The (Construction of a) Global Market for Traded Health Services: The Case of The Netherlands

Bachelor Thesis

Soeske Hartjes
Professor Tulpstraat 36
1018 HA Amsterdam
Student number 312155
E: soeske.hartjes@gmail.com
T: +31 (0)6 30 04 38 55

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Dr. Teun Zuiderent
E: zuiderent@bmg.eur.nl
J8-35
Anne-Fleur Roos, PhD
E: roos@bmg.eur.nl
J8-01

Institute for Health Policy & Management
Erasmus University Rotterdam

Acknowledgements

The project took a while to complete, but finally here it is: my thesis for the fulfilment of my Bachelor of Science in Healthcare Policy and Management degree from the Erasmus University Rotterdam. The idea for the topic of an international market in health services originates from my course in Development Economics, which I took at the Erasmus School of Economics. Dr. Annette Pelkmans-Balaoing inspired me with her enthusiastic classes focused on poverty: why are poor countries poor and rich countries rich? We learned how the economic development of countries works and how complicated the current issues poor countries are facing. After class, she would take time to explain how she would go to the Philippines for her dental care and how trade in international (health) services works.

Talking to Ms. Pelkmans-Balaoing, I became interested in health services in low income countries and started reading about the high quality of care in countries such as Thailand, Singapore or the Philippines. I would read about Americans flying to Thailand with their partner to stay at top-tier hotels / hospitals for a tenth of the cost of medical care in the United States. This trade in health services was just common sense. However, the Dutch healthcare system is slightly different, as I found out. Even though Dutch involvement in this market is not yet as far progressed as in the US or Canada, the topic was extremely interesting to research. I would like to use this opportunity to express my deep gratitude to Dr. Pelkmans-Balaoing for her inspiration.

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Abstract

The purpose of this study is to explore current patterns and trends of Dutch patients consuming healthcare services abroad. In particular, the patient group going abroad with the sole purpose of pursuing an elective non-emergency medical treatment, which is about 35-45% of all patients consuming healthcare abroad.

Economic international trade theory explains why producing simple and standardized health services can be cheaper in low-income countries and how the whole world can benefit from trading health services in a global market. However, these economic theories may not be able to tell the whole story. If things were this obvious and straightforward, would not more people have already gone abroad for treatment? To gain a greater understanding on the topic, this study analyzes from a social-constructivist perspective how a global market for health services is constructed, how social relationships build the actual global market, and how human and non-human entities can be acting forces in the construction of tradable health services.

By summarizing existing knowledge, this qualitative case study about Dutch involvement in medical tourism endeavors to inform people to understand how this global market developed and what the gains and risks from trade in healthcare services. Dutch politicians are encouraged to take notice of this study and understand the possible gains for the future, especially regarding the upcoming proposed legislation by Ms. Edith Schippers to withdraw reimbursement outside Europe. In addition, the study suggests that Dutch health insurers seek to establish contracts with health service providers abroad who offer their services at more competitive prices. This way, their role as care path managers can be reinforced.

Literature was reviewed, government policies were studied, and interviews with key experts (e.g. decision makers at health insurance companies) with specific knowledge about the topic were conducted. The interviews were used to support and expand the information obtained from the literature and to build a greater understanding on the topic.

Samenvatting

Het doel van deze studie is om huidige trends onder Nederlandse patienten die voor medische behandelingen naar het buitenland gaan in kaart te brengen. In het bijzonder de groep patienten die naar het buitenland gaat met als enige doel een electieve niet-spoedeisende behandeling te ondergaan. Deze groep is zo'n 35-45% van alle patienten die in het buitenland behandeld wordt, andere groepen zijn bijvoorbeeld vakantiegangers met spoedeisende klachten of expats die voor langere tijd in het buitenland wonen.

Economische theorieën die gaan over internationale handel verklaren waarom eenvoudige en standaard medische behandelingen goedkoper uitgevoerd kunnen worden in lage inkomens landen zoals Thailand of India en waarom het voor de hele wereld voordeliger zou zijn om vervolgens deze met elkaar te verhandelen. Echter is deze economische theorie wellicht niet in staat om het hele fenomeen te uit te leggen. Immers als de voordelen zo duidelijk zijn als de economische theorie voorspelt, zouden er dan niet al meer mensen voor behandeling naar het buitenland zijn gegaan? Om een beter begrip te krijgen van dit onderwerp zal deze studie vanuit een sociaal-constructivistisch perspectief analyseren hoe een concurrerende wereldmarkt voor zorgdiensten kan ontstaan. Hoe netwerken van sociale relaties tussen organizaties, mensen maar ook niet-menselijke entiteiten een sturende rol spelen in de ontwikkeling van deze wereld markt en hoe zorg diensten eigenlijk tot een internationaal verhandelbaar goed worden gemaakt.

