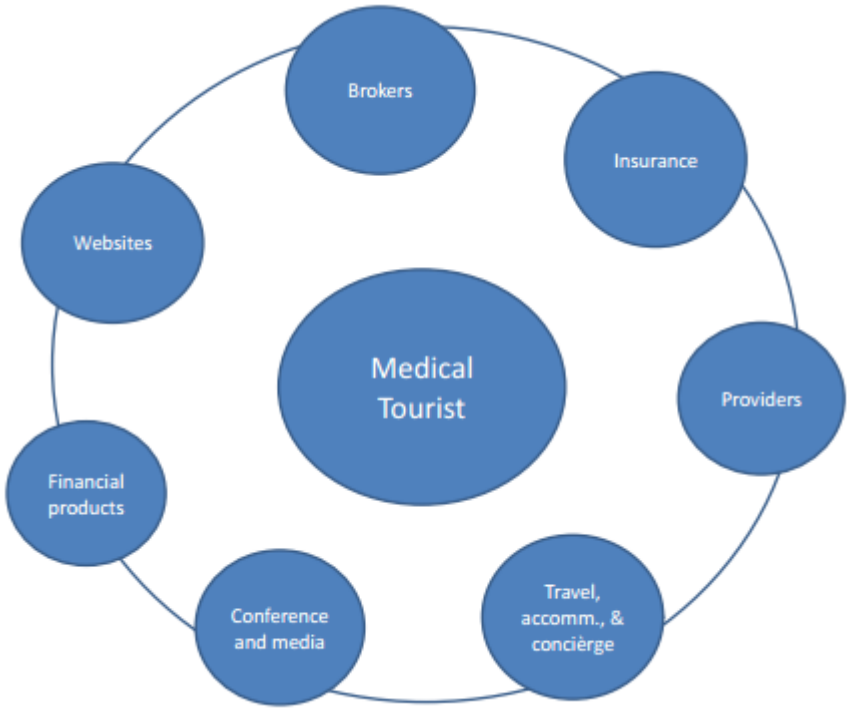
writes that health tourism often includes treatments like balneotherapy or thermal baths. Also the outcomes of medical tourism and health tourism are different. The outcomes of medical tourism are typically substantial and long-term, whereas the main motivator to health tourism is relaxation and wellbeing (Connell 2006).

2.2.1 Medical tourism as a global phenomenon

Medical tourism is a growing international business area. Medical tourism is one form of globalization of health care and tourism (Connell 2006; Freire 2012). In recent years medical tourism has increased mainly due to high costs and long waiting lists in health care in many countries as well as lower global travel costs and increased Internet marketing (Connell 2006).

As an emerging global industry medical tourism has a large range of different stakeholders (Lunt et al. 2012) that have different interests. Key stakeholders in the industry are described in the Figure 2.

Figure 2 ***Medical tourism industry and its key stakeholders***



Source: Lunt et al. (2012, p. 18)

However, although Lunt et al. (2012) present medical tourists in the core of the medical tourism phenomenon, this study positions health care companies ("providers" in the figure) in the core of the phenomenon and approaches the research problems and questions from their perspective.

Although medical tourism has received a lot of media coverage in recent years, travelling abroad for health care or well-being is not a new phenomenon (Connell 2006, Morgan 2010, Lunt et al. 2012). For decades affluent people have travelled in search of health care that is more affordable, of better quality or provides something that cannot be done in home country. Interestingly, one of the earliest forms of tourism is health tourism, as 'taking the waters' in spas became common by the 18th century especially in Europe but also elsewhere, and started the local tourism in many places (Connell 2006, p. 1093). A bit later recreation and tourism shifted mainly to sea resorts in developed economies, as also sea bathing became the healthiest form of recreation, and tourism spread from elites towards working classes (Gilbert 1954, cited in Connell 2006). During the 20th century affluent people from less developed countries travelled to developed countries to access the highly trained health care professionals and better quality facilities (Lunt et al. 2012). Also in more recent times affluent people have travelled seeking the latest technologies and highest quality services in exclusive private clinics around the globe (Morgan 2010).

However, although health tourism or wellbeing tourism are not novel phenomena, medical tourism is somewhat more contemporary trend. In recent years – or decades – medical tourism has risen to be a global high-volume phenomenon due to affordable cross-border travel and rapid development of information technologies (Lunt & Carrera 2011). Lunt et al. (2012) suggest that there are certain features that distinguish the contemporary 21st century medical tourism from its previous forms. These key features include: 1) the large number of people travelling in search of health care, 2) the shift towards patients from wealthy developed nations travelling to less developed countries to obtain medical services, largely driven by the low-cost treatments and low-cost air travel, 3) new enabling infrastructure: affordable and accessible global air travel as well as Internet as an information platform, 4) industry development: both private and public sectors in developed and developing countries have been promoting medical tourism as a source of foreign revenue. Connell (2006) points out that also the rise of new kind of companies has facilitated the growth of medical tourism;

these companies are brokers that operate between international patients and hospitals and clinics.

The estimations on the amount of global medical tourists and the size of the industry range a lot. One challenge in collecting exact figures about medical tourism is that there is no established definition for medical tourism (Carrera & Bridges 2006; Martinsen 2007; Nordic Healthcare Group 2010). There is also lack of proper statistics and disagreements whether accompanying family members or other travelling companion should be included in the patient flow volumes (Connell 2006). Martinsen (2007) notes that there is no statistical data on medical tourism volumes either in the European Union, although medical tourism is somewhat common in the EU area. Consequently, many researchers have aimed to estimate the global number of medical tourists, but due to lack of proper data and a common definition of medical tourism, all the estimations are mainly educated guesses.

In the academia, the most cited figures of the global medical tourism seem to be by Deloitte (2008 and 2009), but Deloitte's figures are solely focusing on inbound and outbound medical tourists in the Unites States. According to Deloitte's (2008) estimation the number of US citizens leaving the country for medical services was around 750,000 in 2007. Similarly, Deloitte (2008) estimates that medical tourism is globally an industry worth $60 billion. Lunt et al. (2012) estimate that US medical tourists represent approximately 10% of the global number of medical tourists, which would suggest that the global total number of medical tourists lies somewhere between 30 and 50 million tourists annually. However, Lunt et al. (2012) emphasize that this is only an estimation, but proper figures on medical tourism would be important to quantify the economic impact of the phenomenon in different countries and also assess the potential risks to both the receiving and sending health care systems. Freire (2012) reminds that medical tourism figures should be reported at the same time as tourism statistics and health care statistics due to the fact that medical tourism is both tourism and health care at the same time; this would also enable cross-checking the data.

According to Freire's (2012) approximation, medical tourism corresponds to around 2% of the world tourism and globally 4% of all hospital admissions. Carrera and Bridges (2006) estimate that medical tourism accounts for over a quarter but less than a half of total revenues of health tourism, which is even larger phenomenon due to its availability and easier treatments. However, it must be kept in mind that in many countries medical tourism is still a

relatively small phenomenon especially when compared to the size of the whole health care sector (Morgan 2010). All in all, the global streams of medical tourists are extensive already currently. In addition, due to severe problems with health care systems in many countries combined with aging population and thus, increased need for health care services, medical tourism is an area with a very high growth potential. Many researchers (e.g. Freire 2012) predict that medical tourism will increase significantly in the future.

Medical tourism may raise the question of why a hospital should receive foreign patients. Naturally, solely from the business perspective, the most important reason for receiving medical tourists is the fact that medical tourists bring money to the hospital and the receiving country (Glinos & Baeten 2006). Besides, medical tourism can increase the expertise of medical professionals due to increased patient volumes and demanding operations that are made to medical tourists (Glinos & Baeten 2006). The fact that hospitals receive foreign patients often indicates that hospitals have overcapacity especially in medical fields that are not so common. Consequently, medical tourism is also one solution to tackle overcapacity in domestic hospitals (Glinos & Baeten 2006).

Although medical tourism can enable better and more affordable health care services for the patients as well as increasing patient volumes for clinics and hospitals, academic research also recognizes some drawbacks for the global phenomenon. These drawbacks could form their own research area, but as those are not the focus of this study, only the most important and most frequently stated are mentioned here.

One critical challenge is the continuum of care: during one treatment period the patient meets many doctors and other medical professionals, and the process includes multiple phases (Nordic Healthcare Group 2010). Before the patient can even travel, the health problem must be noticed and often also diagnosed and after the treatment the patient typically needs medical follow-up and often rehabilitation. Thus, it is not that simple to divide all the phases of a medical process between two countries and two different health care systems and medical treatment abroad often interrupts the continuum of care, which can have severe consequences not only for the patient but also for the local health care system (Carrera & Bridges 2006; Freire 2012). With respect to this, in medical tourism it is also challenging to get the proper patient information, as domestic legislation does not necessarily allow sharing patient information with third parties, like hospitals in other countries (Freire 2012).

Also the responsibility issues can become problematic: if something unexpected happens after a medical treatment abroad, it may be unclear who is responsible for the patient and the costs occurred (Tseng 2013). Thus, it is possible that in medical tourism the potential complications, side effects and postoperative care become the responsibility of the patient and his/her local health care system, which can in many cases defeat the cost-saving justification for seeking health care abroad (Carrera & Bridges 2006; Freire 2012; Tseng 2013). Many researchers (e.g. Wang 2012; Tseng 2013) remind that it is almost impossible for the medical traveller to get any compensation if some kind of medical error occurs after an operation conducted abroad. However, researchers (Lunt et al. 2012; Tseng 2013) note that at the moment relatively little is known about the clinical outcomes, complications or follow-up treatments of medical tourism operations.

2.2.2 Where do medical tourists travel?

Connell (2006), Nordic Healthcare Group (2010) and Wang (2012) estimate that currently Asia is the main market for medical tourism and traditionally India, Singapore and Thailand have been the most popular destination countries. Connell (2006) points out that in recent decades medical tourism has grown particularly in India, Singapore and Thailand due to the fact that these countries have been able to combine medical services to conventional tourism particularly in the countries' various beach resorts. Another explanation for Thailand becoming such a popular medical tourism destination already since 1970s is its specialization in sex change operations and various cosmetic surgery operations (Connell 2006). For a long time India has been the 'contemporary global center for medical tourism' and one reason for this is its population's widespread English-speaking skills (Connell 2006, p. 1095). As a response to India, many large international hospitals focusing on medical tourists employ teams of professional interpreters and as an example, Thailand's Phuket Hospital is told to provide interpreters in 15 different languages (Connell 2006). It must be noted that the hospital receives annually about 20,000 international patients (Connell 2006).

On the other hand, Carrera and Bridges (2006) see Europe as the leading market especially for health tourism due to the long-term tradition of health tourism (e.g. spas) in Europe. The European Union legislation about patient's right to choose hie/her own hospital has also enabled medical tourism within Europe (Martinsen 2007). Nordic Healthcare Group (2010) suggests that the most popular medical tourism destinations in Europe are Germany, Czech

Republic, Turkey, Poland and Italy. Both Connell (2006) and Nordic Healthcare Group (2010) note that many Eastern European countries – particularly Belarus, Latvia, Lithuania, Hungary and Poland – have specialized in dental care and plastic surgery.

Nevertheless, medical tourism is not only taking place in Asia and Europe. Other major medical tourism destinations are South Africa, Israel, Latin America and Middle East (particularly Dubai, Jordan and Saudi Arabia) (Connell 2006; Nordic Healthcare Group 2010). For example Israel is a popular destination among international Jewish patients, but also others, and it has specialized in different kinds of female fertility treatments as well as high-risk pregnancies (Connell 2006).

Lunt et al. (2012) note that geographical proximity is an important, but not a decisive, factor in medical tourism. This is highlighted by the fact that medical travellers tend to travel also due to touristic motives and not only by medical treatments as the sole reason (Lunt et al. 2012).

2.2.3 Drivers of medical tourism

Academic research recognizes multiple reasons for why people travel abroad for health care. Researchers have a consensus that medical tourism is a result of increased globalization in many areas, like economies, travel, culture and technology. Freire (2012) also suggests that the growing life expectation together with social security deficits and health system challenges and reforms in many countries is a major driver of medical tourism phenomenon.

Medical tourism can be seen as a two-tier system: some patients travel to more developed countries, whereas some patients to developing countries. Historically medical tourism flows have been from lower to higher income countries due to high-income countries' more developed medical facilities and higher educated health care personnel (Lunt et al. 2012). This trend is now changing and many travellers travel to less developed countries in search of reasonably prized medical services (Lunt et al. 2012). Many countries can simultaneously act as countries of origin and destination for medical tourism; quite often high-income countries are this kind of destinations (Lunt et al. 2012). According to Connell (2006), currently the majority of medical tourists are from developed countries, mainly from North America, Western Europe and the Middle East. However, medical tourists are not only from developed countries, but also from developing countries (Connell 2006).

Probably the most proposed explanation for medical tourism is high costs of elective treatments in domestic health care system (Carrera and Bridges 2006; Connell 2006; Martinsen 2007; Morgan 2010; Levary 2011; Freire 2012). Due to high costs of health care in many countries, people are increasingly looking for options for expensive domestic health care services and travelling to cheaper countries than their own home country. Lack of proper health insurances is one of the key main reasons for medical tourism (Deloitte 2008; Tseng 2013). Also the quality/price ratio may be more favorable abroad than in patient's home country (Freire 2012) or solely the quality of treatment significantly better (Lunt et al. 2012). Prices for some selected medical operations in different countries are presented in the Table 1.

Table 1 ***Prices for medical operations in selected countries***

Procedure	US	India	Thailand	Singapore	Malaysia	Mexico	Cuba	Poland	Hungary	UK
Heart bypass (CABG)	113 000	10 000	13 000	20 000	9 000	3 250		7 140		13 921
Heart Valve replacement	150 000	9 500	11 000	13 000	9 000	18 000		9 520		
Angioplasty	47 000	11 000	10 000	13 000	11 000	15 000		7 300		8 000
Hip replacement	47 000	9 000	12 000	11 000	10 000	17 300		6 120	7 500	12 000
Knee replacement	48 000	8 500	10 000	13 000	8 000	14 650		6 375		10 162
Gastric bypass	35 000	11 000	15 000	20 000	13 000	8 000		11 069		
Hip resurfacing	47 000	8 250	10 000	12 000	12 500	12 500		7 905		
Spinal fusion	43 000	5 500	7 000	9 000		15 000				
Mastectomy	17 000	7 500	9 000	12 400		7 500				
Rhinoplasty	4 500	2 000	2 500	4 375	2 083	3 200	1 535	1 700	2 858	3 500
Tummy Tuck	6 400	2 900	3 500	6 250	3 903	3 000	1 831	3 500	3 136	4 810
Breast reduction	5 200	2 500	3 750	8 000	3 343	3 000	1 668	3 146	3 490	5 075
Breast implants	6 000	2 200	2 600	8 000	3 308	2 500	1 248	5 243	3 871	4 350
Crown	385	180	243	400	250	300		246	322	330
Tooth whitening	289	100	100		400	350		174	350	500
Dental implants	1 188	1 100	1 429	1 500	2 636	950		953	650	1 600

* Costs of surgeries around the world. Costs given in US$

** The price comparisons for surgery take into account hospital and doctor charges, but do not include the costs of flights and hotel bills for the expected length of stay.

Source: Lunt et al. (2012, p. 12)

For example, in the United States context the main motivator to travel abroad for health care is high costs of health care (Forgione & Smith 2006). According to Deloitte (2008), from the United States patients mainly travel to more affordable countries, such as Latin American countries, South Africa, India and many other countries in Asia. Forgione and Smith (2006) write that it is commonly advertised in the United States that it is possible to save anywhere between 50-90% per operation compared to health care prices in the United States by

travelling to less developed countries for health care services. However, Carrera and Bridges (2006) note that the majority of global medical tourist flows is towards developed countries, which implies that people travel in search of health care that is of better quality. Like already mentioned, the developing world is catching up, but only slowly (Carrera & Bridges 2006).

Another key driver is long waiting lists in health care in many countries; by travelling abroad for health care patients can avoid long waits and reach the care quickly (Carrera & Bridges 2006; Connell 2006; Morgan 2010; Levary 2011; Freire 2012; Tseng 2013). For example, in the UK many non-essential surgeries, like a knee reconstruction, may have waiting lists of even 18 months, whereas the same operation can be done in India under a week and the patient can travel home after approximately 10 days' recovering period (Connell 2006).

Today there are also fewer barriers to travel abroad than there used to be (Carrera & Bridges 2006). The price level of global low-cost transportation, particularly international air travel, is lower than ever and there is a well-functioning global network of flights (Connell 2006; Deloitte 2009; Wang 2012), which makes travelling for health care easy. Also Internet as a platform has played a key role in increased medical tourism (Connell 2006; Morgan 2010; Lunt & Carrera 2011; Lunt et al. 2012) due to the fact that Internet platforms offer an easy access to health care information as well as advertising from anywhere in the world. Lunt and Carrera (2011) even claim that Internet is such a key driver in medical tourism that there would be no contemporary medical tourism without Internet. All in all, Internet connects patients with health care providers and broker companies (Lunt & Carrera 2011).

Medical travellers search Internet for health care destinations, providers and prices (Lunt & Carrera 2011). Internet is a tool for health care providers and even countries to market their health care services and destinations (Lunt & Carrera 2011). Nowadays there are numerous websites dedicated to medical tourism, and Internet is the main platform for potential patients to seek information on health and medical operations abroad (Morgan 2010). The most common forms of medical tourism websites include portals (focused on information on health care providers as well as treatments and operations available), media sites, consumer-driven sites (blogs and reviews), professional sites (professional organizations and state regulatory institutions) and commerce-related sites (information on extra services) (Lunt & Carrera 2011; Lunt et al. 2012).

Another common driver of medical tourism is that the patient is seeking for treatments that are not available in his/her home country (Morgan 2010; Levary 2011; Freire 2012; Tseng 2013). Some treatments may be illegal or taboos in patient's origin country, like abortions, euthanasia, fertility treatments and sex changes. For example, Thailand has been a popular destination for sex change operations already since the 1970s (Connell 2006). With respect to this, Freire (2012) notes that one common reason for medical tourism is also the possibility to hide medical interventions. Many patients want intimacy and anonymity when overcoming procedures such as plastic surgery or sex change, and travelling abroad for the operation and convalescence offers a perfect cover for the patient (Connell 2006; Freire 2012).

One driver is the possibility to combine 'the useful and unpleasant with the pleasant' (Freire 2012, p. 43). This psychological driver will possibly help the patient to assimilate the unpleasant memories and misery with some pleasant memories and experiences gained during the holiday abroad (Freire 2012). In other words, foreign exoticism, leisure activities and probably convalescence in a luxurious hotel room may compensate the suffering in patient's mind. There is also 'diaspora' which means immigrants seeking treatment back in their home countries (Deloitte 2008). Turner (2010, cited in Tseng 2013) states that one reason for immigrants travelling back to their home countries is that they want to receive health care services in the culture and in a language they know best.

Also the recent cultural changes and changes in the role of a consumer have boosted global medical tourism. Many patients want to be treated by the best or most famous doctors (Freire 2012) and many medical travellers travel in search of the latest technologies used in medical treatments (Connell 2006). Carrera and Bridges (2006) mention the general rise of health awareness and health care expectations as a driver of medical tourism. Medical tourism is also a form consumerism since it includes patients acting as consumers and making their own decisions concerning their health needs, treatments and the most appropriate provider (Lunt et al. 2012).

As a summary, Nordic Healthcare Group (2010) has categorized patients who travel abroad for health care into three different categories: 1) patients who are looking for more affordable health care than what is available in their home countries, 2) patients who are looking for health services that are not available in their home countries or the health services have long waiting lists and the private health sector in their home country cannot meet the lack of

capacity, and 3) patients who are looking for health services that are illegal in their home countries (e.g. abortion, fertility treatments).

2.2.3.1 Specific drivers of medical tourism in the European Union

One reason for the growing phenomenon of medical tourism is the increasing freedom of patients to choose their own place of treatment. Practically, medical tourism is a form of voluntary patient mobility, as patients travel abroad to obtain medical services in hospitals and clinics they have chosen themselves. In fact, typically in European studies medical tourism is presented as international 'mobility of patients' (Martinsen 2007; Wagner & Linder 2010; Freire 2012, p. 42; Lunt et al. 2012; Moreira 2013a).

European Union is the biggest market for medical tourism due to the fact that EU citizens have the legal 'right to seek medical treatment within the single market and get reimbursement for expenses in ambulatory care even in the absence of prior authorization from one's insurer/sickness fund' (Carrera and Bridges 2006, p. 447). That is to say, European citizens can enjoy the free circulation of people also in health care, as they can choose freely their clinic or hospital also in other EU Member States than their own country of residence (Freire 2012). Currently there is not much data on medical tourism in the European Union particularly due to the free circulation of people in the EU (Freire 2012).

Nordic Healthcare Group (2010) notes that in Europe medical tourism has most typically taken place in border districts that especially in Middle Europe are quite often culturally homogenous and share the same language. It is typical in Europe that patients living in border districts can go to the nearest hospitals also in cases when the hospital is located in the neighboring country (Martinsen 2007; Nordic Healthcare Group 2010).

Furthermore, patient mobility in the European Union has been further boosted by the new Patient Directive of the European Union, enforced in 2014, that enables people to travel abroad for health care. From the beginning of 2014 European Union Member State citizens are entitled to receive health care in any EU country. Under the directive patients are entitled to seek treatment in another EU country without any special permission and referral, and they must be attended in the health care system in the same way as the citizens of the receiving country. In addition, patients travelling to another EU country for health care should receive reimbursement for the treatment on the same basis as if they were receiving care in their home

country. (Ministry of Social Affairs and Health 2013.) Accordingly, for example Moreira (2013b) estimates that in the near future it is likely that a growing number of EU citizens use their right to seek medical care in another European Union Member State.

2.3 The role of language and communication in services

The purpose of this part of the literature review is to discuss the role of language and communication in services. This chapter stems mainly from the service marketing literature. It is highlighted in this chapter that based on previous empirical research on the topic, language and communication are integral parts of service encounters and in some services – particularly high involvement services – the role of customer's native language is particularly important.

2.3.1 Language issues of an international service company

Language influence in services is a rather new research area in the service marketing literature. In recent years Professor Jonas Holmqvist from Hanken School of Economics in Helsinki, Finland, has done groundbreaking empirical research in this area (please see Holmqvist 2009; Holmqvist 2011; Holmqvist & Grönroos 2012; Holmqvist & Van Vaerenbergh 2013; Van Vaerenbergh & Holmqvist 2013). Traditionally language research in the field of service marketing has focused on communication and customer involvement in service encounters (e.g. Bitner et al. 1997), but the majority of earlier research has until Holmqvist's (2009; 2011; 2012; 2013) studies assumed that the consumer and the service provider are able to interact, share the same language and communicate fluently with each other (Holmqvist 2009; Holmqvist & Van Vaerenbergh 2013). Thus, traditionally the service marketing literature has taken a common language between a company and its customers for granted by assuming that the customer and service personnel are always able to speak a common language (Marcella & Davies 2004; Holmqvist 2009).

However, the homogenous market is not reality anymore in the globalized world of the 21st century where both countries and markets are becoming increasingly heterogeneous and monolingual markets are rare (Holmqvist 2009). To give an example, when combining minority languages and immigrants' languages together, European Union has altogether about 100 million residents who speak another language as their native language than the largest language of the country they live in (Holmqvist 2009). Thus, it cannot be assumed that the

consumer and the service provider always share a common language. Nevertheless, markets are not only becoming more multilingual but also less reliant on national borders due to multinational companies and expatriates working in many countries (Holmqvist 2009).

Holmqvist and Grönroos (2012) point out that so far language research within service marketing has focused on indirect communication, such as branding, advertising, written messages and other one-way communication channels. For example, a considerable research area in marketing focuses on understanding how language influences consumers in advertising context (Van Vaerenbergh & Holmqvist 2013). However, while acknowledging the importance of language in advertising context, Holmqvist and Grönroos (2012) argue that the interactive nature of services (e.g. Surprenant & Solomon 1987) makes understanding language use during dyadic service encounters even more crucial than in indirect settings such as advertising.

The importance of the mutual interaction between a consumer and a service provider in a service encounter has been widely recognized already for a long time (e.g. Grönroos 1984; Bitner et al. 1997). Also Holmqvist (2011) notes that if a consumer and a service provider do not share a common language, it may have consequences on the service encounter as well as the outcome of the service. This will be discussed in the following chapter in more detail. Correspondingly, Marcella and Davies (2004) point out that the lack of a common native language between the consumer and the company presents a potential problem also for marketing communication. All in all, Holmqvist (2009) notes that understanding how language influences customers in service encounters on different markets is an important question for an international service company.

2.3.2 Communication and native language use in service encounters

Communication is an integral part of any service encounter (Holmqvist 2009). The concept of *service encounter* is used to describe the dyadic interaction in services between a consumer and a service provider (Surprenant & Solomon 1987). In service encounters, both the consumer and the service provider are actively taking part (Grönroos 1984; Surprenant & Solomon 1987). Service encounter always involves at least some interaction and communication and thus, usually also a language between the customer and the service provider is needed (Holmqvist 2009). However, the exchange of information in service

encounters can be more or less extensive, but it is almost always found at least to some extent in majority of service encounters (Holmqvist 2009).

Both Grönroos (1984) and Bitner et al. (1997) note that the way the consumer and the service provider communicate in a service encounter essentially determine the outcome of the service encounter. In other words, the quality of communication in service encounters is crucial for the outcome. Holmqvist (2011) has demonstrated empirically that if a consumer and a service provider do not share a common language, it may have consequences on the service encounter as well as the outcome of the service. In services encounters, in which the customer and the service provider do not share a common language, but communication is possible to at least some degree, it may still have implications on the consumer's perception of the whole service (Holmqvist 2009). Grönroos (1984) as well as Van Vaerenbergh and Holmqvist (2013) point out that the interaction between the consumer and a service provider determine how consumers perceive service quality.

Research suggests that native language has a special role in service encounters. For example, Jacobs et al. (2006) state that it is not enough that a consumer can communicate with a service provider in a second language he/she is able to speak. In fact, when the consumer and the service provider do not share a common native language, there is always a risk of communication problems (Jacobs et al. 2006). These risks are also dependent on consumer's own language competence: how well he/she is able to speak the language the service provider is using in cases when the service provider is not using consumer's native language (Marcella & Davies 2004). Marcella and Davies (2004) conclude that the degree to which one of the parties in a service encounter is able to speak the other's native language is influencing the communication quality.

The quality perception of a service customer is strongly determined by the behavior of service providers they are communicating with (Czinkota & Ronkainen 2010, p. 494). Naturally, communication between the consumer and the service provider has a key role in this. If they are not able to communicate fluently, there is a potential problem for the whole service. Holmqvist (2011) notes that if a customer and a service provider do not share a common language, there is possibility for adverse impact on the personal interaction, which is at the core of the service communication and thus, the whole service itself. Also Bitner et al. (1997)

conclude that efficient communication is of great importance to the outcome of the service encounter.

In service encounters, consumers do not only evaluate the quality of the service they receive, but also the language in which they receive the service (Fernandez et al. 2004; John-Baptiste et al. 2004). Although consumers may be perfectly fluent in another langauge than their native language, they may still prefer using their native language – and sometimes very strongly – for other reasons than merely ease of communication. For example, Holmqvist (2011) has studied empirically the language preferences of consumers from four different language groups (bilingual consumers in Finland and Canada). According to Holmqvist's (2011) empirical findings, all consumers preferred using their native language in service encounters and some consumers went so far that they refused to even consider service providers who do provide services in their native language.

The main reason for consumers' preference to use their native languages in service encounters is that language often influences consumers in service encounters in an emotional way (Holmqvist 2011). Many people have strong emotional bonds with their native languages and they link their native language strongly to their identity or the identity of a group they belong to (Holmqvist 2009). Thus, language is not merely a neutral tool of communication, but rather a part of personality, which is important even in services with very little communication (Holmqvist 2011). These emotional rather than functional reasons explain why even perfectly fluent bilingual customers often prefer using their native language in service encounters (Fernandez et al. 2004). Holmqvist (2009, p. 2) notes that 'not being served in their native language may thus have additional consequences for consumers than merely communicative ones'. In other words, the importance of native language in service encounters go beyond communication.

Holmqvist (2011) also provides other explanations on consumers' native language preferences in service encounters: political reasons and convenience reasons. Holmqvist's (2011) findings suggest that some consumers have ideological objections to using other language than their native language in service encounters (political reasons) and many find some services (e.g. medical visits) too important to have a risk of linguistic misunderstanding (convenience reasons). In regard to convenience reasons, consumers want to be served in their

native language and do not want to switch to their second language in situations where they feel uncomfortable (Holmqvist 2011).

Holmqvist and Grönroos (2012) point out that language is not only an issue *during* the service encounter. In fact, language may pose a challenge already even *before* the service encounter begins, as the service provider's service language can influence the consumer's decision to use the service. Holmqvist (2009) notes that in a situation in which the consumer can choose between multiple service providers, the service provider's possibility to provide the language in consumer's native language may influence the consumer's decision.

Similarly, *after* the service encounter the language used during the service encounter may influence consumer's repurchase intention, overall customer satisfaction as well as tendency to spread positive or negative word-of-mouth about the service provider (Holmqvist & Grönroos 2012). However, Holmqvist and Grönroos (2012) conclude that language influence on consumers is most significant *during* the service encounter when the consumer interaction between the consumer and the service provider is taking place.

2.3.3 Consumer involvement in services and its implications on language

Consumer involvement in the production of services is a prevalent concept in the service marketing literature (e.g. Bitner et al. 1997; Bloemer & De Ruyter 1999; Holmqvist 2009; Czinkota & Ronkainen 2010; Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013). Consumer involvement refers to the degree to which the consumer participates in the service encounter (Holmqvist 2009) and it may vary between different services. The most common classification of service encounters is into low involvement, middle involvement and high involvement services (e.g. Bitner et al. 1997; Bloemer & De Ruyter 1999; Holmqvist 2009). The higher the involvement of a service the more a consumer participates in the service encounter.

Based on previous two chapters, it is evident that communication and native language use have an important role in service encounters. However, academic research (Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013) provides evidence on how effective communication and native language are particularly important in some services; these services are called *high involvement services*.

According to Bloemer and De Ruyter (1999), high involvement services refer to services where the service delivery takes place over an extended period of time and the customer has an important role. In high involvement services active consumer participation in co-production is essential (Holmqvist & Van Vaerenbergh 2013) and the service is often customized for the consumer (Bitner et al. 1997). In fact, service delivery of a high involvement service cannot take place without active consumer participation, and the service includes a high risk or high uncertainty for the consumer (Holmqvist & Grönroos 2012). Typical examples of high involvement services are financial, legal and medical services as well as education (Bitner et al. 1997; Holmqvist 2009; Holmqvist & Grönroos 2012).

Low involvement services are services, in which customer presence is required during the service delivery, but the service provider provides the service and the service requires little participation and co-production from the customer (Bitner et al. 1997; Holmqvist & Van Vaerembergh 2013). In low involvement services is the service encounter with a service provider is often of very short duration (Bloemer & De Ruyter 1997). Typical examples of low involvement services are fast food restaurant or a cafeteria visit and a symphony concert (Bitner et al. 1997; Holmqvist 2011). In middle involvement services customer inputs (e.g. material, information) are required for service creation, but the service provider provides a somewhat standard service that can be customized slightly (Bitner et al. 1997). Examples of middle involvement services are full service restaurant and a haircut (Bitner et al. 1997; Holmqvist 2011).

In high involvement services the service outcome is dependent on consumer participation and how well the consumer performs his/her role (Bitner et al. 1997). To give an example, Bitner et al. (1997) note that patients in health care are part of the health service production process as they contribute the process by providing information about their ailment and symptoms. If patients provide precise medical information about themselves in a timely manner, their doctors are able to do more accurate diagnoses. Thus, the quality of information that the patient is providing can ultimately affect the quality of the treatment outcome (Bitner et a. 1997). On the other hand, patients also need to follow their doctors' advices in order to receive the desired outcome, so the patient also needs to participate and engage during the treatment process.

Empirical research in service marketing field (e.g. Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013) has found a relationship between consumer involvement in services and native language use. Holmqvist (2011) concludes in his empirical study that native language use is important for consumers in all service encounters. However, at the same time it is particularly important in high involvement services, like bank services and health care, which were also found to be the two high involvement services in which native language use is most important for consumers (Holmqvist 2011). Correspondingly, Holmqvist and Van Vaerenbergh's (2013) findings suggest that across studies in three countries (Belgium, Canada, Finland) all consumer groups studied – both bilingual and not bilingual, female and male as well as young and old – find it important to be served in their native language in high involvement services, whereas in low involvement services native language use is less important. The same study suggests that in low involvement services older consumers find it more important to be served in their native language than younger consumers (Holmqvist & Van Vaerenbergh 2013).

The importance of native language use in high involvement services is due to the fact that in high involvement services special vocabulary is often needed and increased consumer involvement also often indicates increased communication between the parties (Holmqvist & Van Vaerenbergh 2013). In general, high involvement services often have a large impact on a consumer. McDougall and Levesque (2000) note that consumers view those service encounters differently that directly affect their person in some way, and they have demonstrated empirically that service encounters that could potentially cause pain for a customer (e.g. dentist) or can have a negative impact on customer's appearance (e.g. hairdresser) are evaluated in a different way than more neutral service encounters like a restaurant visit.

As already mentioned in the previous chapter, consumers also have an emotional connection to their native languages (Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013), which also affects their language preferences. Besides, in low involvement services (such as grocery shopping or a cafeteria visit), it is easier to gain the desired outcome of the service by using other language than one's native language (Holmqvist & Van Vaerenbergh 2013). Low involvement services are less dependent on consumer co-production in service encounters, which makes it less important to understand every word of the interaction with the service provider (Holmqvist & Van Vaerenbergh 2013).

Native language use also affects consumers' behavioral reactions and actual behavior in service encounters, for example the consumer's willingness to pay about the service (Van Vaerenbergh and Holmqvist 2013). Holmqvist (2009) has found in his study that most consumers are willing to pay a premium even in low involvement services if they have the possibility to be served in their native languages. Besides, in general consumers prefer being served in their native language to the extent that they require a large price discount when switching to a company that is not providing service in their native language (Holmqvist 2009). Correspondingly, Van Vaerenbergh and Holmqvist (2013) demonstrate that consumers are more eager to tip the service provider when they are served in their native language. Van Vaerenbergh and Holmqvist's (2013) study also indicates that consumers who are served in their native language perceive higher service quality than consumers who are served in their second language.

All in all, Holmqvist (2011) concludes that consumers consider it essential to use their native language in services that include high physical or financial risk (e.g. medical and financial services). Similarly, they find native language use less important in less risky service contexts, like in a cafeteria or grocery store. Holmqvist (2009, p. 35) writes:

Being able to communicate effortlessly with the service provider is an important part of good service communication, an importance that grows the more involved the consumer is.

2.4 Language and communication in health care

Currently the main body of literature on language issues in health care services is focusing on Spanish-speaking patients in the United States in primary care or emergency department settings (Carrasquillo et al. 1999; Morales et al. 1999; Rivadeneyra et al. 2000; Sarver & Baker 2000; Lee et al. 2002; Fagan et al. 2003; Fernandez et al. 2004; Jacobs et al. 2006). Interestingly, Jacobs et al. (2006) also note that the majority of the previous literature of language issues in health care is quantitative by nature, which was also my observation during familiarizing myself with the literature (e.g. Carrasquillo et al. 1999; Morales et al. 1999; Rivadeneyra et al. 2000; Bernstein et al. 2002; Lee et al. 2002; Bonacruz Kazzi & Cooper 2003; Fagan et al. 2003; Fernandez et al. 2004).

Language issues in health care have traditionally been of special interest in the North American context due to large amounts of ethnic minorities and immigrants who do not speak the language of the majority (English). Thus, Jacobs et al. (2006) note that many U.S. residents, who speak only little English, face language barriers in health care even in their home country.

As language and communication have been researched mainly in the North American context, is *limited English proficiency* (LEP) a vital concept in this research stream (Carrasquillo et al. 1999; Fagan et al. 2003; Jacobs et al. 2006; Karliner et al. 2007). In the North American context patients with limited English proficiency are patients whose native language is not English and whose skills in English are limited; in this chapter these patients are called *LEP patients.* Thus, in practice LEP patients are patients who face language barriers in health care encounters.

2.4.1 The importance of communication between patient and health care personnel

Based on previous studies on interaction and communication in health care, it seems evident that communication between patient and health care personnel has an important role. Morales et al. (1999, p. 414) highlight that optimal treatment outcomes depend strongly on 'satisfactory communication between patients and physicians on medical test results, medications and treatment options'. Rivadeneyra et al. (2000) add that the quality of the doctor-patient relationship influences the diagnosis, treatment and even the recovery of the patient. Rivadeneyra et al. (1999) also note that patients must be treated as partners in the medical dialogue rather than mainly as reporters of their symptoms. Jacobs et al. (2006, p.111) emphasize the role of language and communication in health care by stating that the communication between doctor and patient is recognized to be of 'diagnostic import and therapeutic benefit'. Jacobs et al. (2006) also point out that miscommunication in medical encounters can lead to lost work time due to delayed diagnoses, unnecessary visits to clinic or hospital and even preventable medical errors.

In health care services, patient has a key role as a source of medical information. In order to be able to do a proper diagnosis and treat the patient, the doctor needs to understand the symptoms and the clinical picture of a patient (Aantaa 2012). Thus, in the beginning of a treatment process patient provides medical information for medical personnel by explaining his/her medical history, describing his/her current ailment and symptoms; this process is

called anamnesis (Aantaa 2012) which can also be conducted by patient's family member or similar if the patient is too unwell to do it himself/herself. Anamnesis is an important premise for diagnosis and in some cases it can be even more practical method than typical machine-based examination of a patient (Aantaa 2012). Nowadays quite often at least part of anamnesis is outsourced to the patient himself, as patients often have to complete a preliminary information form. In anamnesis the doctor has to be able to ask the right questions, but also the patient has an important role, as he/she needs to be truthful and open. The more explicitly a patient can tell about his/her symptoms, the better preconditions the doctor has to treat him/her (Aantaa 2012.)

Anamnesis is a very important phase in the health care process, as medical information given by the patient may have an impact on the success of the health care encounter. A challenge in anamnesis is that in many occasions patient and medical personnel are not using similar kind of vocabulary or jargon (Aantaa 2012). In other words, they use different vocabulary for similar symptoms and diseases. However, Aantaa (2012) notes that patients cannot be expected to understand specific medical vocabulary. This is why Aantaa (2012) suggests that medical personnel should approach patients in their native language and explain all medical terms they are using. Comprehensive medical information cannot be given if the patient and service provider are not sharing the same language. The success of anamnesis may also have a significant impact on patient safety (Aantaa 2012). If the patient and health care personnel do not share a language in which they are able to communicate and thus, the patient cannot share his/her medical history there is potentially an adverse impact for the patient safety.

Many researchers have noted the importance of native language use in health care services (Lee et al. 1998; Jacobs et al. 2006). However, it must be noted that the importance of native language use in health care has been studied mainly in the context of Hispanic (LEP) patients in Californian hospitals. It has been shown empirically (Fernandez et al. 2004; Morales et al. 1999) that patients prefer communication in their native language in health care encounters, although they also have a second language they are fluent in. Moreover, Fernandez et al. (2004) and Morales et al. (1999) conclude that Hispanic LEP patients perceive higher quality for their medical treatment, when they can speak their native language with their doctors.

Native language also has an important role in trust building between the patient and medical personnel. Ekman et al. (1993; please see Jacobs et al. 2006) have found in an empirical study

that language competence of medical personnel is vital in creating trustful relationship between patients and medical personnel, as native language use affects positively patient's identity and well-being.

2.4.2 Language barriers in health care and their impact on patient

As language issues in general, also language barriers in health care have been researched mainly in the North American context from the perspective of LEP patients. According to Jacobs et al. (2006), language barriers in health care can have significant impact on the success of the health care encounter. In health care services the success of the health care encounter is particularly important as it may have an impact on patient's survival and also health in the long run. If there is a language barrier, it is possible that doctor has less understanding of the full nature of patient's problems due to communication problems (Sarver & Baker 2000). Fernandez et al. (2004) note that language barriers have a negative impact on LEP patients' experiences of care.

Jacobs et al. (2006) have been researching language barriers in health care in the context of patients from the Spanish-speaking minority in the US (LEP patients). According to Jacobs et al. (2006), many U.S. residents with limited skills in English face severe language barriers when using health care services. Language barriers in health care have several consequences on patients (Jacobs et al. 2006). First of all, Jacobs et al. (2006) note that LEP patients are less likely to receive the care they would need.

Secondly, LEP patients are also more likely to be admitted to the hospital (Lee et al. 1998) and they often have longer hospital stays for medical and surgical conditions than patients who speak English as their native language (John-Baptiste et. al 2004). However, based on empirical research it is not completely clear *why* LEP patients are admitted to the hospital more frequently (Lee et al. 1998) and why they typically have longer hospital stays (John-Baptiste et al. 2004). In the United States context some explanations for more likely hospital admissions of LEP patients include cultural barriers, socioeconomic factors and delays in accessing health care (Lee et al. 1998). In addition, Jacobs et al. (2006) consider that doctors may be more likely to blunder on the side of caution when they feel they cannot rely on the patient's history and LEP patients do not always receive appropriate outpatient care as quickly as English-speaking patients do.

Morales et al. (1999) have found that language barriers between a patient and a doctor may cause excessive ordering of additional medical tests and unnecessary diagnostic testing, as the doctor tries to establish a proper diagnosis in the absence of sufficient patient history. LEP patients may also be at greater risk of suffering medical errors than fluent English speakers (Flores et al. 2003). However, according to John-Baptiste et al. (2004) limited English proficiency does not affect in-hospital mortality. In addition, LEP patients have a poorer overall understanding of the care they have received (Kazzi Bonacruz & Cooper 2003) and they are also less likely to receive follow-up appointments and follow the recommendations for further treatments and follow-up visits compared with patients who native language is English (Sarver & Baker 2000).

Language and language barriers also have a significant impact on patient satisfaction in health care services (Morales et al. 1999; Jacobs et al. 2006). Based on several studies on the topic, it seems evident that LEP patients are less satisfied with their health care (Morales et al. 1999; Fernandez et al. 2004; Jacobs et. al 2006). LEP patients who only speak Spanish have also been shown to be significantly more dissatisfied with communication with health care providers than the patients who speak English fluently (Carrasquillo et al. 1999; Morales et al. 1999). LEP patients are also less satisfied with the care they receive and they are also more likely to report overall problems with their care than are native English speakers (Carrasquillo et al. 1999). In addition, as language barriers with a health care provider often lead to greater patient dissatisfaction, this dissatisfaction may result in inappropriate treatment follow-up and even doctor shopping (Morales et al. 1999).

Morales et al. (1999) conclude that due to language barriers with health care providers, LEP patients are at greater risk of lower quality of care and poor health outcomes. On the other hand, it must be noted that also health care providers are more dissatisfied with their interactions with patients when they face a language barrier (Hornberger, Itakura & Wilson 1997). Language barrier thus influences both parties of the health care encounter. All in all, according to Jacobs et. al (2006), language barriers adversely affect patients with limited English proficiency (LEP) in their access to health care, comprehension and adherence, quality of care as well as patient and provider satisfaction.

2.4.3 Interventions to overcome language barriers in health care

Reducing language barriers in health care settings has also been investigated mainly in the context of Spanish-speaking LEP patients in the United States (Jacobs et al. 2006). In the European context language barriers in health care have been researched significantly less, but there are still some examples on how language barriers in health care are seen as a challenge also in the European context (e.g. Martinsen 2007; Wagner & Linder 2010; Jansson 2014). Wagner & Linder (2010) have studied patient mobility in the European setting and they note that problems with language is one of the main reasons for patient dissatisfaction with medical treatments carried out in other EU country than the patient's home country. Other major reasons for patient dissatisfaction in Europe are high additional costs and poorer quality of treatments (Wagner & Linder 2010).