Door een overzicht te geven van de huidige stand van zaken en kennis over het onderwerp in kaart te brengen, tracht deze kwalitatieve case study de Nederlandse betrokkenheid te schetsen. Ook wordt er getracht uit te leggen wat de voordelen maar ook eventuele risico's van international concurrentie zijn. Nederlandse politici worden van harte uitgenodigd om kennis te nemen van deze studie en de mogelijke voordelen voor de Nederlandse zorg en toekomst te begrijpen. Met name met betrekking tot het aanstaande wetsvoorstel van mevrouw Schippers om de werelddekking uit het basispakket te halen. Daarnaast zou deze studie Nederlandse zorgverzekeraars willen aanraden om meer gebruik te maken van hun sturende rol als zorg manager, mogelijkheden om te werken met preferred providers verder te onderzoeken en te kijken naar contracten met buitenlandse zorgaanbueders die hun diensten aanbieden tegen aantrekkelijke en competitieve kostprijzen.

Er werd een literatuurstudie verricht, overheids en Europees beleid werd bestudeerd en er warden interviews gehouden met key experts, i.e. representatieve personen binnen de

stakeholders met specifieke kennis over het onderwerp. De interviews werden gebruikt om de rest van de empirische bevindingen uit de literatuur en documenten te ondersteunen en te verbreden.

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List of Abbreviations

ANT	Actor Network Theory
DBC	in Dutch: Diagnose Behandel Combinatie (DRG in English)
DOT	in Dutch: DBC Opweg naar Transparantie (DBC On its way to Transparancy)
DRG	Diagnose Related Groups
ECJ	European Court of Justice
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GP	General Practitioner
HO	Heckscher-Ohlin Model
NPCF	in Dutch: Nederlandse Patienten Consumenten Federatie (Dutch Patients and Consumers Federation)
NTB	Non-Tariff Barriers
OECD	Organisation for Economic Cooperation and Development
SEM	Single European Market
SKGZ	in Dutch: Stichting Klachten en Geschillen Zorgverzekeringen (the Complaints and Conflicts Health Insurance Establishment)
WHO	World Health Organization
WTO	World Trade Organization
ZVW	in Dutch: ZorgVerzekerings Wet (The Health Insurance Act)

CHAPTER 1: Introduction

1.1 Overview

Healthcare expenditure as a share of GDP has risen remarkably in the past few decades. In 2009, OECD-countries spent on average more than 9% of their GDP on healthcare. In 1970, this average was only 5% and by 1990, had already risen to 7% (OECD, 2012).

Prices for medical treatments in developing countries differ substantially from prices for medical treatments in OECD countries (Arunanondchai, 2007; Cattaneo, 2009; Lunt, 2011). These price differences across countries (as shown in *Table 1.1* below) are a major incentive to trade in these services. Price differences are largely caused by differences in labor costs. Because of this trade, consumers gain access to a greater variety of health services (Mattoo, 2008:84). Mattoo and Rathindran (2006) estimated that US healthcare could save USD 1.4 billion annually if one in ten patients were to go abroad for a limited set of 15 highly tradable, low risk, elective, non-emergency treatments.

However, health services are different from other professional services. Health is a public good and governments regulate domestic healthcare markets in order to protect their citizens. A side-effect of domestic regulation is that it often works as a barrier to international trade. By liberalizing trade in health services, economists predict that there would likely be substantial gains (Mattoo, 2008:19,104,128).

In an economic period where healthcare budget deficits add directly to the national debt and where European governments are constrained by austerity measures (Stuiveling, 2011:11), the promised gains from international trade in health services and healthcare liberalization are worth exploring. This study will examine the construction of a global market of health services from a socio-constructivist perspective and will focus on the social processes by which medical treatments become tradable, how this market is performed by its actors and how the Dutch healthcare system can save money by bringing Dutch demand and (cheaper) foreign supply together. A central aim of this study is finding out how the Netherlands is involved in trade in health services and how these contemplated gains from international trade theories can accrue to the Dutch healthcare system.

Besides the theoretical aims, this study will examine the likelihood of Dutch health insurance companies contracting with foreign hospitals. Since choice for trade liberalization

(i.e., economic integration strategies) is in most instances dictated by political considerations, politicians are encouraged to take notice of this thesis and understand the long-term benefits of trade in health services in a global competitive market.

Table 1.1 Comparative Costs Surgical Procedures

	Costs in USD				Costs compared to the USA		
	USA	Singapore	Thailand	India	Singapore	Thailand	India
Heart bypass	130000	18500	11000	10000	14.2%	8.5%	7.7%
Heart valve replacement	160000	12500	10000	9000	7.8%	6.3%	5.6%
Angioplasty	57000	13000	13000	11000	22.8%	22.8%	19.3%
Hip replacement	43000	12000	12000	9000	27.9%	27.9%	20.9%
Hysterectomy	20000	6000	4500	3000	30.0%	22.5%	15.0%
Knee replacement	40000	13000	10000	8500	32.5%	25.0%	21.3%
Spinal fusion	62000	9000	7000	5500	14.5%	11.3%	8.9%

Source: Cattaneo, The World Bank, 2009.

1.2 Problem Analysis

The development of a global health services market is a long and complex process. What makes the development of an international market even more complex is that health is a public good and governments therefore regulate national healthcare markets. This domestic regulation causes barriers to trade in these services. However, recent trade patterns do show signs of an existing global market where encounters between demand and supply are somehow organized. Patients from developed countries travel more and more to developing (i.e., low income) countries. However, estimates about the magnitude of this trend vary greatly between sources. The World Health Organization ("WHO") estimated that the number of patients annually seeking care abroad is up to 4 million worldwide, with a global market value estimated at USD 20-40 billion annually (Cattaneo, 2009). Popular destinations for medical tourism include Thailand, the Philippines, Singapore, and India.

These recent trade patterns are mainly driven by low-cost, high-quality treatments and cheap flights (Lunt et al., 2011:6). Other drivers that create incentives for going abroad are waiting lists in the home country. Quicker access, the presence of more highly skilled health personnel, access to more sophisticated medical technology, differences in institutions and legal and regulatory systems are all factors that create incentives to trade. However, demand and supply are being brought together more frequently, while levels of Dutch patients going abroad are still relatively small. Research by NIVEL (2012) shows that of all patients, only 3% go abroad for medical treatment. However, if patients had been offered the choice to pursue medical treatment abroad, 58.1% would do so. The survey

supports the notion that patients are largely unaware of the possibilities of going abroad for medical treatment.

The actual number can partly be explained by the misconception that the sick cannot travel and so care should be delivered at home (Mattoo and Rathindran, 2006:359). In some instances, this is indeed true. For example, patients using emergency care cannot travel abroad. Also, where patients are physically unable to travel, medical care needs to be delivered close to home. However, there are many types of treatments that do not necessarily need to be delivered close to home. For example, for a knee replacement or eye surgery, patients can wait and travel. Another misconception is that the quality of care abroad (e.g., Thailand or India) is inferior to that provided by in industrialized countries. In fact, many doctors practicing in development countries have been educated or trained at leading medical schools and research hospitals in the United States or the United Kingdom. In the United States, one out of four medical graduate students are of foreign origin (Ibid.:359) and a substantial percentage intend to return to their home countries post-graduation to practice. Moreover, it is not the average quality of care in developing countries that is comparable to medical care in OECD countries. Only the top medical institutions (e.g., Bumrungrad in Bangkok, Thailand; or Apollo in New Delhi, India) treat foreign patients and have internationally educated doctors and nurses, with extremely high surgical success rates.

One key difference that makes health services different from other professional services is that the average consumer does not pay for the provided services. Generally, it is the government or the private health insurer. In the Dutch healthcare system, health insurers are legally responsible (Healthcare Act; in Dutch: Zorgverzekeringswet, 2006) to organize care for their insured clients and to reimburse medical care, depending on their contract with the client. This means that health insurers have the power to decide whether or not to reimburse costs for health services obtained abroad. In a recent article, Mattoo and Rathindran (2006) point out that a big barrier to trade in health services is this portability of health insurance. Health insurers often discriminate explicitly or implicitly against treatment abroad. However, because health insurers in the Netherlands are still heavily regulated by the Dutch government, this might indirectly be caused by a different agenda than their own.

A central issue in government (trade or healthcare) policy is that it is dictated largely by political considerations, not economic free trade theories that are poorly understood by most politicians. Free trade is often opposed by Keynesian economists, mercantilists, or economic nationalists. Paul Krugman, a renown American economist, often tries to explain the misconceptions about free trade and the theory of *comparative advantage*. According to

Krugman (1996) it should not be assumed that people understand nor accept the idea of the *comparative advantage* because it is relatively complex. This lack of understanding can cause a bias towards more protectionist policies.

Snyder et al. (2011) researched trade in health services in Canada. Similarly to the study conducted by Mattoo and Rathindran (2006), Snyder et al. identified problems with health insurance coverage as an obstacle to trade in health services. Another driving force that was identified was facilitation (brokerage) companies. These were able to raise awareness through advertisement and marketing mailings. Moreover, foreign hospitals selling health services were able to raise awareness through seminars and conferences. These are among what Michel Callon (2005) calls calculative economic agents, non-human actors that can steer human behaviour in certain directions. In this case, these actors increase trade for health services abroad. According to Callon, these actors are important to organize encounters between demand and supply, patients and health service providers.