Jansson (2014) has studied how health care personnel overcome language barriers and especially how interaction including a language barrier is enabled with elderly patients suffering from dementia. Jansson's (2014) study suggests that although patients and health care personnel are not sharing a common language, or share it only to a limited extent, the care workers have multiple ways to enable interactive health care encounters that allow them to perform care task with both empathy and efficiency. According to Jansson (2014), the most typical approaches are learning at least some phrases of patient's native language and creating rapport that way, or trying to match the patient with medical personnel who speak a language that has the most in common with patient's native language. In addition, when language barriers occur, empathic moves like prosody, body language and hand gestures are also important (Jansson 2014).

Jacobs et al. (2006) have also been studying language barriers in health care extensively and they have searched for effective interventions to reduce language barriers. Jacobs et al. (2006) note that there are two broad categories of interventions to reduce language barriers in health care: 1) Matching LEP patients with health care providers who speak their native language (language concordance) and 2) Finding a third person (an interpreter) who speaks both the patient's native language and the language of the health care personnel. These two interventions to reduce language barriers in health care will be discussed in more detail in the following. Jacobs et al. (2006) have also written about language training as an intervention to reduce language barriers; this method will be discussed as well.

1) Language concordance

Studies of health care encounters where the provider and patient speak the same language, also known as *language concordance*, have found higher rates of patient satisfaction (Morales et al. 1999; Freeman et al. 2002; Lee et al. 2002) compared with language-discordant patient-health care provider pairs. Also better patient well-being have been reported with language concordant patient-health care provider pairs (Perez-Stable, Napoles-Springer & Miramontes 1997, please see Jacobs et al. 2006). Morales et al. (1999) have discovered that bilingual doctors, who have an adequate fluency in patient's native language, can improve patients' understanding of their diseases and overall satisfaction with care. Language concordance has also a positive impact on patient visit recall and the overall interaction between patient and doctor (Seijo, Gomez & Freidenberg 1991, please see Jacobs et al. 2006).

2) Interpreting in health care encounters

Interpreter in medical services can be a professional interpreter employed specifically to interpret, or a non-professional or 'ad hoc' interpreter, like another patient, family member, friend, untrained employee or non-fluent health care professional (Jacobs et al. 2006). Typically in cases when it is not possible to communicate with the patient, health care personnel often rely on other patients, family members (even children), friends and untrained nonclinical employees to communicate with their patients and use them as 'ad hoc' interpreters (Jacobs et al. 2006). Bernstein et al. (2002) note that many emergency department (ED) doctors still rely primarily on patient's family members, friends or nonprofessional hospital employees for interpretation.

When it comes to professional interpreters, it has been found that professional interpreter services increase LEP patients' receiving of primary and preventive care (Jacobs et al. 2001). Karliner et al. (2007) have found that the use of professional interpreters is associated with improved medical care more than the use of 'ad hoc' interpreters, and professional interpreters seem to raise the quality of medical care for LEP patients. Bernstein et al. (2002) found that the use of professional interpreters in the emergency department (ED) reduced emergency department costs and utilization, when compared with care encounters where non-professional interpreters or no interpreters at all were used. According to Fagan et al. (2003), non-professional interpreters and telephone interpretation are associated with longer hospital stays, whereas full-time professional hospital interpreters result in shorter hospital stays. Morales et al. (1999) have found that professional using professional interpreters can improve

patient satisfaction. On the other hand, Fernandez et al. (2004) note that although professional interpreters are used, LEP patients are still less satisfied with their care than English-speaking patients and LEP patients are also less likely to rate their health care provider to be respectful and concerned about them.

There are also possibilities for using different technological modalities for interpretation (Jacobs et al. 2006). For example in remote simultaneous medical interpretation (RSMI) the interpreter is off-site and communicates with both medical personnel and patient through microphone headsets (Hornberger et al. 1996). For example in Hornberger et al.'s study (1996) the RSMI method was responded positively by both medical personnel and patients, and patients found it even more appropriate than traditional face-to-face interpreting. Correspondingly, Fagan et al. (2003) have researched telephone interpreters and they found that telephone interpreters are associated with longer hospital visits than when full-time professional hospital interpreters are used.

Studies observing non-professional or 'ad hoc' interpreting have found mixed results (Jacobs et al. 2006). Some studies (Sarver & Baker 2000) have found that using 'ad hoc' interpreters result in greater patient satisfaction, better patient comprehension and more patients receiving follow-up visits after leaving the hospital, whereas some studies (Bernstein et al. 2002; Flores et al. 2003; Rivadeneyra et al. 2000) conclude that 'ad hoc' interpreting causes various challenges. Bernstein et al. (2002, p. 171) describe the challenges related to non-professional interpreters in health care encounters in the following:

This use of translators who lack medical knowledge and training in effective communication can result in omissions, additions, and substitutions of pertinent medical history, under- and overutilization of diagnostic and therapeutic procedures, misdiagnosis, and treatment errors.

Flores et al. (2003) add that non-professional interpreters understandably make errors in interpreting, which may lead to clinically significant errors in communication and thus, even misdiagnosis and delivery of inaccurate medical treatment. Non-professional interpreters may also lead patients to ask fewer questions and limit the doctor's responses (Rivadeneyra et al. 2000). Besides, Hornberger, Itakura & Wilson (1997) have found that the use of non-professional interpreter leads to less satisfaction by both LEP patients and doctors when compared with the use of professional interpreters.

3) Language training

Literature also acknowledges language training as one intervention to reduce language barriers in health care (Prince & Nelson 1995; Morales et al. 1999). Empirical research has demonstrated an increase in patient-health care professional comprehension and fluency after language training (Prince & Nelson 1995). However, research concluded that although medical language courses can be a useful adjunct to interpreters, they cannot replace professional interpreters (Prince & Nelson 1995). Prince and Nelson (1995) note that significant errors may occur in health care when health care providers, after taking a language course, assume that their knowledge is sufficient enough and thus, provide medical care without an interpreter present.

Which method is the most applicable?

Jacobs et al. (2006) have come to a conclusion that it has a positive effect on patient's recall, adherence and satisfaction when the patient and health care provider are able to speak the same language (language concordance). Similarly, using professional interpreters in health care can favorably affect utilization, quality and adherence (Jacobs et al. 2006). Using non-professional interpreters and providing language training for medical personnel seem to have mixed effects on patients (Jacobs et al. 2006). Jansson (2014) notes that although there are various solutions to overcome language barriers in health care, the best way is to match the patient with medical personnel who share a common native language, as the linguistic matching enables most efficient interaction.

In general, literature presents only little guidance on which technique – and under which circumstances – is the best intervention to overcome language barriers in health care (Jacobs et al. 2006). This is also one key reason for why further research on language issues, especially language barriers, in health care is needed.

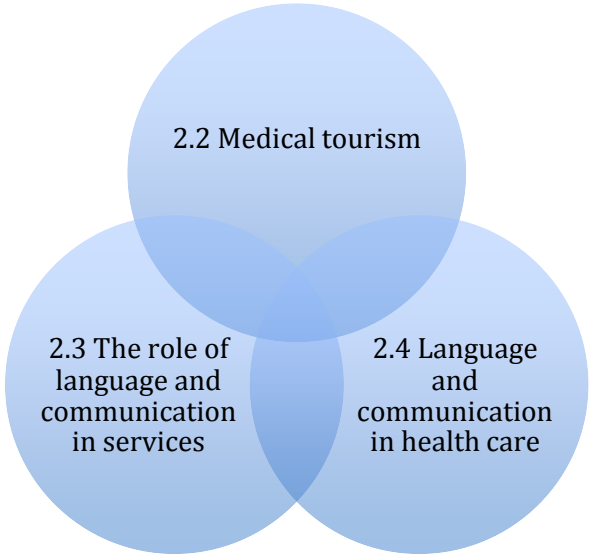
2.5 Intersection of the research areas and theoretical framework

This part draws together the previous parts of the literature review and provides a clear synthesis between them in a form of a theoretical framework. As the theoretical framework combines the previously presented three independent research areas, first the intersection of these areas is briefly discussed.

2.5.1 Intersection of the research areas: language and medical tourism

The theoretical framework of my thesis is in the intersection of three separate areas: l) medical tourism, 2) the role of language and communication in services and finally 3) language and communication in health care. The intersection of the research areas is presented in the Figure 3 below.

Figure 3 ***The intersection of the research areas***



The role of language and language barriers as well as patient's expectations on service language have not been researched extensively in the medical tourism context. However, research acknowledges that medical tourism might cause difficult language barriers (Wang 2012). Nordic Healthcare Group (2010) points out that language and cultural differences between patient and health care professionals might be a problematic area in medical tourism. Wang (2012) writes that quite often patients travelling abroad for health care face difficulties in foreign language communication particularly with doctors and other medical personnel, which may have problematic consequences. Wang (2012, p. 482) sees the services of a professional interpreter as a potential option to overcome language barriers caused by medical tourism:

To attract global medical tourists, medical tourism providers might consider offering the services of a professional interpreter with specialized medical knowledge to support the patient through all stages of treatment during his/her stay at the hospital.

There is some empirical evidence (Levary 2011; Peters & Sauer 2011) on the importance of patient's native language in medical tourism. For example, Levary (2011) has researched empirically the decision criteria of medical travellers in order to understand what kind of decision criteria medical travellers use in choosing their medical tourism destinations. In his research Levary had four different decision criteria: 1) expected cost, 2) ability to speak the patient's native language, 3) distance from the patient's home country and 4) destination country's political stability. Levary (2011) found in his study that the medical personnel's ability to speak patient's native language in medical tourism destination is the most important destination decision criterion for a patient, even more important than the destination country's political stability which was the second most important criterion. Distance to patient's home country was the least important criterion. The same study also ranked some popular medical tourism destinations based on these criteria, and India was found to have the highest ranking due to its English-speaking population and low expected costs for medical operations.

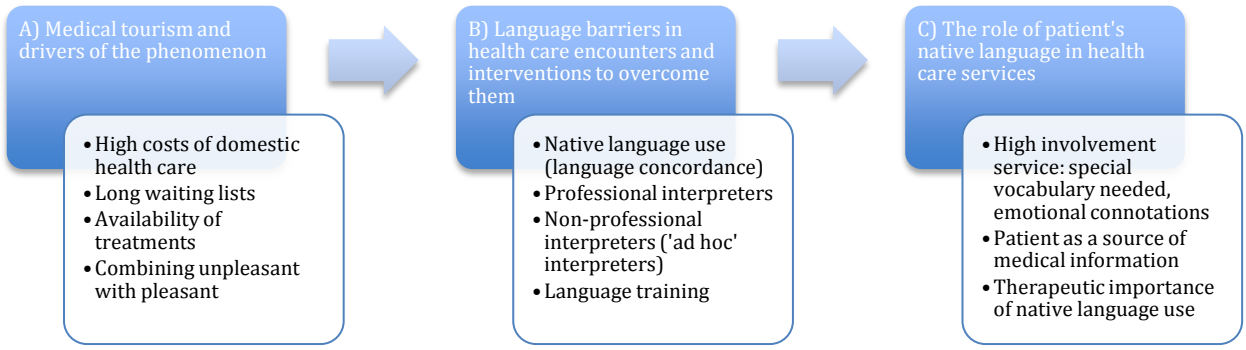
Correspondingly, Peters & Sauer (2011) have researched medical tourism service companies and particularly the providers' views on which features of a medical trip are important to their customers. They have found the following criteria: volume of medical tourists served, company's experience and reputation, quality of medical care and medical follow-up, quality of facilities, costs and the ability to communicate in patient's native language. Also distance from patient's home country, ease of travel and recommendations from acquaintances were found to be important for medical tourists. In Peters and Sauer's (2011) study, the ability to communicate in patient's native language was found to be the third most important factor for medical tourists after quality of medical care and quality of facilities.

2.5.2 Theoretical framework

Based on the literature review, the theoretical framework for this study is presented in the Figure 4. The theoretical framework follows the logic of the research objectives and research questions and it has three different parts, as seen in the figure below. The third research question, the sub-question, (*What kind of phenomenon is medical tourism in the Finnish context?*) is presented in the part A of the theoretical framework. The first research question *How do language barriers affect health care encounters and how do health care companies overcome them?* is presented in the part B and the second research question *How important is*

the role of patient's native language in health care services and when is the use of patient's native language particularly important? in the part C of the theoretical framework.

Figure 4 ***Theoretical framework***



A) Medical tourism and drivers of the phenomenon

Medical tourism and drivers behind the phenomenon were discussed in chapter 2.2 of this report. Medical tourism is not a novel phenomenon, but it has recently turned into a multi-billion business due to affordable cross-border travel and Internet as a marketing and information platform. There are no exact figures on global streams of medical tourists, as the definitions of medical tourism vary and there are several statistical methods. Traditionally, medical tourist streams have been from developing countries to developed countries, but this is now changing to exactly opposite direction due to patients from developed countries who are looking for affordable health services provided in some less-developed countries. However, it must be noted that many countries (particularly developed) are sending and receiving medical tourists at the same time.

There are various reasons for medical tourism. First of all, health care is expensive in many places globally and patients are increasingly searching for more affordable options or better price-quality ratio than provided by their domestic health care. There are also long waiting lists to mandatory and non-mandatory operations in many countries, and by travelling abroad patients want to avoid the waiting lists. Patients also travel in search of treatments that are not available in their home countries, as some treatments may be taboos (e.g. fertility treatments, sex change operations, plastic surgery) and some simply illegal (e.g. abortion, euthanasia). In

some cases travelling abroad for health care also eases the psychological burden of a medical operation: patients want to combine the unpleasant and probably painful experiences with happy moments and memories experienced together with family or friends abroad.

B) Language barriers in health care encounters and interventions to overcome them

Medical tourism generates service encounters in which patient and the service provider are not always sharing a common language, which indicates language barriers. Previous academic literature recognizes the concept of language barriers in health care services. The problems related to language barriers in health care and their multiple impacts on patients were discussed in chapter 2.4.2. All in all, language barriers are often very problematic in health care services and they may have several adverse effects on the success of the health care encounter, patient satisfaction and even the result of the treatment.

There is also some literature on interventions to overcome language barriers, but this kind of literature is limited. Based on previous literature on the topic, the main interventions for overcoming language barriers in health care are native language use (language concordance), utilizing professional or non-professional interpreters or different technological solutions to interpreting as well as providing language training for health care personnel in health care organizations.

C) The role of patient's native language in health care services

According to previous studies in the field of service marketing (the role of language and communication in services) as well as language and communication research in health care, patient's native language seems to be particularly important in health care services. This topic was discussed in chapters 2.3 and 2.4 more thoroughly. All in all, health care is a high involvement service and previous research (Holmqvist 2011; Holmqvist & Van Vaerenbergh 2013) implies that native language use is particularly important in high involvement services. This is due to the fact that in high involvement services special vocabulary is often needed and customer has an important role in co-production of the service. High involvement services also often require increased communication between service provider and customer (Holmqvist & Van Vaerenbergh 2013). In health care services patient is also a source of medical information, which is important for a successful diagnosis (Jacobs et al. 2006; Aantaa 2012).

3. RESEARCH METHODOLOGY

This chapter outlines the research design and methodology chosen for this study. Thus, in this chapter I will present and justify my research design and methods as well as describe my research process, data collection and data analysis methods. In the end of this chapter also the reliability and validity of the study are assessed.

3.1 Research method, strategy and approach

The empirical part of the study was implemented by using qualitative multiple case study as a research method and interviews as the primary data gathering method. In the following I will present my research method and research approach in more detail.

3.1.1 Qualitative research method

Research method can be defined as the master plan identifying the methods and procedures for collecting and analyzing the data (Zikmund 2000, p. 59). Generally speaking there are quantitative and qualitative research methods, and as already stated, this research is a qualitative research. Qualitative research method was chosen as it fits the research objectives of this study. Qualitative research is a broad approach to the exploration of social phenomena (Marshall and Rossman 2006, p. 2) and qualitative research is a suitable method especially when the phenomenon under investigation is rather little known (Marshall and Rossman 2006, p. 53; Yin 1981). Another major difference between qualitative and quantitative research is the orientation of the research: archetypally qualitative research focuses on constructing and investigating, whereas quantitative research on testing and verification (Thietart et al. 2001, p. 80).

This study investigates language barriers and the role of language in health care services as well as medical tourism as a phenomenon. In other words, this study does not measure or quantify any object or does not try to test or verify previous theories. According to Marshall and Rossman (2006, p. 2), qualitative research is 'pragmatic, interpretive and grounded in the lived experiences of people' and thus, perfectly suitable for the objectives and purpose of this study.

One of the main differences of qualitative and quantitative research methods is also the nature of the data. In qualitative research the empirical data is composed of for example impressions, words, sentences, photos, symbols, whereas in quantitative research the data is typically comprised of numbers (Neuman 2006, p. 151). The choice of qualitative research method was also due to availability of data, as there is only very limited quantitative data or information available about language issues in medical tourism in the Finnish context. Besides, as the study aims at exploring the reasons and meanings of a phenomenon, like qualitative research often does (Ghauri 2004), it would have been almost possible to conduct the study only in numerical or quantitative terms.

3.1.2 Multiple case study and justification of the selected strategy

In this study the research problem and research objectives determined the research method, and after a thorough analysis of different research strategies, I chose qualitative case study approach for this study. However, it must be noted that case study research can be conducted by using both qualitative and quantitative methods with various data collection techniques, as case study is not a method itself, but rather an objective of a study (Yin 1981; Eisenhardt 1989; Ghauri 2004). According to Neuman (2006, p. 40), the formal definition of a case study research is as follows:

Case study research is research that is an in-depth examination of an extensive amount of information about very few units or cases for one period or across multiple periods of time.

In general, as a research strategy, case studies have been used in many situations to contribute the knowledge of individual, group, organizational, social, political, and related phenomena (Yin 2003, p. 1). Eisenhardt (1989) and Ghauri (2004, p. 109) note that case study is a particularly useful method when the research area is relatively little known, existing theory seems to be insufficient, the researcher undertakes theory-building type of research and the main objective of the study is to gain a holistic picture of the topic. These attributes of case study research support my research objectives and research questions. Besides, according to Yin (2003, p. 1), case study method is particularly suitable for "how" and "why" research questions, like the research questions are in this study. Yin (2003, p. 1) notes that case study method is appropriate for research where the focus is on a contemporary phenomenon – in this study medical tourism – within some real-life context. Ghauri (2004, p. 112) notes that

case studies are particularly suitable for occasions when the phenomenon under investigation is difficult to study outside its natural setting.

In case study research it is possible to do both single and multiple case studies (Yin 2003, p. 14). This study is a multiple case study in order to enable comparison between the health care companies and provide an enriched picture of the language issues as well as medical tourism field in Finland. Ghauri (2004, p. 114) writes that the core of a multiple or comparative case study is to 'ask or study the same questions in a number of organizations and compare them with each other to draw conclusions'. Piekkari, Welch and Paavilainen (2009) note that multiple case studies have been favored in international business research.

In addition to enabling comparison between the health care companies, there are also other reasons for why I chose multiple case study method for this study. According to Yin (2003, p. 46), the evidence from a multiple case study is often regarded more compelling than from a single case study and thus, the overall study is considered as being more robust. Also Thietart et al. (2001, p. 165) argue that confidence accorded to the results of qualitative research tends to increase in relation to sample size.

On the other hand, single case study would have allowed an in-depth analysis of one company, but in this study the purpose is to contrast the practices in different organizations. Typically the results of a single case study are only applicable to the case company in question (Eisenhardt 1989). Besides, many researchers (e.g. Thietart et al. 2001, p. 164) argue that the findings of a single case study cannot be generalized to a larger population, whereas the findings of a multiple case study can be not only better generalized but also more soundly validated (Eisenhardt 1989). On the other hand, the main purpose of a case study is not to generate generalizable results, but to gain rich data on the phenomenon under study (Yin 2003).

3.1.3 Research approach: inductive reasoning with deductive elements

In the academic research there are two main schools of reasoning: *deductive* and *inductive*. Inductive approach means to defend the truth of a general proposition by considering certain cases that support it (Thietart et al. 2001, p. 53); inductive approach is a bottom-up process that moves from observation to theory. In other words, inductive logic permits researcher to move from particular observations to general statements (Thietart et al. 2001, p. 25). On the contrary, deductive logic focuses on testing hypotheses based on existing literature; if the

hypotheses created initially are true, then the conclusion that follows logically from these premises must be completely true too (Thietart et al. 2001, p. 52). Thus, deductive reasoning is a top-down process that starts with a theory and hypotheses and then finally moves towards observation and confirmation or rejection of the hypotheses.

However, contemporary researchers acknowledge that the approaches are not exclusive and quite often studies include some features from both of them (Ghauri 2005). Zikmund (2000, p. 44) reminds that very often the theory construction is a combination of both deductive and inductive reasoning; inductive research approach can absorb deductive elements and vice versa.

Thus, the research approach of my study is mainly inductive, but with deductive elements. Flick (2002, p. 2) writes that very often the most suitable research approaches in the contemporary research are inductive strategies; rather than testing different theories and hypotheses, inductive research focuses on 'sensitizing concepts'. In line with Flick's statement, this study aims at gathering knowledge about the role of language and language barriers in health care services as well as medical tourism in the Finnish context. Flick (2002, p. 2) also notes the traditional deductive research – forming research questions and hypotheses from prior theoretical models and testing them against new empirical evidence – is failing in the differentiation of objects. However, before I started gathering empirical data for this study I built a strong theoretical base, which is in accordance with deductive reasoning.

3.2 Choice of the case companies and sampling decisions

Eisenhardt (1989) and Yin (2003, p. 22) note that selection of cases – and especially defining them – is an important part of a multiple case study. According to Neuman (2006, p. 40), the 'cases' under examination can be for example individuals, groups, organizations, movements, events or geographic units. Eisenhardt (1989) notes that the cases can be chosen for example to replicate previous cases or broaden emergent theory as well as fill theoretical categories and provide examples of extreme types. Eisenhardt (1989) also points out that sometimes cases are chosen randomly, which is, however, not a preferable method.

In this study the four different Finnish health care companies constitute the 'cases' or units of analysis. Eisenhardt (1989) notes that although there is no ideal number of cases, a number between four and ten usually works well. Respectively, Yin (2003) states that conclusions from studies with two or more cases have stronger generalizability than single case studies. Furthermore, this study is an embedded case study, and not a holistic one, which means that several sub-levels of analysis will be examined within each case (Yin 2003). In this study each case has three sub-levels of analysis: the company itself, involvement in medical tourism as well as communication and interaction with Russian patients.