But the economic and socio-constructivist perspectives do not necessarily contradict one another in researching the development of a global market for health services. Both perspectives have added value in the construction of such a global market. In economic trade theories, much emphasis is placed on the adverse effects of trade liberalization whereas these in socio-constructivist, in researching social processes, often get less attention. In the socio-constructivist view, the development of a global market is continuously in action and adverse effects are seen as the starting point of new developments, whereas in the economic view, these adverse effects are perceived more static and unchangeable. The question remains whether trade or healthcare policy needs to be readjusted, or whether the perception of the effects needs to be readjusted.

A central aim of this study is to finding out how the Netherlands is involved in trade in health services and how these promised gains from international trade theories can accrue to the Dutch healthcare system. The focus will be on social processes, relationships, and medical technologies which drive the development of a global market and make health services tradable.

1.3 Problem Statement

It is the recent trend of patients from industrialized, high-income countries travelling to low-income countries for medical services that prompted this study. Although economic trade theories explain a lot about trade patterns, they perhaps focus too much on their

models and too little on social processes and other aspects that can play a role in the development of a global market for trade in health services. That is why a socio-constructivist perspective is used and led to the following problem statement and sub-questions.

> "*If a foreign country can supply us with a commodity cheaper than we ourselves can make it, better buy it of them with some part of the produce of our own industry."*
> (Adam Smith, 1776 cited in Irwin, 1996:79).

In the light of both economic and socio-constructivist perspectives, the question driving and guiding this explorative study is:

> *"How is the Netherlands involved in (the construction of)*
> *the global market for health services, and will this change in the future?"*

To further uncover the topic and to get an idea how the Netherlands is involved in medical tourism, the next sub-questions will help guide the research and will help uncover an answer to the central problem statement / research question.

i. "*How has demand and supply in the healthcare market changed over time?*"

ii. "*What is the tradability of health services?*"

iii. "*What opportunities and threats do the ministries, health insurance companies, patient groups and brokers see?*"

iv. "*How could trade in health services be further fostered / encouraged?*"

These sub-questions will be used as a starting point for the analysis of the theory. Finally, based on the findings to these sub-questions, the research question will be answered.

CHAPTER 2. Theoretical Framework

2.1 One Case Study, Multiple Perspectives

Traditionally the topic of trade in (health) services is explained by international economic trade theories. These theories comprise two major concepts: comparative advantage and increasing returns to scale. Both concepts are explained by multiple factors. However, linear economic models are not sufficient to explain a phenomenon that is more complex and liquid than these rigid models are able to show. Based on those economic concepts, one would expect a lot more trade in international health services. The development of a (global) market of health services is a long and complex process. To assist, I will also use a different tool: the socio-constructivist perspective. Michel Callon (2005:1230) writes: "*solely an economic analysis of how the law of demand works can be too abstract and formal*." In this socio-constructivist perspective, there is more emphasis on the complexity of processes. Bruno Latour and Michel Callon were the first to develop a new approach to social processes: the Actor-Network-Theory ("ANT") (Latour, 1987). From this perspective, not only humans but also things can be actors, with for example new technologies having the ability to steer human behaviour in certain directions.

Before starting on the economic concepts of international trade, a theoretical history about trade in the Netherlands will be examined, followed by concepts of international trade theory (the economic perspective) and an explanation for what it is that makes health services different and why it is not just any commodity or service. The last part of this chapter will contain the concepts from the development of markets and tradable goods from a socio-constructivist perspective.

2.2 Economic Perspective

2.2.1 Mercantilism

The Netherlands has a rich history of international trade. Trade expanded strongly and flourished in the 16th and 17th century following the creation of the Dutch East India and West India Companies. During this period, the Netherlands became an international hub in shipping, finance and trade (Israel, 1989). The Golden Age in trade (science and art) is sometimes referred to as regarded as the age of *mercantilism* (Irwin, 1991:1297). Mercantilism is the economic belief that gains from international trade will arise from increasing exports and decreasing imports. Mercantilism implies that international trade

gains are a *zero-sum game*. A zero-sum game in international trade presumes a fixed amount of world wealth. A frequently used metaphor is a pie with fixed world wealth, which can be divided into pieces. Any piece one party wins, another loses.

In mercantilist economies, governments have a fierce (protectionist) role in the regulation of trade, by subsidizing exports, and charging tariffs or imposing non-tariff barriers (NTB) on imports. This way, governments ensure gains accrue to themselves and protect their own (infant) markets. In contrast to mercantilism, Free Trade Theory does not believe that world wealth is fixed, but that wealth can be created by increased labour and productivity. The next section will explain how Free Trade trade works.