Sampling decisions

There were two separate samples in my study: the number of case companies and the number of interviewees. Regarding both of the two samples, choosing the appropriate sample size for the study was not simple. According to Thietart et al. (2001, p. 165), in determining the appropriate sample size – also in qualitative research – the goal is to determine the minimum size that will enable a satisfactory level of confidence in the results. Consequently, in this study as large sample as possible was tried to achieve, but at the same time taking theoretical saturation into account. Theoretical saturation refers to a situation where no new information is gained as the informants are mainly replicating each other's ideas (Thietart et al. 2001, p. 166). Due to theoretical saturation it is not often suitable to increase the sample size extensively and Eisenhardt (1989) notes that adding new cases should stop when theoretical saturation is reached. Besides, although the dependability of results tends to increase in relation to the sample size, having a notably large sample size increases the time and cost of collecting data (Thietart et al. 2001, p. 165; Eisenhardt 1989). In my study also gaining access to health care companies as well as the limited number of companies in Finland receiving Russian medical tourists presented restrictions to increasing the sample size.

For this study four case companies were chosen: Joint Replacement Hospital Coxa, Docrates, Hospital Neo and Orton. The criteria to choose the companies was based on my evaluation on where I could get the most enriched data. In other words, my goal was to find case companies that could fit the research problem as soundly as possible and thus, could provide high-quality data for answering the research questions. Therefore, it was crucial that the companies had received several Russian medical tourists in recent years, as it was important that the companies had experience in communicating and interacting with Russian medical tourists in order to be able to tell about their experiences and processes.

The case companies were selected among the participants of FinlandCare program. FinlandCare is a program organized in cooperation by Finpro and Ministry of Employment and the Economy of Finland. The purpose of the program is to promote medical tourism in Finland and help companies to attract especially Russian patients. Companies included in the FinlandCare program were preferred as they serve also foreign patients and they have already gained experience in medical tourists. However, it must be noted that not all of the FinlandCare companies were suitable case companies for this study, as not all of them are health care service companies, because in the program there are also health care education, consulting and technology companies. Further information on FinlandCare program can be found in the chapter 4.1 of this report.

In choosing the case companies also 'snowball' or 'chain' sampling was used. Snowball sampling is possibly one of the most frequently used sampling methods in qualitative research across various disciplines (Noy 2008). Snowball sampling refers to a sampling method where the informants are chosen on the basis of referrals from previous informants or new informants are accessed through contact information provided by previous informants (Noy 2008).

The very first interview for this study was conducted with Marketing Director of the FinlandCare program and she gave me some very valuable insight on which companies in the Finnish medical tourism industry would be the most suitable for this kind of study. Also the other expert interviewee from Ministry of Employment and the Economy gave her opinions on which companies to choose. After the first interview with the FinlandCare program representative and reviewing the webpages of several FinlandCare program member companies, a list with potentially suitable case companies was made and these companies were contacted by telephone or e-mail. All the companies contacted accepted the invitation to join the study, and the four case companies were found.

Snowball sampling was also used in each case company when choosing suitable interviewees for this study. In the case companies a director/management-level person was first contacted and asked for an interview. When the contact person accepted the request for an interview, then he/she was asked to recommend other suitable interviewees, particularly medical personnel, in the company. The criterion for recommending other interviewees was that the interviewees should have experience in communicating and interacting with Russian patients

and potentially language skills in Russian. Based on this method, altogether 14 interviewees were found to join this study.

3.3 Research process

This thesis project started in January 2014 by defining the topic, creating a research plan and reviewing relevant literature and theories for the study. In the beginning of the research process the focus was on reviewing the previous literature and building the foundations and structure for the qualitative interviews. Writing the literature review in the early phases of the process also helped me to familiarize myself with the topic. However, in the initial stages of the research process the literature review was not finalized, but it was updated and reiterated throughout the process. An initial frame of reference was drafted after reviewing the literature, but it was also modified later.

Also the research objectives and questions were defined in the early stages of the research process, but they were revised several times during the process. However, there was an initial research question already in the beginning of the research process, as for example (Eisenhardt 1989) notes that an initial version of a research question is important in case study research. Eisenhardt (1989) also points out that in case study research, research questions are typically tentative in the beginning of the research process and they may shift during the process.

Case companies and expert interviewees were contacted in March-May 2014, and qualitative interviews conducted in April-May and September 2014. Full transcriptions of 13 interviews took a significant amount of time and they were made during June-October 2014. Data gathered in interviews was analyzed in November 2014-March 2015, and Findings as well as Discussion were written in January-April 2015. The final report was finalized in April 2015.

3.4 Data collection

In this chapter I will present my data collection methods. I will start with my primary data collection method and then move on to my secondary data sources. Primary data can be defined as data that is gathered and assembled specifically for the research in question, and secondary data is data gathered originally for some other purpose (Zikmund 2000, p. 58).

3.4.1 Qualitative interviews

According to Thietart et al. (2001, p. 180) interviewing is one of the principal methods in collecting primary data for qualitative research and Yin (2003, p. 89) writes that especially in case study research interviews are an essential source of data. Qualitative interviews are the primary data collection method for this research, and for this study altogether 13 interviews were conducted.

I gathered primary data by interviewing three different groups: 1) management of health care companies 2) nurses and doctors working in the companies in question and thus, dealing with Russian patients and 3) Finpro and Ministry of Employment and the Economy (MEE) representatives. As mentioned in the previous chapter, the case companies for my study included four Finnish health care companies involved in the medical tourism industry.

Figure 5 ***The three groups of informants***

Each of the three interviewee groups had a special role in my study. Finpro and Ministry of Employment and the Economy representatives served my study as "expert interviews" and they can be seen as *key industry informants*: they were able to give an overview on the medical tourism field in the Finnish context. They were also able to discuss language barriers and medical tourism on a general level. Thus, it was useful that these interviews were conducted in the beginning of the data gathering process.

Also the two informant groups within each case company had specific roles in my study. Director/Management-level personnel in the case companies were able to share detailed information on the strategic perspectives on language issues and medical tourism, whereas medical personnel in the case companies had practical experience in communicating and interacting with Russian patients.

Semi-structured interviews, interview guide and interview schedule

There are different types of interviews in academic research: for example *structured, unstructured, semi-structured* and *focus group interviews*. For my study I used *semi-structured interviews*. In general, Yin (2003, p. 90) argues that typically case study interviews tend to be open-ended.

In practice, semi-structured interview means an interview where the researcher has defined a series of subject areas in advance, but at the same time allows new questions to emerge (Thietart et al. 2001, p. 181). Thus, in a semi-structured interview it is possible to bring new ideas and questions to the discussion based on the interviewees' answers. This kind of approach was chosen, as I was interested in language issues in case companies and medical tourism as a phenomenon, but I did not want to guide or manipulate the discussion too much. Semi-structured interviews allowed the interviewees to tell their "stories" and experiences from their own perspective. On the other hand, it was important that the interviews included similar main topics and themes in order to allow comparison between them. Although there were pre-defined topics to be discussed, the interviews still remained rather conversational.

The topics were outlined in interview guides (e.g. Patton 1987), which were adapted to each informant group and used in all interviews. In interview guide approach the topics to be covered are specified in advance, but the sequence and wording of questions may vary from one interview to another (Patton 1989). In other words, interview guide approach allows the researcher to make adjustments to the interview questions, such as adding questions (Eisenhardt 1989), and thus, allows news topics raised during the interview to be discussed. Asking additional and follow-up questions during the interviews can help gaining more insight on the research topic from the interviewees and thus, can enhance the quality of the study. The approach also allows leaving some question out of the interview, in case some pre-defined questions are not suitable or relevant for the interviewee. These alterations are possible, because especially in case study research the objective is to understand each case

individually and as profoundly as possible and not to produce summary statistics about a collection of observations (Eisenhardt 1989). Thus, mainly the same themes were discussed in all interviews, but some questions and topics were tailored to better fit the specific company or interviewee. The topics included in the interview guide were defined based on the previous literature and the first expert interview with the Finpro representative. The full interview guides for each informant group can be found in the Appendices 1-3.

Altogether 13 interviews with 14 interviewees were made for this study. Interviews took place during April-May 2014 and September 2014. All the interviews were made one-by-one basis apart from one interview, which was a group interview: the interview with CEO and Project Director at Hospital Neo was done as a group interview due to their tight work schedules. Other interviews were conducted in Finnish, but two of them were conducted in English due to the wish and preference of the interviewee. It should be noted that as 11 interviews were conducted in Finnish and two in English, I have translated all the quotations from the interviews in Finnish.

All interviews took place at the case companies' or expert interviewees' premises. All interviews were made face-to-face apart from one interview with Orton representative who preferred a telephone interview due to schedule challenges. All the interviews were recorded with an iPhone with the permission of the interviewees and fully transcribed afterwards. However, although the interviews were recorded, extensive written notes were also taken. The transcription was made due to the fact that written data is simpler to analyze than tape-recorded data. Full transcriptions also enabled presenting direct quotations drawn from the interviews; these are presented in the next chapter of this thesis. In the Table 2 all the interviews conducted for my study are presented in a chronological order.

Table 2 ***Interview schedule and overview***

Date and place	**Company / organization**	**Type of interview and group of interviewee**	**Language of the interview**	**Interviewee**	**Gender**
4.4.2014 Helsinki	Finpro	One-by-one, expert interview	Finnish	*Marketing Director, FinlandCare program*	Female

15.5.2014 Helsinki	Docrates	One-by-one, management	English	*Manager*	Female
15.5.2014 Helsinki	Docrates	One-by-one, medical personnel	English	*Doctor*	Female
15.5.2014 Helsinki	Docrates	One-by-one, medical personnel	Finnish	*Nurse*	Female
22.5.2014 Turku	Hospital Neo	Group interview, management	Finnish	*CEO* *Project Director*	Male Male
22.5.2014 Turku	Hospital Neo	One-by-one, medical personnel	Finnish	*Medical Director*	Male
22.5.2014 Turku	Hospital Neo	One-by-one, medical personnel	Finnish	*Nurse*	Female
23.5.2014 Helsinki	Ministry of Employment and the Economy	One-by-one, expert interview	Finnish	*Development Director*	Female
26.5.2014 Telephone	Orton	One-by-one, medical personnel	Finnish	*Patient Coordinator*	Female
28.5.2014 Helsinki	Orton	One-by-one, management	Finnish	*CEO*	Male
9.9.2014 Tampere	Coxa	One-by-one, management	Finnish	*CEO*	Male
9.9.2014 Tampere	Coxa	One-by-one, medical personnel	Finnish	*Doctor*	Female
9.9.2014 Tampere	Coxa	One-by-one, medical personnel	Finnish	*Nurse*	Male
Total number of interviews	**13**	**Total number of interviewees**		**14**	

3.4.2 Secondary data

In addition to my primary data also some secondary data sources were used in this study. Zikmund (2000, p. 58) defines secondary data as data that is previously collected and assembled for some other purpose than the research in question.

The secondary sources were used to better understand the primary data as well as enrich and complement the data. As secondary data sources, I have used case company webpages, newspaper articles, Finpro materials and presentations as well as the webpage of FinlandCare program.

3.5 Data analysis

According to Ghauri (2004, p. 117), analyzing and interpreting qualitative data is probably the most difficult phase in a qualitative case study research, and quite often the least codified part of the research process (Eisenhardt 1989). However, at the same time it is often one of the most important parts during the research process. Eisenhardt (1989, p. 539) even states that 'analyzing the data is the heart of building theory from case studies'.

In qualitative research, it is often very difficult to separate different data analysis methods. Thus, typically several data analysis methods are used simultaneously (Eisenhardt 1989), and also for this study the analysis of written interview transcriptions was an iterative process, as they were analyzed in various phases using different data analysis methods. First, a within-case analysis was conducted within each case separately. Within case analysis typically includes written and detailed case study write-ups for each case, but there is no standard format for this type of analysis and each researcher has his/her own approach (Eisenhardt 1989). The main purpose of within-case analysis is to help covering the large size of data, which is typical in case study research, and familiarize researcher with each case as a stand-alone entity (Eisenhardt 1989). My within-case analyses included separately made written summaries on each case highlighting the main findings and observations from each company.

In the second phase coding of the interview data was conducted by cross-case analysis with simultaneously utilizing suitable elements from thematic content analysis. Malhotra et al. (2012) point out that the coding process is particularly important in qualitative research as it

enables researcher to notice the most common themes in the data and decrease irrelevant data. Cross-case analysis is useful particularly in multiple case studies and aims at searching patterns between cases (Eisenhardt 1989). There are various tactics in conducting cross-case analysis, for example selecting specific categories and dimensions and looking for 'within-group similarities coupled with intergroup differences', selecting pairs of cases and listing similarities and differences between cases and dividing data by data source (Eisenhardt 1989, p. 540).

As already mentioned, also elements from thematic content analysis were used together with cross-case analysis. Thematic content analysis is especially common when analyzing interview data and the main purpose of this analysis method is to decrease the amount of data by summarizing, structuring and simplifying the data (Malthotra et al. 2012). After transcribing the interview data and doing the within-case analyses the data was coded by emphasizing the most common themes raised during the interviews (thematic content analysis) and after that some sub-themes were categorized under the main themes. During this exercise also similarities and differences between cases were searched for and coded (cross-case analysis). Using multiple data analysis methods required multiple rounds of reading, coding and processing the data, but enabled me to be familiar with my data.

3.6 Research evaluation

Even in the case of a qualitative research the validity and reliability of a study must be assured. In this part I will evaluate the validity and reliability of my study. Validity and reliability are common criteria for good measurement of a study (Zikmund 2000, p. 279). To ensure the quality and accuracy of my research, I am following Yin's (2003) approach. Yin (2003, p. 34) has created four tests that establish the quality of any empirical research: *construct validity*, *internal validity*, *external validity* and *reliability*. These tests will be explained in the following sub-chapters in more detail.

3.6.1 Validity

In practice, validity represents the accuracy and trustworthiness of a study. Validity indicates the research's ability to measure what it is intended to measure (Zikmund 2000, p. 281). In other words, when the measure measures what it is intended to measure, there can be said to be a good validity. Validity needs to apply to all parts of the study including for example

research methods and research questions. As already mentioned, Yin (2003, p. 34) has further categorized validity into three different groups: *construct validity*, *internal validity* and *external validity*. Each of these tests ensures the quality of the research in a different way and focuses on a different phase of the research process.

Construct validity refers to using correct operational measures for the concepts being studied. Construct validity focuses on the data collection phase of the research process. Many researchers claim that especially construct validity is problematic in case study research, because it is not always simple to develop a sufficiently operational set of measures and almost always some subjectivity must be used. However, construct validity can be increased by using multiple sources of evidence, establishing a chain of evidence and having key informants review draft reports. (Yin 2003, p. 34-36.) Thus, I have used a relatively large group of informants for this study (14 interviewees) as well as also some secondary data sources to complement my primary data. Also the three different groups of interviewees ensure the construct validity of the data, as three different perspectives on the topic are included in the data collection and thus, data is triangulated.

Internal validity refers to establishing causal relationships; whether event x has led to event y (Yin 2003, p. 36). Internal validity focuses on the data analysis part of the research process. As this study is an exploratory study, aiming to understand the phenomenon of Russian medical tourism in Finland and the role of patient's native language in it, internal validity cannot be assessed. Internal validity is an instrument for explanatory and causal studies only and not for descriptive or explanatory studies (Yin 2003, p. 34).

The third test deals with *external validity*; the problem of knowing whether a study's findings can be generalized to a larger context (Yin 2003, p. 37). External validity occurs in the research design phase of a research project, and it is possible to increase external validity by using theory in single case studies and replication logic in multiple case studies (Yin 2003, p. 37). Often critics state that the generalization of especially single case studies is poor and consequently many researchers (e.g. Eisenhardt 1989; Yin 2003) support multiple case studies in order to validate the study. Better validity is also one rationale why I decided to have a multiple case method for this study.

Finally, Thietart et al. (2001, p. 206) have written about the validity of interviews as a data collection method. Interviews are a somewhat problematic data collection method, as it is difficult to assess whether interview data measures exactly what it is supposed to measure. On the other hand, as interviews are typically transcribed in qualitative research, they can therefore be assessed almost as any other written document (Thietart et al. 2001, p. 205). Thus, careful word-to-word transcriptions of all interviews were carried out in my study and thus, the validity of interview data was ensured.

3.6.2 Reliability

Reliability refers to the degree of measures free of errors or consistent results of the study (Zikmund 2000, p. 280). Consequently, if a later researcher followed the same procedures as described by an earlier researcher and conducted the same case study again, the later researcher would arrive at the same findings and conclusions (Yin 2003, p. 37). All in all, the goal of reliability is to minimize the errors and biases in a study and enable at least some replication (Yin 2003, p. 37). Yin (2003, p. 37) notes that one common way to increase the reliability of a study is to document all the steps taken during the research process in detail. Thus, in order to increase the reliability of this study, the research process was documented in detail by taking thorough notes throughout the progression and the process has been explained thoroughly in this chapter of the report. Also all the relevant documents, including for example the interview schedule and full interview guides, are included in this report. This enables another researcher to conduct a similar type of a research in a different setting and context.

Thietart et al. (2001, p. 205) have written about the reliability of interviews as a data collection method. According to Thietart (2001, p. 205), the most important tool to enable reliable interview data is to code the interviews unambiguously. As already mentioned, the interviews were carefully transcribed word-to-word and also some secondary sources were used to validate the interview data, which further decreases the interviewee bias in this study.

4. EMPIRICAL FINDINGS

In this chapter the empirical findings of this study are presented. First, FinlandCare program and its language strategy are discussed after that medical tourism from Russia to Finland is covered. Finally, detailed findings from each case company – Coxa Hospital for Joint Replecement, Docrates Cancer Center, Hospital Neo and Orton – are reported. As discussed in the previous chapter, the findings in this chapter are based on 13 interviews, including five interviews with managers/directors and seven medical professionals in case companies as well as two expert interviews with Finpro and Ministry of Employment and the Economy representatives. It should be noted that as 11 of the interviews were conducted in Finnish and 2 in English, I have translated all the quotations from the interviews held in Finnish.

4.1 FinlandCare program

As already mentioned in the previous part of this thesis, all the four case companies included in this study are part of the FinlandCare program organized together by Finpro[1] and Ministry of Employment and the Economy of Finland. Ministry of Employment and the Economy of Finland has launched FinlandCare program in 2011 as a part of their strategic Welfare Service Development Program HYVÄ[2]. The aim of HYVÄ program is to improve the labor and industrial policies in social and health care services in Finland, and develop health care and wellness sectors into growing and internationalizing industries. Specifically the program aims at developing the preconditions of business and growth within the social and health care sector. A key focus area in the program is to promote export of health care services and developing health care sector into an internationalizing growth industry, and FinlandCare subprogram has been established to achieve this goal. (Ministry of Employment and the Economy 2015.)

[1] Finpro is an organization that helps Finnish SMEs internationalize, encourages foreign direct investment and promotes tourism to Finland. For further information, please see https://www.finpro.fi/web/finpro-eng

[2] Hyvinvointiohjelma. For further information, please see https://www.tem.fi/en/current_issues/pending_projects/strategic_programmes_and_flagship_projects/welfare_service_development_programme_-_hyva

The purpose of FinlandCare program is to bring together Finnish companies engaged in the health and wellbeing businesses, related technology companies as well as education and consulting services within the industry, and promote the exports and internationalization of the health care sector. The program is aimed at actors in the Finnish health care sector that are capable of international business operations and are willing to further internationalize their operations. FinlandCare program is operated by Finpro and designed in collaboration with the Ministry of Employment and the Economy. There are also other parties included in the partner network of the program, like FIHTA – Finnish Healthtech, The Finnish Tourist Board/Visit Finland, Ministry of Social Affairs and Health and Team Finland. (FinlandCare 2015.)

FinlandCare program has been launched due to Finland's constantly changing economic structure. Finland's traditional export industries – like electronics, forest and metal industries – are diminishing in importance, and services are becoming more significant both nationally and internationally. Finland is well-known for its high level of education also in the health care sector, effective health care sector compared to its gross domestic product as well as top-quality treatments in a number of specialized health care areas. Especially in the areas of cancer treatment, children's cardiac surgery and neurosurgery Finland's treatment results are globally among the best, and FinlandCare program aims specifically at promoting Finnish special expertise in medical services. Finland is also a pioneer in the areas of wellness and medical technology. There are multiple reasons for the high level of medical results in Finland: the use of the latest technologies, the rapid application of medical research into practice and the high education of medical staff. At the same time, the global market for health care is growing strongly due to aging population and lowering communications and travelling costs. Consequently, the export of health care services and related industries can possibly offer a new potential export industry for Finland. (Ministry of Employment and the Economy 2015.)

The most important goal for FinlandCare program is to attract more foreign medical tourists to Finland. The first focus market of the program is Russia and particularly St. Petersburg, Moscow and Yekaterinburg areas. The tourism from Russia to Finland is growing on an annual basis and the interest towards Finnish health care services is increasing. Later on the program plans on expanding to other markets as well, like Eastern Europe and Persian Gulf

area. Another key goal for the program is to improve the visibility and awareness of the Finnish health care sector in the global markets. (FinlandCare 2015.)

FinlandCare program has five core focus areas: 1) health (special health care for patients from other countries), 2) care (nursing services and sheltered housing for senior citizens and disabled persons), 3) rehabilitation (rehabilitation after surgeries and other treatment procedures, interval rehabilitation), 4) technology (health care technology, devices and software) and 5) consulting & education (development of health care services). In April 2015 there were altogether 35 different companies and other actors involved in the FinlandCare program: 18 health care service providers, two nursing service providers, four rehabilitation service providers, seven medical device and software providers, and four actors from the education and consulting side. Majority of the companies included in the program are small and medium-sized enterprises. (FinlandCare 2015.)

Although the FinlandCare program is organized and designed in cooperation with Finpro and Ministry of Employment and the Economy, Finpro is responsible for the practical implementation of the program. Ministry of Employment and the Economy finances the program and provides supports at the state and national level, whereas Finpro is responsible for marketing Finnish health care services particularly in Russia and provides the common FinlandCare brand. Finpro also offers common brand and marketing actions for the member companies, and the member companies must have the FinlandCare logo on their webpage.

The financing of FinlandCare program is divided between 1) Ministry of Employment and the Economy and 2) participation fees from the member companies. 75% of the funding comes from Ministry of Employment and the Economy and the remainder 25% from the member companies. The participation fee for member companies is based on their size. However, in the future the goal is that the public sector and Finpro would have as little role as possible in the program and the program could be corporate-driven. However, in the beginning of the program, it has been vital that Ministry of Employment and the Economy has been involved in the program, as it has been the activator of the program and it has provided significant funding for the program. It was also mentioned by many interviewees that involvement of the public sector has provided credibility for the program.

4.1.1 Language strategy of FinlandCare program

Currently, FinlandCare program does not have a common or explicit language strategy for its member companies. In other words, the member companies can choose whether to provide services in Russian or not and the companies are not provided with any support with interpreters or written translations. However, although there is no common language strategy as such or other requirements for Russian-speaking personnel or provision of interpreter services, the expert interviewees had explicit points of view on the topic:

"It is probably too much to call it a rule or a strategy, but we have certain principles for our [FinlandCare] companies to follow. One key principal is that the companies must have the capabilities to providing services in Russian. Providing services in Russian must happen by having personnel that speak Russian. When it comes to health care services, the patient must be able to communicate in his/her native language. This is self-evident. -- Russian patients do not speak English very well. Using interpreters in medical encounters is not appropriate, when patients pay a lot of money for the services."
(Director, Ministry of Employment and the Economy)

"I would say that for example having a webpage in Russian is not a requirement, but it is a strong recommendation. Companies involved in the program should invest in having both Russian-speaking personnel and the webpage in Russian."
(Marketing and Communications Director, FinlandCare program)

"Language is a key question in medical tourism and Russian patients definitely expect to be served in Russian. A Russian patient does not travel abroad [in search of health care] unless he/she can speak his/her native language with the medical staff."
(Director, Ministry of Employment and the Economy)

However, at the same time Ministry of Employment and the Economy representative acknowledges that the companies involved in the program are in different stages in their internationalization processes:

"I would say that in general the preparedness to provide services in Russian is really good [in FinlandCare companies]. -- However, some companies are very small and they have just started marketing their services for Russian patients and making some internationalization

plans. It is a huge step and also a risk for a small company to recruit personnel that speak Russian, as personnel is naturally a big investment. Obviously the bigger companies have better capabilities for providing medical services in Russian. On the other hand, if there are not that many Russian patients coming to the company, it is not very cost-effective to have personnel that speaks Russian." (Director, Ministry of Employment and the Economy)

The expert interviewees as well as the interviewees in the case companies also mentioned the need for a company webpage translated into Russian. Although it is not required in the program, all four case companies have their webpage available in Finnish, English and Russian. One interviewee noted the relationship between the corporate webpage in Russian and the actual service in Russian:

"If the webpage and telephone service is in Russian, it is natural that the patient expects also the physical service to be in the same language. -- It is very bad marketing for your company, if you cannot serve your Russian patients in Russian and believe me, your bad reputation will spread in Russia." (Director, Ministry of Employment and the Economy)

4.2 Medical tourism from Russia to Finland

One key objective of this study was to understand the phenomenon of medical tourism from Russia to Finland. Russian patients have been seen as the most potential medical tourist group in Finland (Nordic Healthcare Group 2010). In this chapter medical tourism from Russia to Finland is discussed from four different perspectives: 1) the number and characteristics of Russian medical travellers in Finland and elsewhere, 2) Finland as a medical tourism destination, 3) reasons for medical tourism from Russia and 4) marketing medical services to Russian patients.

4.2.1 Russian medical tourists in Finland and elsewhere

Russian medical tourists' favorite destinations wee commonly known among the interviewees: Germany, Israel and Switzerland are the most popular medical tourism destinations among Russian travelers. The Moscow News article, written by Stambler (2013), estimates that annually there are approximately 200,000 Russians travelling abroad for medical purposes and that they spend altogether $2.5 billion during their stays. Israel is

Russian medical tourists' favorite destination and Germany is the second most important destination (Levary 2011; Stambler 2013; Makeeva 2014). Also Turkey, France, Switzerland and England are popular among Russian medical travelers (Makeeva 2014), and interviewees also mentioned that Russian medical tourists tend to travel also to Baltic countries, Eastern Europe and some Asian countries, like India and Thailand.

Stambler (2013) estimates that in 2012 around 50,000 Russian medical tourists visited Israel and contributed the Israeli economy by around $1 billion. Levary (2011) points out that Russian patients prefer obtaining medical services in Israel mainly due to large Israeli minority that is fluent in Russian language and thus, the services can be provided also in Russian. Interviewees note that in Germany and Switzerland the health services can be usually provided in Russian.

"Medical tourism is not a new phenomenon in Russia. For decades people have travelled to Germany, Israel and Switzerland for treatments and it has become quite normal in Russia for certain people. Basically anyone who has the opportunity to pay and leave, they leave."
(Manager, Docrates)

However, despite the FinlandCare program, there are no exact figures available on the annual total amount of medical tourists from Russia to Finland or from other countries. So far FinlandCare program has not defined explicit goals on the amounts of Russian medical travellers it aims at reaching annually. Finland does not compile statistics on medical tourism volumes, so there is no statistical data on medical tourists in Finland (Nordic Healthcare Group 2010). Makeeva (2014) points out that there are no proper statistics on medical travelers from Russia in Finland, as many Russians do not mention the purpose of the trip when applying for a visa. However, to give some idea about the size of the phenomenon in the context of Russian patients, Makeeva (2014) writes that it was found in a study on Russian medical travelers to Germany that out of 100,000 medical travellers from Russia to Germany only 8,000 patients were issued a health care visa. One interviewee described the challenges related to estimating the medical tourist flows from Russia to Finland:

"It is very challenging to estimate the total amount of Russian medical tourists in Finland, as also unintended or accidental medical tourism must be taken into account. In other words, if a Russian tourist suddenly gets ill in Finland, he/she has the right to be treated here in

Finland in public health care. -- In addition, there are no figures available on Russian travellers, who travel to Lappeenranta to do some grocery shopping and decide to go to dentist on the same trip. -- Obviously it is almost impossible to estimate their total amount."
(Director, Ministry of Employment and the Economy)

However, the interviewee from Ministry of Employment and the Economy also mentioned that in the long run the patient volumes must be estimated and measured more thoroughly, and this is also the plan within the scope of the FinlandCare program.

All interviewees were asked to describe a typical Russian medical tourist. Most typically Russian medical tourists travel abroad for cancer treatments, orthopedics and joint replacement surgery as well as heart operations (Makeeva 2014). This was also proved by this study, as Docrates provides cancer treatments, Coxa joint replacement surgery and Hospital Neo and Orton different orthopedic operations, and they all receive several medical tourists annually. According to the interviewees, Russian medical travellers are usually middle-class people typically from St. Petersburg, Moscow or other big city in the European part of Russia; these are also the cities from which the case companies are mainly reaching Russian medical tourists. Especially St. Petersburg is an important market due to its geographical proximity to Finland.

"They are middle-class people, very normal in many sense." (CEO, Coxa)

"Typically they are middle-class or 'middle-class plus' people who have saved money and decided that they finally want to get rid of the pain they have been suffering from. -- I would say quite normal Russian people." (Project Director, Hospital Neo)

"For example St. Petersburg is actually a perfect target market to reach medical travellers as there is living about the same amount of people as the whole in Finland."
(Marketing and Communications Director, FinlandCare program)

"St. Petersburg is geographically close, but many patients also come from Moscow, as there is a lot of people and money there." (Project Director, Hospital Neo)

Language skills of Russian medical tourists are typically poor in other languages than their native language. It was highlighted by almost all interviewees that typically medical travellers from Russia don't speak other languages than Russian. Typically Russian medical travellers are middle-aged or older, which is reflected in their foreign language skills.

"Unfortunately, about 95% of the Russian patients do not speak any other language than Russia, so they need the help of either an interpreter to come and help them or the clinic providing services in Russian. -- And even though some patients might speak English, they still feel more comfortable, when there is someone Russian-speaking with them at the appointment making sure they understand everything that the doctor is saying."
(Manager, Docrates)

"In that sense Russian patients are a specific group that quite often they don't speak English at all. -- And if they have someone, like a family member, with them here, it is quite typical that neither the family member can speak a word of any other languages than Russian. So you just can't use English with these kind of patients." (Nurse, Hospital Neo)

"I would say that the younger generation of Russians can speak English, but older generations definitely not. -- Besides, if a Russian person cannot speak English, he/she will definitely not admit it." (Marketing and Communications Director, FinlandCare program)

"Having Russian-speaking personnel is a very big deal, because there a quite a lot of Russian people who do not speak English at all. Russian patients are often not familiar with any foreign languages, especially middle-aged patients, and majority of our cancer patients are particularly middle-aged." (Doctor, Docrates)

"Typically Russian patients come here with their family members, but it doesn't help, as usually their family members can't speak English either." (Nurse, Coxa)

Many interviewees also emphasized that Russian medical travellers are typically very price and quality conscious. Before booking any treatments, they do careful analysis on the Internet and compare thoroughly different clinics, treatments, destinations and prices.

"They are very quality, price and cost conscious. They know exactly what they can get in different countries and for which price. I think when they are comparing different destinations and making the decision, they compare travelling costs and costs of the treatments."
(CEO, Coxa)

"I think they always have like 2-3 options open. I mean they have agreed everything with 2-3 health care companies: the date, the treatment and the price. But they decide at the eleventh hour where to go for a treatment." (CEO, Hospital Neo)

4.2.2 Finland as a medical tourism destination

In Finland many private as well as public sector hospitals provide services to medical tourists, but the main providers are private sector hospitals and clinics. Especially the number of patients from Russia has increased in Finland in recent years. However, despite the number of patients from Russia, medical tourism has been relatively slender in Finland, especially when compared to other European countries. For example Sweden has promoted medical tourism on the government level already since 1970s and it has had a corresponding organization to FinlandCare, Swecare, already since then. (Keinänen et al. 2012.)

Finland has various benefits as a medical tourism destination. According to interviewees, Finnish companies and their services have a very good and reliable reputation in Russia.

"What we are selling to Russian patients is Finnish special know-how in health care, particularly neurology and neurosurgery, cancer treatments and heart disease treatment. – Russian patients travel abroad in search of special health care"
(Marketing and Communications Director, FinlandCare program)

"First of all, Russian travellers know that Finland is known for high quality and they know that they are going to get a high-quality treatment here. -- We are also geographically close, so it is easy to reach us from Moscow or St. Petersburg. -- We have very good specialists who are among the best in Finland. We also have the most state-of –the-art and modern technologies, and people who know how to use these technologies." (Manager, Docrates)

Although Finland is known as a relatively expensive country, the cost level of Finland as a medical tourism destination is competitive compared to other European countries, like Germany. From the price perspective, it can be said that Germany is Finland's main competitor in Russian medical tourism. Other Russian medical tourists' favorite destinations have different kinds of features to offer: Switzerland is definitely more expensive, so typically middle-class Russians cannot afford travelling to Switzerland for medical treatments. Besides, Turkey and Israel are somewhat more affordable than Finland and offer foreign exoticism, but medical treatments and technologies are not always on the same level as in Finland. On the other hand, there were also views that Finland's price level is about the same as for example Germany's price level.

"Our price level is a bit cheaper than in Germany. But that is also our goal: we want to keep our prices like that on purpose." (CEO, Coxa)

"This has been a discussion topic here at Docrates. The prices of health care services for Russian patients are very competitive here in Finland. -- Besides, Russian patients like that they can trust us, and companies are open and transparent here in Finland. For example, in Finland you can always see the price list for different treatments before your own treatment, which is not typical in Russia. And billing is always transparent." (Nurse, Docrates)

"Prices are about the same as for example in Germany. -- First we thought private health care services are a lot cheaper here in Finland. But then we realized they are not, so we can't trust only price competition." (CEO, Hospital Neo)

Besides, Finland's difference to other major Russian tourists' destinations (Israel, Germany, Switzerland) is that in Finland accommodation or extra services are not provided to patients' travelling companion.

"In Germany and Israel it is typical that the hospital organizes city tours and other additional services for patients' family members while the patient is in the hospital. -- But we don't have time or resources to do that. -- The extra services offered to patients' travelling companion could add the attractiveness of some destination." (Doctor, Coxa)

On the other hand, although medical tourism is an emerging industry in Finland, some interviewees also pointed out that at the moment Finland's image as a medical tourism destination is not as strong as many other European countries'.

"Finnish specialists and technologies are good, but people don't think of Finland in that sense." (Manager, Docrates)

4.2.3 Drivers of medical tourism from Russia to Finland

All the interviewees were asked to give their insights and views on why Russian patients travel abroad in search of health care. As there were several reasons and explanations given for medical tourism from Russia to Finland, I have categorized the drivers into two groups: push factors and pull factors. The push factors are different reasons to leave Russia in search of health care, whereas the pull factors are different reasons to travel specifically to Finland.

4.2.3.1 Push factors

The empirical data highlights various reasons for why Russian patients leave abroad for health care. The main reasons mentioned by interviewees were problems with Russian health care system and the varying quality of available health care services in Russia: many private clinics and hospitals offer Western-level treatments and services, but in the public sector the clinics and hospitals can be very simple. Besides, not all treatments that are available in Western countries are available in Russia or the prices may be very high. According to interviewees, in general Russian patients do not trust their public medical providers and clinics or other public services due to the Soviet Union history.

"Unfortunately, the health care system in Russia is not in a very good state. Russian patients don't trust the health care system or the doctors in Russia. That is the main reason to leave abroad. You leave abroad if you have an opportunity to get the most up-to-date treatment." (Manager, Docrates)

"I think Russian patients' basic trust towards their local health care system is very low. For example, in Finland the professions people trust most in are doctors and the police. It is exactly the opposite in Russia: militiamen and doctors are not trusted."
(Project Director, Hospital Neo)

"An average Russian patient does not trust Russian clinics. There are a lot of scams in health care sector in Russia." (Director, Ministry of Employment and the Economy)

"The quality of health care is really bad in Russia and they cannot always take care of all special health care cases, things that can be done in Finland easily. -- Russia is a huge country, so of course there are also exclusive private clinics, but those represent about 2% of all clinics at the moment. Majority of clinics and hospitals are rather old-fashioned when compared to for example Finnish standards."
(Marketing and Communications Director, FinlandCare program)

"The quality of health care services varies a lot in Russia. There are some very good clinics, but also some really bad. You can never know what you get. Partly because of this, Russians don't trust their own health care sector." (CEO, Coxa)

As resources are limited in the health care sector also in Russia, access to treatments is not always guaranteed. Quite often Russian patients do not get treatments that they would need, and it is typical that Russian patients who travel abroad for health care are cases that cannot be taken care of in Russia due to lack of technologies, personnel or resources in general. Some interviewees also mentioned the less-skilled employees in the medical sector in Russia and the brain drain of the most highly skilled doctors and nurses from Russia.

"The city of St. Petersburg has about the same population as the whole Finland, but still only 7000-8000 joint replacement operations are made there per year. In Finland the same number is about 20 000 per year." (Doctor, Coxa)

"Patients do not always get the medical treatments they would need in Russia. -- It is easy for the government to save from this. -- Quite often patients are told that you are too old or fat for this kind of operation." (CEO, Coxa)

"We only receive very difficult cases from Russia. -- Usually they have many illnesses and they have been told that you cannot be treated here in Russia anymore."
(Patient Coordinator, Orton)

"They do imaging in Russia, but sometimes the quality is bad or sometimes the people who describe it don't have enough competence. -- The diagnosis can be very different when they finally come here in Finland to recheck something." (Doctor, Docrates)

Although the municipal health care sector is even more problematic, there are also challenges in the private sector.

"Especially the municipal health care sector is very problematic in Russia. There is a lot of red tape, very long queues, lack of both doctors and nurses. -- And overall lack of resources, medicines and trust. -- And unfortunately it is almost the same in the private sector as well. -- I have heard some horror stories." (Nurse, Docrates)

"In the Russian private sector patients get easily cheated and cashed." (Nurse, Docrates)

The interviewees also mentioned some other reasons, such as long waiting lists to treatments and fake medicines occurring in Russia.

"Other reasons… Well, those are the same as in other countries: long queues, especially in cancer treatment, so people have to wait a long time for a treatment. -- Sometimes the most modern treatments or some types of diagnostics or treatments are not available in Russia." (Manager, Docrates)

"Russian patients say quite often that there are problems with cancer drugs in Russia, meaning that there are quite a lot of not real drugs under the real trademark names." (Doctor, Docrates)

4.2.3.2 Pull factors

The most frequently mentioned pull factor was the good quality of health care in Finland; Russian patients are searching for higher quality treatments that they would get in their home country. Many interviewees also highlighted that in Finland it is possible to get medical treatments with the most state-of-the-art and modern medical technologies and in general, treatment methods that are not always available in Russia. Besides, typically Russian patients travel abroad when they have a demanding ailment and are searching help from a specialist in

some medical field. According to interviewees, Finnish health care system seems to be very appreciated in Russia.

"They all know that Finland is known for quality, they know that they are going to have a high-quality treatment here. -- One of the most important things is also that we have some diagnostic methods and treatments that are not even available in Russia."
(Manager, Docrates)

"At least our patients only travel abroad for very demanding operations and not some trivial procedures. When travelling abroad, Russian patients are searching for health care that is world-class." (CEO, Coxa)

"Patients that travel to Finland are searching for better treatments that they could get in Russia." (Project Director, Hospital Neo)

"In general, I think Russian patients value Finnish health care highly."
(Nurse, Hospital Neo)

Besides, in Finland many complicated cases can be taken care of even if it is not possible in Russia. Some treatments, like joint replacement operations, are not very common in Russia and they may not be enough expertise. Besides, in Finland medical staff is also always highly educated unlike in Russia. According to interviewees, Finland also has an image as a clean and safe country, which attracts Russian medical travellers.

"In Russia there is no long experience for example in knee joint surgeries. They started those operations only about 10-15 years ago." (Doctor, Coxa)

In addition, as already mentioned in the previous section, the price level of Finland as a medical tourism destination is typically more affordable than for example Germany's or Switzerland's price level. It also came out in many interviews that private clinics in Russia can be more expensive than private health care in Finland.

"The services we are providing here in Finland are cheaper than services in Germany or Switzerland. The difference can be even 30-50%. But okay, the price difference is absolutely

the opposite, when you travel to Turkey. -- But Turkey doesn't have that 'clean and safe country' image, like Finland does. -- Because of Finland's price benefit, we don't have to provide 5-star extra services." (Medical Director, Hospital Neo)

Many interviewees also mentioned the close geographical location of Finland, which makes travelling easy and convenient for Russian patients. Geographical location is a benefit, as it is not necessarily safe or recommendable to fly after many medical operations. Besides, Russian people are used to travelling to Finland and the visa processes are relatively simple. In addition, it was also highlighted that medical tourism has been on the rise in recent decades, as in general people are more used to travelling abroad for both business and leisure purposes.

"We are geographically close, so it's very easy to reach us especially from Moscow or St. Petersburg." (Manager, Docrates)

"For cancer treatments, some people from St. Petersburg take the morning train here and evening train back home." (Nurse, Docrates)

"People are more and more used to being abroad for their holidays, and this reflects to searching health care services abroad as well." (Doctor, Coxa)

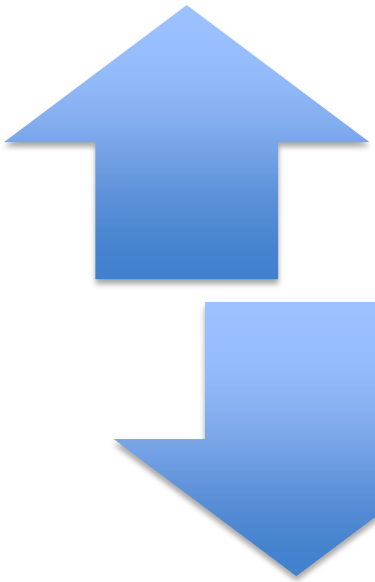
A couple of interviewees also mentioned that in Finland medical services are often available in Russian.

"And of course, it is also important that they can get the service in Russian here. We have received a lot of positive feedback on this." (Manager, Docrates)

"Our geographical benefit compared to other countries also means that there are nurses and doctors living here in Finland who are native in Russian." (CEO, Orton)

The main reasons for medical tourism from Russia to Finland are summarized in the Figure 6.

Figure 6 ***Push and pull factors for medical tourism from Russia to Finland***



Pull factors:
-The most modern treatments and technologies available
-Competitive price level
-Good image of Finland as a clean and safe country
-Geographical location to Russia
-Services available in Russian in many health care companies

Push factors:
-Variable quality of health care in Russia
-Russian patients' lack of trust in their domestic health care system
-Lack of methodologies and technologies in Russia
-Limited access to health care services in Russia, long waiting lists
-Prevalence of dishonesty, like face medicines, in the Russian health care sector

4.2.4 Marketing medical services to Russian patients

The case companies have tried various marketing channels and tools ranging from to different Internet marketing tools to various PR activities like hosting Russian journalists in their premises and providing articles to Russian magazines and newspapers. Some of the companies have also tried television advertising in Russia, radio advertising in Russian radio channels in Finland and direct mail advertising in Russia. However, the case companies have noticed that using traditional marketing channels is problematic in a huge country like Russia.

"Traditional marketing in Russia can get very expensive, as Russia is a very big and fragmented country. That's why we focus on guerrilla marketing and Internet. -- Besides, currently one bottleneck in marketing our services in Russia is that some countries, like Germany and Israel, have a long history providing medical services to Russian medical tourists. So people don't know about Finland…" (Project Director, Hospital Neo)

"If you have very limited marketing resources, like we do, you can't even 'break the surface' in Russia." (Medical Director, Hospital Neo)

However, although all the companies have engaged in various marketing channels in Russia, all interviewees were unanimous which are the most effective tools in reaching Russian

medical tourists: referrals from previous patients (word of mouth) and digital marketing in Internet. Almost all interviewees mentioned the power of word of mouth in reaching Russian patients:

"We have two main marketing channels. -- First of all, all the very satisfied patients who are here for treatment or diagnostics and who tell their family and friends and recommend us. The second channel is definitely Internet." (Manager, Docrates)

"Marketing through the grapevine works surprisingly well in Russia. We have noticed that when we have been treating a Russian patient with a certain ailment, we often get more Russian patients with the same ailments." (CEO, Orton)

"Definitely references. People tell other people about their good experiences and the word spreads." (CEO, Coxa)

"Basically, the people who come here, if they are satisfied, they tell their friends and relatives or whoever. In other words, positive feedback about us brings us a lot of patients."
(Nurse, Docrates)

"When somebody says 'I had very good hospital care there', that is always the best advertisement your hospital can get." (Doctor, Coxa)

Some case companies also mentioned the personal networks of their doctors which have brought them patients from other countries.