2.2.2a Free Trade - Comparative Advantage

In his book *The Wealth of Nations* (1776), Adam Smith criticized mercantilism and encouraged free trade. According to Smith, mercantilism would lower overall wealth levels. Theories of international trade are based on Smith's (international) division of labour. Like the division of labour in the pin factory, illustrated in Smith's book, the world could be seen as a factory which produces a wide range of goods. If each factory worker would specialize on just one task, the total number of goods produced would be far greater than that by one (unspecialized) factory worker producing a range of goods. If countries, like factory workers, would specialize in specific goods and then trade, the total world output would exceed the sum of autarkic produced output by the individual countries.

Where Adam Smith took absolute advantage as a starting point for trade, David Ricardo (1817) showed that even when looking at two countries, with one country having an absolute advantage in producing both goods, both countries could still gain from trade. The good in which a country should specialize would be the good which the country has the least absolute disadvantage and the greatest absolute advantage: *the comparative advantage*.

At the beginning of the 20th century, Eli Heckscher and Bertil Ohlin came up with their Heckscher-Ohlin (HO) model. Whereas Ricardo only assumed one factor of production: labour, the HO-model is more elaborate. The HO-model assumes multiple production factors (e.g., labour, land, capital, natural resources). Different goods require different factors in the production process, which can lead to price differences. Technological, institutional, or legal differences can be important as well when it comes to the trust and confidence one has in the production. That together with the price differences will create incentives to trade (Mattoo, 2008:88). This way, countries can still develop a comparative advantage. Countries will specialize in those goods which require a relatively large amount of the factors of production

that they are well endowed with. Furthermore, the model assumes that all countries will have equal access to choose production techniques but the actual choice will depend on the *factor price* within that country.

However these theories are not perfect. They can show unrealistic predictions of trade patterns and cannot explain trade occurring between countries with similar technological levels. But they do still explain motives for trade between developing and developed countries. We present a short example to better illustrate what happens when developed and developing countries trade. Assume that two countries, let's say the Netherlands and Thailand, produce two goods / services, a hip replacement and a complex spinal surgery, and there is only one production factor: labour. *Table 2.1* below shows the units of production factors required to produce a unit of output (passed surgeries).

Table 2.1 Comparative Advantage: Units of Labour

Number	Operation	Netherlands	Thailand
10	Complex spinal surgery	2 units	4 units
100	Hip replacement	3 units	4 units

Even though the Netherlands may have an absolute advantage in producing both hip replacements and complex spinal surgeries, Thailand has a comparative advantage in providing hip replacement services. It costs more to produce hip replacements in the Netherlands than in Thailand given that there is an implicit cost of providing hip replacement services in the Netherlands. There is an *opportunity cost* of not being able to provide complex spinal surgeries that would otherwise have been possible. Using three units of labour required to produce 100 hip replacements in the Netherlands required sacrificing the production of 15 complex spinal surgeries. Using the four units of labour required to produce 100 hip replacements in Thailand required sacrificing only 10 complex spinal surgeries. The comparative advantage is the compared difference in what has to be sacrificed. Thailand produces hip replacements for only two-thirds as much as it costs in the Netherlands. The Netherlands can produce 10 complex spinal surgeries for each 66 hip replacements, while Thailand can produce 10 complex spinal surgeries for each 100 hip replacements.

2.2.2b Comparative Advantage in Health Services

From the economic perspective, goods and services differ from each other. Key differences in economic terms are that services are highly heterogeneous, services require intense skilled labour, and they require high initial investment in education for the necessary expertise (Markusen, 2005). Health services especially are labour intensive. Skilled wages in

developing countries are relatively low compared to skilled wages in developed nations. Because of the initial investment services require, countries with substantial capital will have a comparative advantage in producing (health) services (Hindley & Smith, 1984:386).

Wages in developing countries are lower, but also the costs for (health) education. Developing countries well-endowed with a large group of skilled health professionals have a comparative advantage to developed countries and have the potential to combine health services with tourism. Also, the quality of the health facilities can be a part of a country's comparative advantage (Blouin, 2006). However, in contrast to goods, trade in services is directly correlated with trust in the supplier by the consumer (i.e., Dutch health insurers and patients). Because (health) services are tailored to a "consumer's need' and "consumer intensity", it is important for developing countries to develop a good governance and regulatory framework, for example by obtaining international accreditation, if they wish to develop a comparative advantage (Marel, 2011:25). Similarly, Cattaneo et al (2009) emphasize a good reputation and qualified health labour force. These are not built overnight and require investments on education, training, equipment and facilities if countries wish to develop a comparative advantage. Cattaneo (2009) argues that an international quality standard will be necessary to ensure patients of the best quality care abroad.

2.2.3 Free Trade – Increasing Returns to Scale

Whereas *comparative advantage* was able to explain why patients from the United States would go for treatment in Thailand or Singapore or British patients would go for treatment in India, increasing returns to scale will explain why trade between similar countries occurs.