"One of our doctors is originally from Russia and from her home town we have received many patients during the last couple of years. -- Partly because of her and her networks in Russia, we have been able to attract Russian patients here." (Nurse, Coxa)

"Our doctors have contacts to sports clubs and through those contacts we have received a lot of patients." (Project Director, Hospital Neo)

Interviewees emphasized that Russian medical tourists are usually very active Internet users who search on the web for foreign clinics. Thus, Internet was mentioned as the second most

important marketing channel by almost all interviewees and many interviewees mentioned that their company focuses mainly on it. All the four case companies have their webpage available in Finnish, English and Russian and they also engage in various digital channels. Different Internet marketing tools include having webpage in Russian, search engine optimization and marketing in Google, Yandex[3] and other search engines in Russia as well as social media activities in Russia mainly in Vkontakte[4], Facebook and YouTube. Some case companies, like Coxa, have their webpage on the Russian server (with the .ru –ending), which helps their webpage to position higher on Google and Yandex searches. Case companies also noticed that it is important that the Russian webpage is not just a copy of the Finnish one, but it includes information that is important for Russian patients, like résumés of doctors as well as information about prices and available service languages.

"We have tried so many marketing channels, but nothing works like a proper webpage in Russian and the word spread by previous satisfied patients." (Patient Coordinator, Orton)

"Everything digital on the web. Russian patients are searching in the Internet for suitable clinics, so search engine optimization is very useful. -- Also proper webpage in Russian and everything else like that." (Project Director, Hospital Neo)

"We already tried all those old school marketing channels, like advertisements in magazines, newspapers and TV, but realized quite soon that only digital marketing works in Russia. You can put a lot of money on those traditional channels, but get nothing back. -- Digital marketing is also important because about 80-90% of medical tourists are searching on the web for services abroad. -- Also in digital channels we are focused on the St. Petersburg and Moscow area. " (CEO, Orton)

Typically Russian patients find the companies on Internet and contact the companies themselves; thus, there are not any intermediaries. However, some of the companies, like Hospital Neo, have also used brokers and partner companies in Russia, and these partners have directed Russian patients to them. In general, there are basically two kinds of broker companies in medial tourism: 1) private health care companies that offer their patients

[3] Search engine; Russian counterpart to Google https://www.yandex.com
[4] Social media channel; Russian counterpart to Facebook http://vk.com/

possibility to leave abroad for treatments as well as 2) companies that are mainly travel agencies that offer medical tourism packages that include not only the accommodation and tickets but also the medical operations. However, the case companies had mainly rather negative experiences in using brokers to bring patients to them.

"So we have tried this business-to-business marketing in Russia by having some cooperation clinics there. But it didn't work out as we wished, as to be honest, the brokers expected some kind of 'brown envelopes' and other forms of corruption from us, and that wasn't in line with our values and integrity." (CEO, Coxa)

"This is a bit surprising, but there is some evidence that broker companies are expecting 'extra payments' and other dishonest behavior for supplying patients to health care companies. -- We as a Finnish company can't accept that and don't want to be involved in any illegality." (CEO, Orton)

4.3 Overcoming language barriers in medical tourism contexts in case companies

In this part the findings from each case company – Coxa Hospital for Joint Replacement, Docrates Cancer Center, Hospital Neo and Orton – are presented. Firstly, the company is briefly introduced and after that involvement in medical tourism as well as communication and interaction with Russian patients are discussed.

4.3.1 Coxa Hospital for Joint Replacement

Coxa Hospital for Joint Replacement (hereafter Coxa) is the largest hospital in the Nordics specializing in joint replacement[5] operations. Coxa was established in 2002 and it is located in Tampere, Finland. Annually approximately 3000 joint replacement surgeries are undertaken at Coxa. The most typical operations taken at Coxa are hip and knee replacement operations, but the company also specializes in shoulder, elbow, ankle and wrist replacement operations. Although artificial joints are relatively durable, they must be replaced approximately every 15 years. Coxa focuses on replacement re-operations as well as initial joint replacement

[5] In joint replacement surgeries the damaged joint surface is removed and replaced with artificial material. Further information https://www.coxa.fi/en/index/pjl/Leikkaus.html

operations; replacement re-operations are typically particularly demanding. Coxa has also special expertise in the field of tumor treatment and infection patients. Coxa has a strong reputation as the leading joint replacement hospital in Finland, which means that the most challenging joint replacement cases in Finland are typically treated there. Currently Coxa has approximately 200 employees. (Coxa Hospital for Joint Replacement 2015.)

Although various hospitals around the globe make joint replacement operations, Coxa is one of the very few hospitals specializing mainly in joint replacements. Thus, due to its specialization in a niche area Coxa has received patients from other countries since its establishment in 2002. In recent years Russian patients have become the biggest group of foreign patients and annually there are around 20-30 Russian patients at Coxa. There are also foreign patients mainly from Sweden, Norway and Southern Europe. However, Russia is currently the main focus area for Coxa and their goal is to have around 100 Russian patients annually. In recent years the number of Russian patients has been increasing steadily.

"We get about 20 to 30 Russian patients here per year, but the amount of patients contacting us is a lot higher. The e-mail and phone discussions with potential patients take a lot of time, as patients are comparing different places very thoroughly. It can take even 2 to 3 months to discuss with one patient before he/she arrives here. -- Our process is ready for about 100 Russian patients per year." (CEO, Coxa)

Coxa's has tailored a standard treatment package for Russian patients which is bit different than the one offered for Finnish patients.

"The price for Russian patients is a bit higher as there are certain 'extra' things that are not included for Finnish patients. -- The time spent in hospital is a bit longer, as the patient needs to be ready for travelling before going home. Russian patients are here for about 5-7 days, when Finnish patients are approximately 3 days. -- There is also a possibility for interpreter services. And Russian patients demand more time with the doctor, they for example want to be examined by a doctor also during weekends. They also value when they are examined by nurses on a regular basis." (CEO, Coxa)

Communication and interaction with Russian medical tourists at Coxa

According to Coxa's interviewees, Russian patients want to speak their native language in health care encounters and they expect to be served in Russian also in Finland. Coxa meets this expectation by having Russian-speaking personnel: two doctors, two nurses, an in-house interpreter and some hospital assistants who work in operating rooms as orthopedists' assistants. Also Coxa's Marketing Project Director is Russian-speaking and he has been helping with translations to for example company's Russian webpage. One of the Russian-speaking doctors has a role as Russian patients' contact person at Coxa: patients contact her and she arranges their operations and consults with other doctors when needed. Like just mentioned, the discussions with Russian patients can take a lot of time and the Russian-speaking doctor is mainly the one to having the long e-mail discussions with Russian patients.

Coxa is the only one of the case companies to having an in-house professional interpreter/translator. The in-house interpreter and translator works about 50% of her working time in interpreting and translating tasks and about 50% as a service advisor. Her tasks include translating e-mails into Russian for Russian patients and into Finnish from Russian patients as well as translating other materials and texts into Russian. She also does interpreting in doctor's appointments between Finnish-speaking doctors and Russian patients.

At Coxa they aim to receive their Russian patients when the Russian-speaking team is working, especially their in-house interpreter, and they try organize their working times so that at least someone from the Russian-speaking teams is at work all the time. When the in-house interpreter is not available also Russian-speaking nurses and hospital assistants work as interpreters between doctors and Russian patients. However, sometimes they have situations when the Russian-speaking team is not available and for these situations they have written translations. Written translations are basically cardboard signs that include important questions for patients in Russian, like "*Are you feeling pain and how much on a scale from 1 to 10?*" or "*Are you hungry or thirsty?*". The other side of the cardboard sign has the text in Russian and the other side has the same text in Finnish. Interviewees pointed out that Russian patients have reacted to written translations positively, and they have made communicating possible at least to some degree in cases when there is a total language barrier between patient and Coxa's medical personnel. Sometimes also the Russian-speaking doctor, who operates as a contact person between Russian patients and Coxa's medical personnel, interpreters on the phone.

"We have agreed with our nurses and doctors that they can always call me when they have a communication problem with a Russian patient. If they don't understand each other, they can call me at any time, and I can interpret." (Doctor, Coxa)

However, especially the medical personnel interviewed did not find the situations, when health care personnel do not share a common language with a patient, optimal.

"Those are difficult situations when you don't have a common language with a patient. You feel like an outsider. -- Language barrier makes foreign patients a bit more time-consuming than for example Finnish patients. -- I think language barrier can even affect the quality of a treatment. To be honest, I really have to think twice before I wake up a Russian patient in the middle of a night, because if we don't share any common language I can't ask how he/she is feeling etc." (Nurse, Coxa)

Due to the steadily growing Russian customer segment, in recent years Coxa has gradually started highlighting skills in Russian language when recruiting new personnel.

"That is a benefit especially for nurses we are recruiting and we try to increase the number of Russian-speaking nurses little by little. But when it comes to orthopedists, we only want to hire the best ones in Finland. Professional skills are the most important in orthopedists, so language skills are not so critical." (CEO, Coxa)

Before starting to focus increasingly on having Russian-speaking personnel, Coxa has also used professional interpreter services. However, it was noticed quite soon that there are some challenges related to interpreting in medical encounters, especially when the interpreter comes outside the company. Besides, the interviewees emphasized that the interpreter cannot be just any interpreter, but she/he must be able to understand medical vocabulary and jargon.

"Using an interpreter in health care is never as good as sharing a common language with the patient, as you are almost automatically lacking all small talk, little jokes and basically all extra communication with the patient. This can make the health care encounter feel a bit cold, as there is no personal emotion and warmth between health care personnel and patient. But interpreter is better than nothing…" (Nurse, Coxa)

"Of course the interpreter needs to understand medical language properly. That's why we used to have always the same professional interpreter who was familiar with health care vocabulary." (CEO, Coxa)

4.3.2 Docrates Cancer Center

Docrates Cancer Center (hereafter Docrates) is a private hospital specialized in diagnosis, treatment and follow-up care of cancer. Docrates is located in Helsinki, Finland, and it was opened in 2009. Docrates utilizes the latest methodologies in cancer treatment and diagnostics as well as the most modern technologies in for example cancer imaging and radiation therapy. Fast service is a key priority for Docrates: an appointment to a cancer specialist can be arranged within 1-2 days, so the treatment can begin without delay, which is a key element in cancer treatment. Although Docrates is a private hospital, it also treats patients with financial commitments by the municipalities and employer payment commitments. In 2013 the turnover of Docrates was around 11 million euros and the number of patients approximately 16 000. Docrates employs around 40 full-time employees and 25 private medical specialists. (Docrates Cancer Center 2015.)

As Docrates is one of the only hospitals in the world specializing solely in cancer treatment, it receives patients from all over the world. Since its foundation in 2009 Docrates has received patients from over 40 countries. Majority of the patients are from Finland, but there are also foreign patients coming regularly from Russia, Norway, Sweden and Estonia. At the moment the treatment of foreign patients generates one-fifth of Docrates' revenue (Docrates Cancer Center 2014).

Russia has been an important focus area for Docrates since the company was founded in 2009. Russian patients form clearly the biggest group of medical travellers. The annual growth of Russian patient volumes has been around 35-40% in recent years, and last year the growth was 35% compared to year 2012. One interviewee at Docrates described the number of Russian patients compared to other nationalities:

"The number of Russian patients is growing from year to year. Last year [in 2013] we had about 200 patients from Russia that came here for diagnostics and treatment. -- Norwegians

are the second biggest patient group. I don't remember the exact number of Norwegian patients, but it is annually something between 10 and 15." (Manager, Docrates)

A manager of Docrates sees the company as a key player in the Finnish medical tourism sector:

"Docrates is the largest exporter of health care services in the Finnish health care industry." (Manager, Docrates)

Communication and interaction with Russian medical tourists at Docrates

At Docrates the Russian patients are served in Russian from the moment they first contact the company: the company has a webpage in Russian and Russian patients call a particular phone number in which they are answered in Russian, and also their emails written in Russian are replied in Russian. At the moment Docrates has a team of seven employees taking care of all the Russian patients the company receives. This team includes: International Client Manager, Marketing Assistant, two doctors and three nurses from different specialization and treatment areas. The one of the doctors takes care of translating all patient documents into English, including preliminary information and previous diagnoses, so that also Docrates personnel who do not speak Russian can understand them. However, in translating webpages and for example marketing materials Docrates uses external translation agencies.

"For serving Russian patients we have the Russian-speaking personnel. It is enough, because we are seven, so we are quite many. And even if a Russian patient has an appointment elsewhere, not in our clinic, somebody from our Russian-speaking team goes with the patient and translates there. So we don't hire any interpreters for Russian patients, but for other nationalities we do." (Manager, Docrates)

However, despite the team of seven there are also translation needs at Docrates. Usually the team takes care of the Russian patients, but sometimes the best specialist for the patient's case is a Finnish-speaking doctor. Besides, sometimes the team is not available due to their holidays or many Russian patients coming to Docrates at the same time. On the other hand, sometimes a Russian patient insists to be treated by a certain doctor who may not speak Russian and the patient does not speak English. In these cases translation is needed, and someone from the team of seven does the translation.

"If the patient can't manage in English and the patient goes to a Finnish-speaking doctor, then somebody from our team goes and does the translation. It is the same when the patient needs to go to an external clinic or partner or we need some other services outside the house, then one of us goes with the patient." (Nurse, Docrates)

"Of course it is so that our patients check our webpage and they check our Finnish doctors and their names and positions and so on. And sometimes when they contact us and come here they say that I want to be treated by this certain doctor. -- Then they have an interpreter -- Someone from our team, usually we are just circling around, depending on who is free." (Doctor, Docrates)

Sometimes even when the patient is able to speak English somebody from the team goes with the patient to the doctor's appointment and translates. According to Docrate's interviewees, this is to further support the patient and provide the best possible customer service.

"*So even when a patient speaks English, they are very happy to have somebody behind their back. This is because there are certain things that are difficult in medical language. -- In case they don't understand something, they can just turn around and ask 'could you explain me more and did I understand this?'"* (Doctor, Docrates)

For other patients than Russian-speaking patients Docrates hires professional medical interpreters, if needed. Usually there is no need for hiring an external interpreter, as typically foreign patients speak English and at Docrates the patients can always be served in English.

"For example, if we have a patient who speaks only Arabic, then we need to hire an interpreter. But Finnish, English, Russian, Swedish, no problem. Swedish is good, because also Norwegian patients can understand that. -- But if the patient insists to have a professional interpreter then we hire, of course. -- But it happens quite seldom."
(Manager, Docrates)

At Docrates medical interpreting has not been used as the main solution to language barriers and some of the interviewees have experienced challenges regarding interpreting in medical encounters:

"Unfortunately, the interpreter is not always there when needed and she/he does not necessarily know the specific terminology. Besides, when the clinic personnel is doing the interpreting, they know what they are talking about. So they are not only able to translate, but also to explain. I think patients feel more comfortable with a staff member from the clinic rather than with an outside interpreter." (Manager, Docrates)

"I think Russian-speaking personnel is much more convenient than hired interpreters, as we also have the suitable education, so we know the medical terms and the jargon and so on." (Nurse, Docrates)

On the other hand, one Docrates interviewees also had positive experiences in interpreting in medical encounters:

"If you have a good professional interpreter, I mean a person who understands pretty well medical language, it can be done very well. -- I think a company can survive by having just interpreters and not Russian-speaking personnel. But of course there are always patients who prefer only Russian-speaking doctor." (Doctor, Docrates)

4.3.3 Hospital Neo

Hospital Neo is a private clinic and hospital that provides general practitioner and specialist-level medical services in several medical fields, including for example neurosurgery, pediatrics, internal diseases, gastroenterology, dermatology, pulmonary diseases, otology, plastic surgery and dentistry. A particular specialization area and the biggest medical field of Hospital Neo is orthopedics and sports medicine: diagnosis and treatment of sports injuries and other musculoskeletal disorders. Hospital Neo is located in Turku, Finland, and it also has a branch in Salo, Finland. Hospital Neo was founded in 2011 and currently it has approximately 70 employees. (Hospital Neo 2015.)

Annually Hospital Neo receives around 100-150 patients from other countries than Finland.
A special characteristic of Hospital Neo's foreign medical tourists is that a clear majority of them come for sports medicine and orthopedics, and currently Hospital Neo's foreign patients are most typically professional athletes from all over Europe. For example, orthopedist and surgeon Sakari Orava, who works for Hospital Neo, has been very popular among Italian and Spanish professional football players after operating many world-class athletes including

footballer David Beckham in Finland some years ago. Hospital Neo has also partnership agreements with some Finnish and foreign sports clubs which bring them foreign patients regularly.

"For a long time our foreign patients coming here has been based on our certain, quite famous doctors. But little by little patients, also from other countries, have started to know also Hospital Neo as such." (CEO, Hospital Neo)

Hospital Neo has had foreign patients since its establishment, but Russian medical travellers are a relatively new focus area for it. The company has started actively marketing its services to Russian patients about one year ago and it is now taking its first steps focusing more on the Russian medical tourist segment. The number of Russian medical tourists is currently about 10 per year, but the number has been growing steadily. Their goal for the next few years is to have about 50-100 Russian patients per year.

"We believe Russian patients will become our biggest group of foreign patients."
(CEO, Hospital Neo)

Hospital Neo's interviewees also raised that medical tourists are not always desired patients for a small hospital and the process of receiving medical tourists must be well planned, otherwise foreign patients will complicate the hospital operations.

"Developing logistics for your foreign patients is important. -- If you have certain processes and you are following a certain logic with your patients, but you don't have a parallel process for your foreign patients, it may cause some interruption."
(Project Director, Hospital Neo)

"Our processes are not optimized for foreign patients… I would say that if we have more than four foreign patients per week, it will complicate our processes."
(Medical Director, Hospital Neo)

Communication and interaction with Russian medical tourists at Hospital Neo

As majority of Hospital Neo's foreign patients are professional athletes, Coxa's personnel is usually communicating with them in English in medical encounters. Hospital Neo is always

prepared to provide services in English and due to its various foreign patients, it expects sufficient English skills from its medical personnel. However, typically medical travellers without sufficient foreign language skills are not travelling alone, but they bring their own "interpreter" with them.

"Quite often Russian patients, who have no skills in Russian, have somebody escorting them. So it is quite seldom that a Russian patient with no skills in English travels alone."
(CEO, Hospital Neo)

"Normally Russian athletes come here with their coach or somebody else from their team who speaks English. So they have solved the language issue already in advance. It is surprising how badly even Russian professional athletes can speak English. -- But in any case, we have to be able to communicate somehow with any patient also because of sufficient patient safety. " (Medical Director, Hospital Neo)

"Once we had this situation that the patient came alone and he didn't speak English or Finnish or any language we speak here. And there was no interpreter. So it was absolutely body language… -- Somehow we managed and we sent the rehabilitation instruction afterwards, because they needed to be translated to Russian first." (Nurse, Hospital Neo)

Due to Russian patients' limited skills in English, Hospital Neo has also hired some personnel who speak Russian: one doctor, one nurse and an outsourced service advisor. The service advisor is an outsourced Russian-speaking resource who answers all the requests by Russian patients and operates a phone service in Russian. Hospital Neo also provides services of a professional interpreter, if needed. Professional interpreter is used in situations the patient requests it or there is no other option due to lack of a common language. As professional interpreter is an outsourced resource and an extra service, patient is responsible for paying it himself/herself. Nevertheless, the interviewees at Hospital Neo have experienced some challenges with outsourced professional interpreters and in the future the plan is to use the newly hired Russian-speaking nurse as an interpreter.

"Sometimes we have to ask the interpreter here, because it is not possible and there is no point in an appointment with a doctor with absolute no common language with the patient. At

least some communication in some language between doctor and patient is a prerequisite for the whole meeting." (CEO, Hospital Neo)

"We have had some interpreters who don't have specialization in medical language. They haven't been always able to brief the patient properly before an operation and there have been some other misunderstanding and mistakes as well." (Nurse, Hospital Neo)

"Interpreter needs to understand our processes… That's why outsourced interpreters are a bit complicated. -- And it is hard to double-check, if the patient has understood for example rehabilitation instructions, when someone is interpreting your speech to a language you don't understand." (Medical Director, Hospital Neo)

However, as Hospital Neo is still taking its first steps in the medical tourism sector and they are used to their foreign patients bringing their own interpreter, they still lack systematic approach in the language issues.

"We are solving these language issues, especially interpreting, on a case-by-case basis."
(Medical Director, Hospital Neo)

4.3.4 Orton

Orton is a private hospital, clinic and rehabilitation center specializing particularly in diagnosis and treatment of musculoskeletal diseases, like back, neck, shoulder, hand, hip, knee and ankle operations. Orton also offers services in other medical specialty fields, such as internal medicine, neurosurgery, pediatrics, rheumatology and sports medicine. In addition, Orton provides joint replacement operations and has a pain management clinic. Orton is located in Helsinki, Finland, and it has approximately 300 employees. (Orton 2015.)

In 2013 Orton received around 200 medical tourists from Russia and in general the number of Russian patients has been growing in recent years. Orton also regularly receives some medical travellers from other countries in Europe, particularly Estonia, Ukraine and Latvia, but their amounts are not as significant as Russian tourists. Besides, Orton also receives medical travellers from all over the world due to complicated insurance arrangements in which the patient needs highly specialized orthopedic aid. However, Russian medical tourists are by far

the biggest group of foreign patients at Orton and the only foreign patient group they are actively marketing to. According to Orton interviewees, the company has been one of the first companies in Finland not only marketing their services to Russian patients but also receiving Russian patients, as it received its first Russian medical tourists already in the mid-1990s. Since the late 2000s Russia has been a focus area for Orton.