There are four ways scale effects can cause trade: (i) through the market niche effect, (ii) through the development of firm specific intangible assets, (iii) through agglomerations, and (iv) through networks. Before we analyze there, it would be helpful to understand three key mechanisms: (i) gains from specialization, (ii) fixed costs, and (iii) the element of lock-in. Mattoo (2008:93) uses an example of the labour market to explain this.

Two students have equally intelligence and equal learning capabilities. They do not yet have a comparative advantage, because they are identical. However, when one chooses to study medicine and the other chooses to study engineering, they develop different skills. They now have the opportunity to trade medical services for engineering services, and vice versa. Their comparative advantage as a *gain from specialization*, has evolved over time. By specializing in one field and then trading their services both students avoid having to pay the

fixed costs for their education twice. To be good in any of these services a large up-front investment in education and skills is required. They could as well both spend their time half being an engineer and the other half of the time a doctor. However this way they will never be able to specialize as good. The up-front investments in education create an element of *lock-in* because once made, it is very costly to switch fields. Therefore past decisions and investments (or e.g. government policies) matter for current and future trade.

Market Niche Effect

The market niche effect means that a firm will produce a specialized variety of goods/services if product variety is being valued by its clients. This is primarily so in larger markets where it is easier to cover the large fixed costs for the establishment of a market niche. In (health) services, many services are tailored to individual patient needs and so product variety is a large element in this kind of services trade. Larger markets allow the development of new services that otherwise would not have been available.

Development of Firm Specific Intangible Assets

Another way scale effects can generate trade via foreign direct investments (FDI) is if firms have developed specialized firm-specific assets, knowledge of organizational or production processes, distribution and supply networks, reputation for quality and reliability (Mattoo, 2008:95).

Agglomeration

Scale effects can cause incentives for trade through agglomerations, i.e. concentration of a particular industry or a multitude of economic activity in a specific area/city/region. This way 'cores' and 'peripheries' of certain (health) services can emerge. There can be spill over effects across hospitals/industries or positive externalities, e.g. knowledge spill over or the access to a common pool of specialized health workforce. Infrastructure can emerge to meet the needs of patients who need a hip replacement and need to use related services too.

Networks

Incentives to trade can be generated through access to large networks. Often the quality and benefits to consumers of (health) services are the result of having access to networks of other consumers and producers. Therefore a critical mass is needed. For example, telephone or e-mail services became standard communication tools after a critical mass had adopted it and had access to it. When a critical mass has been reached, there are enough patients travelling in the global market for health services for positive feedback

effects associated with network externalities to really kick in and for trade in health services to takeoff on a larger scale. Until the critical mass has been reached, there might be doubts about whether the health services in low-income countries will be establish and patients in developed countries may be reluctant to go abroad.

2.2.4 Why are Health Services Different?

After having explained the economic theories on international trade, it is useful to once again point out why trade in health services is different from trade in any commodity or other professional services. Health is a public good and trade in health services has greater objectives than just increasing revenues or maximizing profits. Trade objectives in the health service sector should be consistent with other legitimate social objectives of the Dutch healthcare system, e.g. universal access, solidarity, quality, affordability and efficacy. In healthcare there is, even more crucial than in other professional services, a large asymmetry of information between the professional (doctors) and their patients. Therefore the profession is highly regulated and there are more numerous and complex NTBs than in other service sectors, to protect patients from any kind of malpractice (Smith, 2006:326). Trade in health services does not require health systems to be deregulated, but be better or sometimes even more regulated. For example, in order to assure better quality standards of foreign healthcare providers. The aim is to create efficient health services in a more competitive global market environment (Cattaneo, 2009:3).

2.3 Socio-cultural Perspective

As opposed to the previous paragraph, this chapter will focus on the international market of health services where trade occurs, in a way social scientists like to refer to it; as a process, something that is continually in action (Callon, 2002). It will focus on the entities that mobilize humans and non-humans, explaining how the international market for health services works, how health services actually become tradable, and finally show that the purchase of a medical treatment abroad is the result of social processes (Callon, 2005).

In their work “Economic Markets as Calculative Collective Devices”, Michel Callon and Fabian Muniesa (2005) explain how markets are socio-technical devices that produce or render markets through processes of attachment and detachment, entanglement and disentanglement (McFall, 2009:267). I.e. market processes bring e.g. medical treatments (an economic object) into being a tradable health service. Callon and Muniesa (2005:1230) claim that the observable rationality and the calculative behaviour of market agents are marginal,

and at best an ex-post rationalization for choices grounded in other logics, which will be explained throughout this section.

In their work, Callon and Muniesa (2005) describe how markets contain three elements: (i) calculable goods, (ii) calculative economic agents; and (iii) calculated exchanges/encounters. The remainder of this chapter will follow a similar structure. I will start with the calculability of goods, i.e. the tradability of health services.

2.3.1 The definition of Goods, Services & Products

The World Trade Organization ("WTO") defines globalization as the deeper integration of product, capital and labour markets. In this same economic view, product markets in healthcare are actually service markets, not good markets. Economists distinguish services from goods with several characteristics (e.g. the (in)tangibility and the (in)visibility of services). An element that both economists and sociologist like to use to define a service is the *required (social) interaction* between producers and consumers in order to produce the service (Mattoo, 2008:85; Callon, 2005:1233).

Social-anthropologists make another distinction between goods and services. A distinction which is often missed or the concepts are used interchangeably in the vocabulary of economists (Callon, 2002:197). In this sense, a good is the aim of any economic activity is to satisfy needs. A *good* is a moment in time (a state) in the career of a product and a *product* is a good seen from the point of production, circulation or consumption (a process) (Ibid.:200). A medical treatment (product) is a sequence of transformations, different networks co-ordinate the actors involved (hospitals, health insurers, doctors, nurses, the emergency room, scalpels etcetera) in the design, production, distribution and consumption of the medical treatment (Ibid.:198).

Another way of defining concepts, is in anthropological and legal sense, here a good is a 'thing'. And a good first has to be transformed into a thing, this is called *objectification*, before it is able to be the object of a market transaction. How then is a good or a health service objectified? A health service can be defined by a combination of characteristics that establish its singularity, e.g. the Diagnose-Related-Groups (DRG, in Dutch: DBC, Diagnose Behandel Combinatie). All DBC's or DRG's together are a system of differences and similarities, of distinct and yet connected categories (Callon, 2002:198). Because agreement on the definitions of the characteristics is often hard to achieve and because the definitions of the characteristics continually change as the product develops and changes, it is called a process of qualification and requalification, e.g. DOT-products (DBC On their way to

Transparancy, in Dutch: DBC Opweg naar Transparantie). During this *process* of qualification, characteristics are established, stabilized and attached to the product, whereby it is temporarily transformed into a tradable product in the market. Another word for this social process where things come to be treated as things in the social world is materialization.

Singularizing Medical Treatments

On the demand side, consumers perceive and evaluate differences between products, they qualify and classify them. The singularization through consumers' participation in the qualification of a (health) service depends on the perception of the differences against the background of similitude. Patients compare and evaluate for example a similar hip replacement procedure in hospital A in the Netherlands, versus a similar treatment in hospital B or maybe even abroad. Consumers are guided and assisted by material devices which act as a point of reference and which distributes information. Examples of such material devices can be the rankings of Dutch hospitals in Elsevier magazine or the newspaper Algemeen Dagblad, which Dutch patients can consult. Patients make judgments through comparison and explanation of differences, and such comparisons suggest the existence of a complex socio-technical device that supports the patients in their evaluation work (Callon, 2002:204).

On the supply side (re)qualification can concern the content/quality of the medical treatment (the materiality of the product) or its presentation through advertisement. E.g. advertisements about the quality service of medical treatments in foreign hospitals. This profiling of products, if done correctly, results in the qualities of products which match to the qualities consumers want the products to have and ends with the consumers' attachment (Callon, 2002:205).

What has to be done with health services is, the products first need to be objectified, turned into a thing, a medical treatment. Next the medical treatments need to be singularized, the medical treatment has to get properties which are adjusted to the buyer's world. I.e. for example certain quality standards have to be met before patients are willing to undergo a medical treatment somewhere (Callon, 2005:1235).

Attachment and Detachment

Consumers caught up in routines are consumers attached to certain products. Patients who always go to the same doctor for their plastic surgery are attached to him or her. Their judgment about differences are stabilized and objectified. They know the quality of

the doctor, his team, the hospital, the operating room, scalpels etc., all together performing the medical treatments. A consumer's preference where to undergo treatment is tied to an apparatus of distributed cognition, this contains information and references spread out between many elements (Callon, 2002:205). Health service providers (abroad) can try to reconfigure the socio-cognitive apparatus of patients and detach them from rival competitors in the home country and reattach patients to their own products. This is by repositioning a product e.g. plastic surgery in a way that it becomes visible to consumers, so patients have to re-evaluate their choices and their attachment.

2.3.2 Calculative Economic Agencies

Health services are not tradable on their own. There are individuals, organizations and other *non-human* entities that turn a medical treatment into a tradable or 'liquid' one (Carruthers, 1999:358). The tradability of medical treatments cannot be seen as some sort of status quo, the development of tradability depends on interventions or regulations. Carruthers (1999) calls these entities "market makers". These can be specific institutional features, organizational activities, individuals, contracts or other instruments that take a medical treatment and make it liquid or tradable. Tradability is configured by these market makers. In the case of this study, an example of such a market maker is the European Directive on the application of patients' rights in cross-border healthcare, it makes a medical treatment in Germany for example tradable.