"For a long time the attitude of other Finnish health care companies was that 'we don't want Russian patients to come here.'" (Patient Coordinator, Orton)

"The number of Russian patients has been growing significantly in recent years. In about four and a half years the turnover brought by Russian patients has eight-fold or nine-fold. Turnover by patient is higher with Russian patients than with average Finnish patients. -- Our surgeons like to take Russian patients because they are professionally very demanding cases. Only very difficult cases come here, and as surgery is a 'handicrafts' profession, it is good to have very challenging operations every once in a while." (CEO, Orton)

Orton treats both rehabilitation patient and surgery patients. However, Russian patients they receive tend to come mainly for extensive surgeries.

"Our Russian patients are definitely more typically surgery patients than patients coming to rehabilitation. Surgeries are easier to productize, market and sell to foreign patients. -- There are also cultural differences in what rehabilitation means here and in Russia. In Russia it is more focused on spas and free time activities, but here it happens in a hospital environment. " (CEO, Orton)

Communication and interaction with Russian medical tourists at Orton

Orton has a team of about 25 employees who speak Russian: doctors, nurses, hospital assistants, a Patient Coordinator, and when there are Russian patients, mainly this team takes care of them. In addition, Russian-speaking nurses interpret in doctor's appointments and also in other medical encounters.

"We have been systematically increasing the Russian-speaking team especially in medical personnel. There is a clear need for it. -- This is a 24/7 operation so we have to be able to treat also our Russian patients around the clock." (CEO, Orton)

"It is easy to use our nurses for interpreting purposes, as they know our house and our principles very well." (Patient Coordinator, Orton)

One of the Orton Interviewees was Patient Coordinator whose task is to work as a link between Russian patients and the rest of Orton's personnel, and provide Russian patients with Russian-speaking customer service. When a Russian patient contacts Orton for the first time, his/her contact is delivered to the Patient Coordinator, who also produces all required documents between patient and the hospital and translates documents into Russian and from Russian. Patient Coordinator also books all appointments with the doctors for Russian patients, notifies the patient about the appointments well as answers their questions when needed. If a patient has some questions for his doctor, the patient sends his questions in Russian to Patient Coordinator who then translates them into Finnish and delivers them to the doctor. In general, translation of documents and questions related to medical issues between Russian and Finnish is an important part of Patient Coordinator's work. Sometimes the discussions between Orton and patient take from weeks to even several months. Thus, it was emphasized by Orton interviewees, that the amount of Russian patients in their company (about 200 per year) does not reflect the work that receiving even one medical tourist takes.

"It takes approximately one month of discussing and translating documents before the patients arrives here." (Patient Coordinator, Orton)

In addition to a team of Russian-speaking personnel, Orton has also other solutions helping them to communicate with Russian patients. To give a descriptive example, they have an internal grammar book, made by Patient Coordinator, which includes the most typical phrases and words used with Russian patients. The grammar book has been distributed to all wards in Orton hospital. Orton also provides basic courses in Russian language as well as cultural training to help their medical personnel to interact with Russian patients. The cultural training includes for example basics about cultural differences between Russians and Finns as well as information about the role of body language in customer service encounters.

Orton has also utilized professional interpreters in the past. However, they found out there are some challenges related to interpreting in medical encounters. Besides, it also came out that interpreting is a significant cost in health care. As operations made for Russian patients at Orton typically are extensive orthopedic operations, are patients usually spending long

periods – even 10 days – at hospital after the operation. Consequently, considering the length of the stay, relatively high costs would be generated if professional interpretation was used, and in global competition this cost could have significant impact on the competition. Thus, the cost of interpreting is also one reason why Orton has decided to focus on multilingual personnel instead of professional interpreters.

"I think it is very challenging to keep things rolling properly with an interpreter. The problem with professional interpreters is that they are not always there when needed. We have practical experience in this… And there is more place for all kinds of communication blocks and miscommunication. -- Besides, professional interpreters increase the price a lot when there is one extra person whose only task is to interpret. -- Our patients spend here long time after the operation… And you can't even image how much a professional interpreter costs on a Saturday. -- It is better if you can also do something else than only interpret. "
(CEO, Orton)

All in all, as Orton has acknowledged the challenges related to medical interpreting and they have focused on having Russian-speaking personnel already for many years, there was a consensus among Orton interviewees that multilingual personnel is the most efficient solution at least for their company.

"Serving Russian patients in their native language is self-evident. The Russian patients come to Orton because we can provide services in Russian." (Patient Coordinator, Orton)

"In our early years we didn't have almost any personnel who spoke Russian. It didn't work out too well, I think. When the discussion concerns your health it is better to speak your own language and to be able to express yourself properly. And competition in this sector is rough, so we have felt that if we don't provide services in Russian, we will give the patient to somebody else too easily, as service language may be a determining factor for the patient. -- We have experienced in practice that focusing on language issues has taken us forward in this area. In the beginning we didn't invest in multilingual personnel, but then we didn't either proceed in this area. -- Language is a key area in this." (CEO, Orton)

5. DISCUSSION

This chapter aims at discussing and combining the findings as well as answering the research questions initially presented in the Introduction of this report. The research questions for this study were the following:

Research questions

1. How do language barriers affect health care encounters and how do health care companies overcome them?
2. How important is patient's native language in health care services and when is the use of patient's native language particularly important?

Sub-question

3. What kind of phenomenon is medical tourism in the Finnish context?

In line with the research questions, this chapter is divided into three parts: 5.1, 5.2 and 5.3 of which each is focusing on answering one research question. Chapter 5.1 answers the sub-question of this study and provides summary for the context of the study: medical tourism from Russia to Finland.

5.1 Summary of the context: medical tourism from Russia to Finland

This part answers the sub-question (*What kind of phenomenon is medical tourism in the Finnish context?*), which is related to the context of the study. The purpose of the sub-question was to understand the phenomenon of medical tourism in the Finnish context: for example, how much foreign patients does Finland receive, what are the drivers of the phenomenon in the Finnish context and what kind of medical tourism destination Finland is.

"In Finland medical tourism has received an extensive amount of coverage in the media compared to the volume of the business." (CEO, Hospital Neo)

Although medical tourism is a widely recognized and discussed phenomenon in Finland, it is still a rather fragmented and informal industry in the Finnish context. By far the biggest group

of foreign patients in Finland is Russian medical tourists, mainly coming from St. Petersburg and Moscow areas. Finland also receives foreign patients from other countries than Russia, but they are mainly individual cases and their amounts are smaller than Russian patients'. However, all case companies communicated that their Russian medical tourist volumes have been on increase in recent years. In fact, many Finnish health care companies have only recently started actively marketing their services to Russian patients and even in the companies receiving most Russian tourists the amounts vary from some dozens to a few hundreds Russian patients per year. Currently Finland does not compile statistics on its inbound or outbound medical tourists due to various definitions of medical tourism and the fact that typically Russian patients do not mention the purpose of their trip when applying for a visa (Makeeva 2014).

FinlandCare program, presented in the chapter 4.1 of this report, has brought state-level intervention and interest towards the Finnish medical tourism industry. The purpose of FinlandCare program, which is organized in cooperation by Ministry of Employment and the Economy and Finpro, is to promote medical tourism to Finland particularly from Russia and improve the visibility and awareness of the Finnish health care sector in the global markets. However, FinlandCare is still a rather new organization, founded in 2011, so long-term impacts of the organization cannot be assessed yet. Nevertheless, a state-level project is one step towards a more established medical tourism sector, but its impact won't be seen overnight. Regarding the relative informality of Finnish medical tourism industry, also Nordic Healthcare Group (2010) notes that so far medical tourism has been very demand-driven in the Finnish context: the hospitals have received patients if they have overcapacity and patients want to come to Finland for a treatment. Correspondingly, Nordic Healthcare Group (2010) also supports the finding of this study that Finnish medical tourism has been mainly based on individual doctors and clinics that have been interested in receiving foreign patients, and a common state-level strategy has been lacking until recently.

Based on the empirical findings of this study, one barrier for medical tourism to become an important export industry for Finland is the challenge of marketing medical services for foreign patients. In other words: how to reach the foreign, in the Finnish case particularly Russian, patients? The challenge of marketing services in Russia is that Russia is a huge and geographically fragmented country, and case companies had also tried various marketing activities from direct marketing to TV advertising, but with relatively poor success rate.

However, the empirical findings of this study suggest that digital marketing channels on the Internet (proper company webpage in Russian, social medical activities, search engine optimization, search engine marketing) are the most suitable in Russia not only due to Russia's size but also the fact that medical tourists are typically active Internet users. Similarly, it was also highlighted in empirical findings that referrals from previous satisfied patients (word of mouth) is also a useful tool to reach Russian patients. However, word of mouth does not originate automatically, but it must be gained first.

The drivers of global medical tourism phenomenon were discussed in chapter 2.2.2 of this report and the main drivers are: high costs of elective treatments in many countries, long waiting lists, fewer barriers to travel including low-cost international air travel, Internet as a marketing and information platform as well as treatments and medical technologies/methodologies not available in patient's home country. Somewhat similar drivers, that the previous literature acknowledges, were also found in this study for medical tourism from Russia to Finland. In the previous chapter I presented the drivers of the phenomenon and categorized them into push and pull factors: push factors are related to the problems in Russia's health care system, whereas pull factors relate to Finland as an attractive medical tourism destination. In case of Russian patients the push factors where emphasized: the quality of treatments, technologies and hospitals/clinics available in Russia vary a lot and due to this, many Russian patients do not trust their domestic health care sector. Besides, there are also long waiting lists to particularly public health services, whereas on the private sector prices may be even higher than in Europe. However, at the same time Finland appears as an attractive destination that is located close and where the most modern medical treatments and technologies are available in competitive prices.

At the same time when Finland is taking its first steps towards having an established medical tourism industry, many countries have a long history providing their services for global medical tourists. For example in Sweden medical tourism has been a focus area for the Swedish government already since late 1970s and Sweden's corresponding organization to FinlandCare, called Swecare [6], was founded already in 1978 together by the Swedish government and the health care industry as a semi-governmental non-profit organization. (Swecare 2015.) Currently there are about 350 companies and organizations included in the

[6] For further information on Swecare, please see http://www.swecare.se/Eng/ABOUT

program, whereas Finland's FinlandCare program has about 35 members. State of Finland's medical tourism sector, compared to other countries, was highlighted by many interviewees:

"We have a huge gap to other medical tourism countries. If we want to make this a volume business, we have to pass at least Germany, Switzerland, USA, Turkey and Israel, which are extremely popular destinations among Russian medical tourists. -- We have a gap of around 100 years compared to for example Switzerland. Rich people travelled to Switzerland to treat their ailments in sanatoriums already in the 19th century. Finland was still forest at that time." (Medical Director, Hospital Neo)

"Germans have marketed their services to Russian medical tourists for 30 years and we have just started. We are far behind." (CEO, Coxa)

It is interesting to ponder why Finland's medical tourism industry is still in its infancy compared to many other European countries, although Finland has clearly many benefits as a medical tourism country, like discussed in chapter 4.2.2. Finland has great medical services, the price level is affordable and it is located next to Russia. One possible explanation for this is that as mentioned, in Finland medical tourism has so far been corporate-driven and based even on individual doctors or clinics. FinlandCare is the first project on the national level to promote medical tourism, but it was activated only in 2011.

Another potential reason for Finland's relatively slender medical tourism is probably that the focus has been too much on promoting health care services and too little tourism and the extra services also related to the medical tourism industry. This raises an interesting question: is medical tourism more health care or tourism? Based on this study, it can be said that in Finland it is definitely more health care, whereas in some other medical tourism destinations, particularly in Asia, it is probably more focused on touristic aspects. Besides, in Finland medical tourism is mainly focusing on serving the patient and for example, additional services are not provided to patients' family members. However, it came out in empirical interviews that in many other medical tourism destinations also patients' travelling companion is taken into account more thoroughly and health care companies provide various extra services for them. These two quotations summarize suitably some explanations for Finland's challenges as a medical tourism destination:

"I think people travel to use medical services in places they like to travel anyway. Like Thailand or Dubai." (CEO, Hospital Neo)

"The thing we are missing here in Finland in medical tourism is that we don't have enough tourists… It is easier to go from tourism to medical tourism than the opposite way around. Maybe in Finland we are looking this whole phenomenon from a wrong perspective and we are too focused on health care. -- We could build medical tourism to places where tourists go…Like a Finnish hospital in Alanya, Turkey. -- Maybe this is more about location than medicine." (Medical Director, Hospital Neo)

5.2 Language barriers in health care and interventions to overcome them

The purpose of the first research question (*How do language barriers affect health care encounters and how do health care companies overcome them?*) was to understand how problematic language barriers in health care are and what kind of solutions do health care companies have for overcoming them. Thus, the purpose of this question was to shed light on the problematic nature of language barriers in health care settings.

Based on both previous literature on language and communication in health care as well as the empirical findings of this study, it can be said that language barriers can be very problematic in health care services and they can have various negative impacts on a patient. Besides, although this study focused on language barriers from health care companies' perspective and the previous studies have mainly had patients' perspective, were the findings of this study mostly in line with the previous findings in the field. The case companies have experienced language barriers in medical encounters, mainly due to medical tourists, and found them so problematic that they have created various solutions for overcoming language barriers. Some interviewees even pointed out that a health care encounter cannot take place if a total language barrier occurs, and some saw language barriers as an obstacle for patient safety.

It was discussed in the literature review of this study that language barriers are a problematic area in health care and they may have various consequences on a health care encounter as well as the success of it (Jacobs et al. 2006). One major problem is that if a language barrier occurs, doctor has less understanding of the full nature of patients' problems (Sarver & Baker

2000). This may impact diagnosis and potentially cause excessive testing and examining (Morales et al. 1999), as patient is not able to share his/her patient history and current ailments. On the other hand, language barriers also have a negative impact on how the patient perceives the care (Fernanzed et al. 2004), and in general language barriers may result in increased patient dissatisfaction (Morales et al. 1999; Fernandez et al. 2004; Jacobs et al. 2006). Also health care providers are less satisfied with the health care encounters when a language barrier takes place (Hornberger et al. 1997); this finding was strongly demonstrated by my study.

In general, language barriers are also problematic in other service contexts than health care. Purely from a service encounter perspective, Holmqvist (2011) notes that if a language barrier occurs in a service encounter, it can have consequences on the service encounter as such as well as the final outcome of the service. Besides, even when communication is possible to at some degree, language barrier can still have an impact on consumer's perception of the whole service (Holmqvist 2009). This is because consumers do not only evaluate the quality of the service they receive, but also the language they receive the service (Fernandez et al. 2004; John-Baptiste et al. 2004).

As discussed thoroughly in the literature review of this report, previous research also provides some solutions for overcoming language barriers in health care settings. According to previous studies, the main interventions for overcoming language barriers in health care settings are: native language use (language concordance) (e.g. Morales et al. 19999; Freeman et al. 2002; Lee et al. 2002), professional or non-professional interpreters (e.g. Sarver & Baker 2000; Jacobs et al. 2006; Karliner et al. 2007), different technological solutions to interpreting (remote interpreting and telephone interpreting) (Hornberger et al. 1996) as well as language training provided for health care personnel (Prince & Nelson 1995). However, the solutions in case companies were even more varying and creative than the ones found in previous literature. The solutions of the case companies are summarized in the Table 3.

Table 3 ***Overcoming language barriers in case companies***

Company	**Solutions for overcoming language barriers**
Coxa Hospital for Joint Replacement	▪ Russian-speaking personnel ▪ In-house professional interpreter ▪ Written translation signs/cards
Docrates Cancer Center	▪ Russian-speaking personnel ▪ Professional interpreters upon patient's request (used hardly ever)
Hospital Neo	▪ A small team of Russian-speaking personnel ▪ Non-professional interpreters (patients' travelling companion) ▪ Professional interpreters
Orton	▪ Russian-speaking personnel ▪ Basic language courses in Russian ▪ Written translations, internal grammar book ▪ Cultural training

All the case companies have at least some Russian-speaking personnel, which in literature is called language concordance (e.g. Morales et al. 19999; Freeman et al. 2002; Lee et al. 2002). Having Russian-speaking personnel was seen as the most appropriate solution and it is a matter of both convenience and saving costs; the cost effect of interpreting will be discussed in more detail in the following. Another reason for companies increasingly focusing on having Russian-speaking personnel is that Russian medical travellers quite often expect to be served in their native language also in Finland particularly in health care encounters. One explanation that case companies provided for this explanation was that when for example the company's webpage and marketing actions are in Russian, patients almost automatically expect that the services are provided in the same language.

Interestingly, it was found out in this study, that from the companies' perspective there are various challenges related to professional interpreting in medical settings. Many companies had experience in professional interpreting, but they found it rather inflexible and not too convenient solution. In addition, it was highlighted by interviewees that an interpreter used in medical settings should be able to understand medical language as well as medical processes properly, but it wasn't very easy to find that kind of interpreters. The challenges of

professional and non-professional interpreting have been also recognized in previous literature, as discussed in chapter 2.4.3 of this report. Previous literature suggests that there are various benefits related to using professional interpreters in health care: professional interpreters can for example increase patient satisfaction (Morales et al. 1999) and they are related to shorter hospital stays (Fagan et al. 2003). In general professional interpreters are associated with improved medical care (Karliner et al. 2007), whereas studies have found mixed results on non-professional interpreting. Some studies demonstrate various challenges in non-professional interpreting, including error in communication and even misdiagnosis, whereas some studies conclude that non-professional interpreters result in greater satisfaction and better patient comprehension (Sarver & Baker 2000; Bernstein et al. 2002; Flores et al. 2003). However, in my empirical findings there were more problems related to professional interpreters than non-professional interpreters.

Case companies rely mainly on non-professional interpreting, but like just mentioned, also professional interpreters are used. Based on this study, I find it appropriate to further categorize professional interpreters and non-professional interpreters into two different sub-categories: external and internal, which make altogether four types of different interpreters. Regarding the concepts of internal and external, the categorization is done from health are companies' perspective. The different categories can be found in the Table 4.

Table 4 ***Different kinds of interpreters in health care encounters***

Professional interpreters	A) Internal: in-house hospital interpreter B) External: translating/interpreting agency
Non-professional/'ad-hoc' interpreters	C) Internal: multilingual hospital personnel D) External: family member, friend, other patient

Of the case companies studies, Coxa is the only one to have an internal professional interpreter (category A) whose tasks include interpreting between Russian patients and hospitals' Finnish-speaking personnel in for example doctor's appointments as well as different translation tasks. These types of in-house hospital interpreters seem to be rather

uncommon in health care at least in Finland, although also Finnish health care industry is becoming more and more multilingual. Interestingly, other case companies focus mainly on having either internal or external non-professional interpreters (categories B and C). In all case companies Russian-speaking personnel is used as internal non-professional interpreters (category C) who for example interpret during doctor's appointments. Interpreters from category B (external professional interpreters) are used relatively seldom and mainly when there is no other option.

All in all, based on this study can be said that using external professional interpreters in medical settings can be seen in a way as transition stage towards having multilingual medical personnel; at some point (when patient volume is big enough) it becomes too expensive and complicated to use external professional interpreters and then multilingual personnel is hired. Furthermore, having multilingual medical personnel is also a question of saving costs, which was soundly described by this interviewee below. It is definitely more cost-efficient to have personnel who can not only interpret but also perform other tasks as well. Like mentioned, concerning the international nature of medical tourism, the competition about international patients is intense and interpreting services can increase the price of the medical operation significantly and possibly drive away potential international patients, particularly if the patient spends long time in a hospital. Naturally the cost effect is the more significant the longer the foreign patient stays in a hospital and thus, how long the interpreter is needed.

"Persons who only interpret increase the costs a lot. Having an interpreting here 24/7 is extremely expensive. -- We tried interpreting when we didn't have enough Russian-speaking personnel, but we understood the cost effect of interpreting quite soon. Medical tourism is global competition in which price is an important factor. So all the things that increase the price of our services may drive away our potential foreign customers." (CEO, Orton)

5.3 The importance of patient's native language in health care services

The purpose of the second research question (*How important is the patient's native language in health care services and when is the use of patient's native language particularly important?)* was to understand the role of patient's native language in health care services. The objective of this research question was to shed light on whether patients must be served

in their native language in health care encounters or whether a third language, like English, can be used. Moreover, the goal of the research question was also to understand if there are differences in the usefulness of native language use between different stages during the health care service process. In other words, if native language use is more important in some certain phases during the service process and less important in some other phases. One goal of this research question was to create information that small and medium-sized companies focusing on the medical tourism sector could utilize when allocating Russian-speaking personnel to different phases.

Based on this study, the role of native language seems to be paramount in health care services. As discussed in the previous chapter, case companies had various solutions on how to serve their Russian patients' particularly in their native language, for example by having Russian-speaking personnel or providing professional or non-professional interpreter services. Providing services solely in a third language, like English, was not the primary choice to solve language barriers for any of the case companies, also because Russian medical tourists' foreign language skills are typically quite poor. Besides, interviewees were mainly on the view that is most convenient to use one's own native language, when the discussion concerns something as important and personal as health. In addition, case companies were on the view that language can even steer the choice of a hospital or clinic for a patient; patients go where they can be served in their native language, this is discussed in more detail in the following. Holmqvist and Grönroos (2012) have studied this in practice and they conclude that language can affect customer even before the service encounter, as the service provider's service language can influence the consumer's decision to use the service.

"Patients feel safer when they can speak their native language. -- They feel that they master the situation better when they can speak their own language." (Nurse, Docrates)

Also many other previous empirical studies demonstrate the important role of language in health care services. According to Holmqvist and Grönroos (2012) health care is a high involvement service, like also legal services, and in high involvement services native language use is particularly important. This is because in high involvement services special vocabulary is often needed and there is a high risk for the customer (Holmqvist & Van Vaerenbergh 2013). Besides, native language also influences consumers in an emotional way in service encounters, as people have emotional bonds to their native language and they link

their native language to their identity (Holmqvist 2011). Holmqvist (2009) has also came to a conclusion that consumers prefer to be served in their native language and if they have an opportunity to choose between service providers, they may require a large price discount for not being served in their native language. Besides, in general native language affects patients in health care encounters in many ways, as highlighted in the previous chapter. For example, according to Jansson (2014), it has been empirically confirmed that health care workers even with very limited abilities in patient's native language can impact the health care service positively.

According to this study, language has a key role not only in health care services in general but also in medical tourism. Previous research (Levary 2011; Peters & Sauer 2011) has demonstrated that the possibility for a patient to use his/her native language while receiving health services abroad is one of the most important decision criteria for a medical tourist. There are also same types of findings in the Finnish context. For example Finnmedi (2012) has researched Russian medical travellers empirically and found that in choosing the health care provider 40% of Russian medical travellers find the service provider's ability to provide services in Russian extremely important and 21 percent important. The other factors that Russian patients found extremely important are the top-level doctors and other staff at the health care company (57 percent) and the overall quality image of the health care company (43 percent). Correspondingly, Finnish Tutkimus- ja analysointikeskus TAK Oy has been researching tourism and travellers between Finland and Russia and observed what kind of interpretational and translational needs the Finnish and Russian travellers have when they travelling to the neighboring country. According to TAK (2014), the most important situations where translation is needed are emergencies and health care encounters. 49 percent of the Russian respondents in the survey felt that emergencies are the most important situations where translation help should be available, whereas 53 percent of the Russian respondents felt that health care encounters are the most important situations.

The important role of native language in medical tourism was also revealed by multiple interesting anecdotes told by the interviewees:

"Language is not a trivial thing in medical tourism. This is global competition, so of course also 'small' things matter. I mean our competitors in Germany, Switzerland and Israel have been in this business for 10-20 years and developed their processes to be top-notch, and this

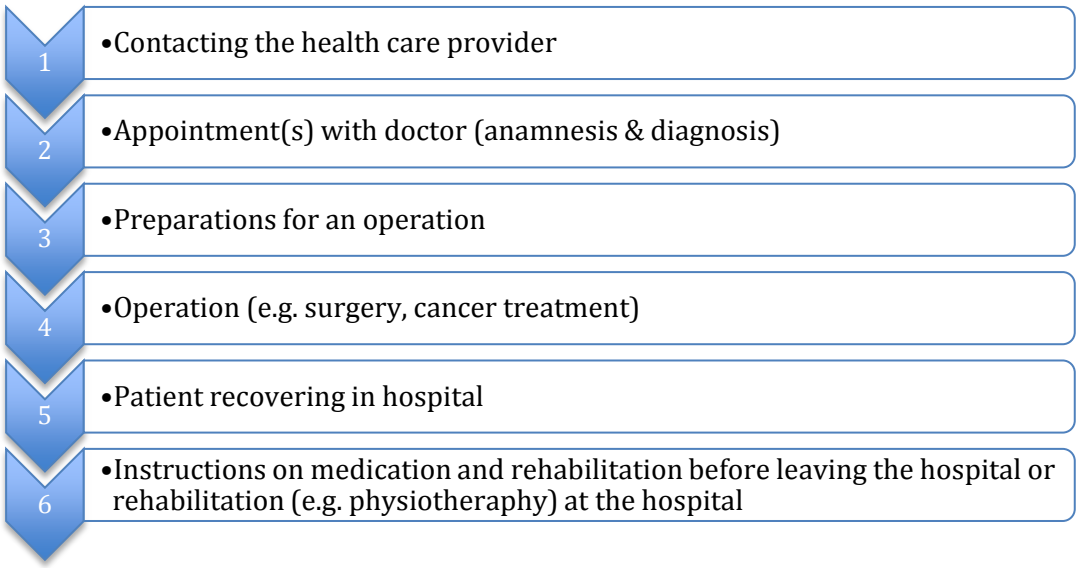
applies also to service language. They can always serve patients in Russian. If you want to play this game, you need to have the same equipment as others." (CEO, Orton)

"Russian patients want to be served in their native language. -- I have a lot of experiences in this kind of situations: I have been sending emails for a long time with elderly Russian patient's family members, and all the paper work and other stuff is ready for her to come here. But just before the operation they cancel and they say they travel to Israel instead, because they can't take it that we don't have a Russian-speaking physiotherapist. So the language thing can affect a lot." (Doctor, Hospital Neo)

The most critical phases in health care services regarding native language use

Before discussing the most important phases in terms of native language use, it is probably in place to present health care service as a process of different phases. According to the empirical data of this study, at least the phases described in the Figure 7 below can be identified in health care services. However, although in this figure the phases are presented in a certain order, the process does not always follow this sequence and there may be also other phases depending on the treatment and health service provider. Typically patient's symptoms or ailments start the process.

Figure 7 ***Different phases in health care services***



Interestingly, previous academic research does not differentiate the importance of native language use in different stages during the health care service process. However, as already mentioned, there is literature on the importance of native language use in health care services

as well as patients' preferences on native language use in health care (e.g. Lee et al. 1998; Morales et al.1999; Fernandez et al. 2004; Jacobs et al. 2006; Holmqvist 2009; Holmqvist 2011; Holmqvist & Van Vaerenberg 2013). Aantaa (2012) notes that effective communication and interaction between a patient and a health care provider is particularly important in the beginning of the health care process, when anamnesis takes places. Anamnesis was discussed in the chapter 2.4.1 and it refers to patient operating as a source of medical information by providing information about his/her medical history and current symptoms or ailments. Anamnesis is an important premise for the diagnosis (Aantaa 2012).

However, despite the limited previous interventions to answer the question about the most critical phases in health care services regarding native language use, based on this study it can be said that although language and especially native language use are important in health care services due to various reasons discussed in the previous chapter, the ability to speak patient's native language is not equally important in all phases during the health care process. Based on the empirical findings of this study, the most important phases in medical services regarding native language use focus on the beginning of the process (phases 1,2 and 3 in the figure above) as well as to the final phase (phase 6) of the process.

Based on the empirical findings of this study, native language is important even before the patient arrives to the hospital/clinic, as typically Russian patients prefer contacting the companies in their native language. It was highlighted in the empirical findings of this study that typically discussions with potential Russian patients take a lot of time, from weeks to even several months, as Russian patients are comparing different health care service providers carefully. Foreign patients have a lot of questions about the practicalities that the companies need to be prepared to answer. All the case companies had some solution for providing the Russian patients with Russian-speaking customer service and it was highlighted by case company interviewees that it is important or even self-evident that Russian patients can contact the company in their native language. Thus, companies found having a Russian-speaking customer service as a prerequisite for getting Russian patients. On the other hand, it was also mentioned in the previous chapter that if a company has a webpage in Russian, patients almost automatically expect that the services are provided in Russian too. Thus, in the beginning of the process it is important to convince the patient about the health care provider and give a good first impression. Some interviewees also noted that it is important to

answer Russian patients' enquiries quickly enough, as often patients are comparing and enquiring into many health care providers at the same time.

In line with Aantaa's (2012) findings, also the anamnesis and diagnosis phase of the process as well as the preparation phase for an operation were found to be particularly important in terms of native language use. Many interviewees emphasized that in order to the doctor to be able to make a diagnosis, the patient needs to be able to tell about his/her medical history and current symptoms or ailments (anamnesis), and it is most convenient to discuss one's own health in native language. However, even more important is that a patient understands realistically the upcoming operation and its expected benefits for the patient, but at the same time also the potential risks related to it.

Correspondingly, also the final phase is an important phase in terms of native language use. Interviewees noted that a patient needs to understand the result of a medical intervention as well as what kind of rehabilitation or follow-up treatment is potentially needed later. Besides, in this phase also instructions on medication are given to the patient.

Altogether, one interviewee summarized soundly the most important phases in heath care services regarding native language use:

"I think there are basically two situations in which it is paramount that the patient and our personnel understand each other perfectly. The first one is when it is discussed with the patient what we are going to do. We interview and examine the patient and choose together which treatment is the most suitable. -- Usually there is not only one option, but every treatment has a pro and a con. -- And the second paramount phase is after the surgery when we tell the patient about the medication, rehabilitation possibilities and possible follow-up treatments. The patient needs to understand what to do after going home."
(Medical Director, Hospital Neo)

6. CONCLUSIONS

In global business it is not enough for an international company to define which language is spoken within the company. Instead, when dealing with international customers, the company also needs to define which language to speak with its customers. Thus, language and language barriers are a current and increasingly important topic in international business and service contexts, as companies are more and more operating in an increasingly global and multilingual business environment.

This study investigated the role of language as well as problems of language barriers in a particular service context, health care services. Health care is, among many other sectors, an internationalizing service industry of which one of the most visible forms is the global phenomenon of medical tourism. This study focused on studying language and language barriers from health care providers' perspective, although previous studies in both service marketing and communication and language literature in health care have mainly taken patients' perspective into account.

Based on this and also some previous studies in related topics, native language has an important role in health care services. Previous research provided strong support for the importance of patients' native language in health care services as well as for the importance of effective communication and interaction between health care personnel and the patient. Health care companies found language barriers extremely problematic and thus, provided various solutions for overcoming the language barriers generated by international patients.

Moreover, based on this study, it also seems that language and particularly native language is not trivial area in medical tourism either. Previous research (Levary 2011; Peters & Sauer 2011) has demonstrated that the possibility for a patient to use his/her native language while receiving health services abroad is one of the most important decision criteria for a medical tourist. In this study it came out that health care companies mainly overcome the language barrier by having personnel that speaks Russian and can thus provide services in patient's native language. Also interpretations services were commonly provided by either professional or non-professional 'ad hoc' interpreters. However, it was clearly stated in the findings od this study that according to Finnish health care companies, Russian patients expect to be served in their native language when travelling abroad for health care services. Besides, their skills in a

third language, like English, are not strong enough that they could use it in health care encounters.

This study also explored the global phenomenon of medical tourism, particularly from the Finnish perspective. Globally medical tourism is a significant phenomenon, although the figures of global medical tourist volumes vary a lot and the size of the industry is not completely assessed. Many countries globally (e.g. Thailand and India in Asia, Germany, Switzerland in Europe) have invested a lot in medical tourism, promoting it and building a strong brand as a medical tourism destination. However, in the Finnish context medical tourism is in its infancy, but still an explicitly existing phenomenon. Russian patients are by far the biggest group of foreign patients in Finland, but overall the foreign patient volumes are still relatively small in Finland and even the biggest operators in the industry only receive from dozens to some hundreds of foreign patients per year. On the other hand, many Finnish health care companies have started focusing on the Russian medical tourist segment only in recent years and marketing their services actively, and the patient volumes from Russia have been increasing at least in all companies studied. At the same time the phenomenon has received relatively lot attention in media, whereas academic research on the topic has been limited especially in Finland. This study was one of the first ones to empirically study medical tourism in the Finnish context.

However, medical tourism is an area with great growth potential and researchers (e.g. Connell 2006; Freire 2012) predict that it will increase in the future due to privatizing health care sectors, aging population and rising costs of health care around the globe. The drivers of the phenomenon, based on both previous research and empirical findings of this study, also highlight the fact that medical tourism is a phenomenon to remain or at least not to diminish in the near future, as the various problems in health care sectors in many countries won't be solved overnight.

6.1 Managerial implications

The most important managerial implication of this study is that a company that wants to be involved in the global medical tourism business cannot neglect the language question. In the case of Russian patients, the health care provider cannot rely solely on using a third language,

like English, as Russian patients' language skills in other languages than Russian are typically poor. Besides, in general, native language has an important role in health care services and previous studies suggest that typically patients prefer to be served in their native language in a high involvement service like health care.

All in all, based on this study, health care companies receiving foreign patients need to overcome the language barrier somehow and they need to have some kind of solution for providing the service in customer's language. Based on the empirical findings of this study, having Russian-speaking personnel seems to be the ideal solution. Also professional medical interpreters can be considered, but according to this study, there are multiple challenges related to interpretation in the medical encounters. As a minimum requirement, if an interpreter is used, he/she must be able to understand medical language properly as well as have at least a basic understanding of medical operations and procedures. Consequently, a person who has interpretation ability as well as medical education would be the most suitable option.

In this study it was also investigated in which phases of the health care service native language use is particularly important. It was found in this study that native language use is particularly important in the first phases of the health care service process as well as in the end of the process. In the beginning of the process native language use is important, as patient needs to provide health care personnel with medical history and medical information as well as understand the upcoming operation and its risks. Correspondingly, in the end of the process native language is important, as patient needs to understand the instructions given on medication and potential follow-up treatments or rehabilitation. Thus, if a health care company receives foreign patients, at least in these phases health care personnel and patient should be able to communicate efficiently.

Regarding marketing medical services to Russian patients, the empirical findings of this study suggest that digital marketing channel on the Internet (proper company webpage in Russian, social medical activities, search engine optimization, search engine marketing) are the most suitable in Russia not only due to Russia's size but also the fact that medical tourists are typically active Internet users. Similarly, it was also found in empirical interviews that referrals from previous satisfied patients (word of mouth) is also an extremely useful tool to reach Russian patients, but of course word of mouth needs to be gained.

In addition, companies should also manage patient's expectations regarding the service language. If a Russian patient finds for example the webpage of a Finnish health care company in Russian, it is only natural that the patient expects the company to provide services in the same language as the webpage is or at least to have a customer service in the same language as the webpage.

6.2 Limitations and suggestions for further research

As already mentioned in the Introduction of this report, also this study has its shortcomings as all empirical research. This study was the first one to study the role of language and language barriers purely in medical tourism context. In general the language research in international business is still in its infancy, although in recent years there have been some advancement in field (see e.g. Holmqvist 2009; Holmqvist 2011; Holmqvist & Grönroos 2012; Holmqvist & Van Vaerenbergh 2013), but this study took a step further to understand the role of native language in a particular service context, health care services.

The limitations of this study can be categorized into groups: theoretical limitations and methodological limitations. The theoretical limitations arise from the fact that the previous literature on language issues in health care services has mainly focused on Spanish-speaking patients in primary care or emergency department settings in the North American context, although this study concentrated on medical tourism in the Finnish context and particularly Russian medical tourists in Finland.

This study was conducted as a qualitative multiple case study focusing on the Finnish health care providers. In other words, this study was conducted without access to Russian patients due to the fact that in Finland health care patients form a group whose personal details or contact information cannot be shared with third parties due to legal constraints. However, a patient-perspective in the research could have helped gaining a wider perspective on the topic. Thus, in the future this kind of study could be conducted by including patient's perspective, if legally possible. In my opinion even ethnographic research methods could be used in this kind of research, like in Jansson's (2014) study.

There are also other limitations related to the methodological choices and particularly the sample sizes. As this study was conducted as a qualitative research, it limits the research to

some degree. On the other hand, a quantitative research would have been impossible to conduct on the topic due to the nature of research objectives and research questions as well as lack of quantitative data. However, a quantitative study with a survey could be conducted in the future, which would allow a larger sample of companies to be included in the study. Besides, although there were altogether 4 case companies and 14 interviewees categorized into three different interviewee groups in the study, the sample size per each interviewee group could have been larger. For example, there were only two expert interviews conducted for the study and a bigger sample of expert interviews could have resulted in a more comprehensive understanding of the industry and phenomenon on a general level. Also the number of interviews per each case company was not the same, ranging from two to four interviews per company.

In general, qualitative interviewing as a primary data collection method can also be seen as a limitation. According to Patton (1987), semi-structured interviews can be seen as a relatively complex data gathering method, as the responses of semi-structured interviews are not totally systematic or standardized. Besides, in this study it was considered appropriate to slightly tailor interview topics and questions as well as the sequence of the questions for each interviewee. This was made to gain as rich data as possible considering the nature of the research objectives, questions and methods, but at the same time it further complicated the analysis of the interview data.

With regard to potential research topics for the future, there are various options in this field. Just to give some examples, medical tourists are not the only group who face language barriers in health care. For example, another group that frequently faces language barriers in medical context, are the immigrants coming to Finland or other countries. On the other hand, the role of language and language barriers could be researched in other service contexts as well. Also the actual costs of language barriers could be investigated. In general, language barriers form an interesting and versatile research topic, as a common language between customer and the service provider cannot be taken for granted in today's globalized world.

Also medical tourism as a research topic is relatively new particularly in the Finnish context, so it provides multiple opportunities to conduct future research. Besides, as the phenomenon is extremely diverse and global, it could be approached from various angles in the future. Martinsen (2007) notes that there ought to be more research on patient mobility in the

European Union context and especially on how the integration of European health care systems affects patient volumes from one country to another. One potential research field could also be to study the criteria that patients use when choosing their medical travel destinations and whether language or language barriers have an explicit role in the criteria, like already demonstrated by some previous studies. Lunt et al. (2012) note that relatively little is known about the socio-demographic factors, ages, genders as well as health conditions of medical tourists. Thus, the profiles of medical travellers could be researched in the Finnish-Russian, Finnish or international context, as this kind of information could be very useful for health care providers targeting and marketing their services to medical travellers.

Also outbound medical tourism from Finland could be researched, as there is no empirical research evidence on that. Estonia is a growing destination for Finnish medical travellers, particularly in the field of outpatient surgery and dental care (Yle 2013). Finnish medical tourists' total amounts, expectations and motives as well as their preferences and opinions on the language issues could be researched. Also medical tourists as a marketing target group could be studied for different perspectives, for example, what kind of information do medical travellers need and search for on company webpages and what kind of extra services do they need and value.

To sum up, language issues are a topical and increasingly important part of international business. For many consumers language is more than just a tool of communication, as it can be a part of identity, and many consumers even prefer using their native language particularly in high-risk and high involvement services like medical care. Thus, all companies operating internationally or serving international customers need to consider language issues somehow. This study, in addition to previous studies, demonstrates the importance of native language use for customers particularly in high involvement services, like health care. Respectively, the role of language and language barriers in different service contexts across various industries could be investigated.

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8. APPENDICES

Appendix 1: Interview guide for expert interviews

Interviewee:
Position of interviewee:
Time and place:

A) FinlandCare program

1. Background for FinlandCare program

2. The roles of Ministry of Employment and the Economy and Finpro in the program

3. Goals and objectives of FinlandCare program

4. Common rules or strategic guidelines for the FinlandCare program member companies defined by Ministry of Employment and the Economy and Finpro

5. Marketing health care services to Russian patients

B) Medical tourism from Russia to Finland

6. Motives and reasons of Russian patients to travel abroad for health care services

7. Current figures on medical tourism
    - E.g. how many Russian medical tourists does Finland receive annually and how many of them travel to other countries

C) Language and communication in medical tourism

8. Potential common guidelines or rules related to language issues for the FinlandCare member companies
    - E.g. webpage in Russian mandatory, Russian-speaking personnel

9. The preparedness of the FinlandCare member companies to provide their services in Russian for the Russian patients

10. Communicating and interacting with Russian patients in practice
    - E.g. Russian-speaking personnel, interpreting services, in English, written translations, ”body language & sign language”

11. Receiving financial support from Ministry of Employment and the Economy or Finpro for e.g. translating documents and their webpage into Russian

12. Companies' marketing activities in Russia

13. Expectations and preferences of Russian medical tourists regarding the service language when they travel to Finland/other countries in search of medical services

D) FinlandCare member companies

14. Advanced FinlandCare member companies in terms of the language issues
    - Sharing best practices?

15. Companies that do not provide services at all/provide less services in Russian

E) Other topics

16. Current hot topics in medical tourism or among FinlandCare member companies

17. Anything you would like to add?

Appendix 2: Interview guide for directors/managers in case companies

Interviewee:
Position of interviewee:
Time and place:
How long have you worked in this company?

A) Basic information about the company

1. Information about the company
   - Size (employees, turnover)
   - Specific branch / field of specialization
   - How long has your company focused on the Russian market?
   - Does your company have employees that speak Russian? If yes, how many?

B) Marketing in Russia

2. Marketing channels in Russia
   - E.g. Facebook, VKontakte, webpages, print advertising, TV advertising
3. Reaching the Russian patients
   - In other words, how do your Russian patients find your company?
4. Why do you think the Russian patients choose your company over your competitors?

C) Medical tourism

5. Annual amount of Russian medical tourists in your company
6. The trend of Russian medical tourists in recent years (increasing / decreasing)
7. Typical medical tourist from Russia
   - E.g. profession, home town, income, travelling alone/with family etc.
8. The effect of FinlandCare program on your company's patient volumes from Russia
9. Russian patients' motives and reasons to travel abroad for health care services

D) Language and communication

10. Communicating and interacting with Russian patients in practice
    - Different solutions
    - E.g. Russian-speaking personnel, interpreting services, in English, written translations, ”body language & sign language”

11. Expectations and preferences of Russian medical tourists regarding the service language when they travel to Finland in search of medical services
    - Do Russian patients expect to be served in Russian?
    - How do they react when they get/do not get the service in Russian?

12. The ability to speak patients’ language in different phases during the health care service
    - At which phase of the service do your customers demand service in their native language?

13. Translating brochures, webpage and other materials into Russian

14. The importance of language skills (particularly in Russian) in recruiting new employees to your company
    - Concerning particularly doctors and nurses

E) Other topics

15. Anything you would like to add?

Appendix 3: Interview guide for medical personnel in case companies

Interviewee:
Position of interviewee:
Time and place:
How long have you worked in this company?

A) Basic information about the company

1. Information about the company

    - How long has your company focused on the Russian market?

    - Does your company have employees that speak Russian? If yes, how many?

B) Marketing in Russia

2. Marketing channels in Russia
    - E.g. Facebook, VKontakte, webpages, print advertising, TV advertising

3. Reaching the Russian patients
    - In other words, how do your Russian patients find your company?

4. Why do you think the Russian patients choose your company over your competitors?

C) Medical tourism

5. The trend of Russian medical tourists in recent years (increasing / decreasing)

6. Typical medical tourist from Russia
    - E.g. profession, home town, income, travelling alone/with family etc.

7. The effect of FinlandCare program on your company's patient volumes from Russia

8. Russian patients' motives and reasons to travel abroad for health care services

D) Language and communication

9. Communicating and interacting with Russian patients in practice
    - Different solutions

- E.g. Russian-speaking personnel, interpreting services, in English, written translations, ”body language & sign language”

10. Expectations and preferences of Russian medical tourists regarding the service language when they travel to Finland in search of medical services
    - Do Russian patients expect to be served in Russian?
    - How do they react when they get/do not get the service in Russian?

11. The ability to speak patients’ language in different phases during the health care service
    - At which phase of the service do your customers demand service in their native language?

12. Translating brochures, webpage and other materials into Russian

13. The importance of language skills (particularly in Russian) in recruiting new employees to your company
    - Concerning particularly doctors and nurses

E) Other topics

14. Anything you would like to add?