Callon (2005) refers to these market makers as the "Calculative economic agencies." These market makers are the acting forces that create the tradability of medical treatments. *All the operations* of making a medical treatment tradable are operations involving humans and *non-humans*. These centres of calculations, as Latour (1987) refers to them, are equipped with instruments. These instruments are the result of a process where "*agents are faced with complicated tasks that, to relieve their brains and enhance their performance, they conceive of tools, create rules and routines or set up organizations to calculate for them*" (Callon, 2005:1236). But these instruments are always used by the agencies in action, i.e. mobilizing the European Directive is the work of agencies (brokerage firms, patients, airlines, doctors or regulation) in action. Simply by being there, the European Directive does not do anything. It is the patients that take action, use it in order to get cross border medical treatment reimbursed. They materialize the European directive and bring it into being.

2.3.3 Calculated Exchanges

As the last of three elements defining concrete markets as organized collective devices that calculate compromises on the value of goods, (the others are the calculable

goods and calculative agencies), the *calculated encounter* or *exchange* is a particular architecture of an exchange. The positions and relations between the transaction and the agents depend on it. They are mechanisms of encountering, organizing the encounter of calculative agencies. Callon (2005:1242) mentions two examples of such calculated exchanges, e.g. the space of a supermarket or mailing lists which are coupled with telephones and directions for contacting potential customers.

Algorithmic configurations of markets, as Callon (2005:1240,1243) calls them, do not exist as present structures in which calculative agencies simply circulate and develop. Agencies are often involved in the design and negotiation of architectures that organize market encounters. For example, health insurers themselves create a structure on how the insured can make a request to go abroad: approval by email or a certain form or another procedure.

The possible options for organizing encounters between demand and supply, buyers and sellers, patients and hospitals are diverse. In this view, the structure of an aggregate market is the result of a large number of singular market transactions. And it is those individual market transactions that define the structure, and not the frame defining the rules and format of those transactions (Callon, 2005:1244).

As you can see in the transactions, i.e. the international trade in health services, it is an abstract market and it therefore requires efforts in abstraction. There is no frame defining the structure of the transactions.

CHAPTER 3: Methodology

3.1 Research Strategy

To be able to chart the topic of trade in health services in a broad explorative way, the research has a qualitative design. The research is conducted as a case study, where the case is the Netherlands in the context of the European and global health services market. "*Case studies are the preferred strategy when "how" or "why" questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context*" (Yin, 2003:1). As the research question guiding this research "*how is the Netherlands involved*" and as the researcher does not have any control over the trade currently happening, this research strategy seems appropriate to contribute to the current degree of knowledge. Case study as a research design allows to retain a holistic and meaningful characteristic of a real-life event (Yin, 2003:2), which in this case is trade in health services.

3.2 Research Methods – Data Collection

In case studies, researchers combine multiple sources of evidence to increase the quality of the research. In this research, a literature study was conducted, which explains definitions and concepts of an international market for trade in health services. It places the economic perspective in contrast to a socio-cultural perspective.

The second source of evidence was (semi-structured) interviews, conducted in Dutch. For the interviews, several stakeholders in the international trade in health services were approached. These include representatives of health insurance companies, government officials of the ministries of economic affairs and health, patient groups, and (broker) entrepreneurs. The aim was to interview 8-10 persons in total, but at least 2 health insurers, 2 government officials, 1 patient group and 1 brokerage firm. It proved difficult to find people willing to undergo an interview. Finally there were 9 interviews, 3 health insurers, 2 government officials, 1 patient, 2 brokers and 1 health service provider (situated in Spain).

Last, documentation was used as a source of evidence, e.g. evaluation studies or progress reports. (European) Government or insurance company's documents were tried to retrieve in order to be able to estimate possible gains, but no such documents on the amount of annual Dutch patients pursuing healthcare abroad were found. Several government documents were retrieved. But overall it seemed hard to realize since the topic of trade with developing countries is not yet widely discussed and relatively new.

According to Yin (2003:85), a good case study will want to use as many sources as possible since various sources are highly complementary. Because of time restrictions, this bachelor thesis has tried to find an answer as complete as possible to the central question by using these three sources.

3.3 Research Design

The research design is the "logical plan" for getting from the initial set of questions about trade in health services to the conclusions (answers) about Dutch involvement in the phenomenon of international trade in health services. It is a blueprint for the research and it structures the following difficulties for the case of Dutch consumption abroad: (i) which questions need to be address, (ii) what data is relevant, (iii) what data is worth collecting and how to analyze the results (Yin, 2003:21). In order to guarantee the quality of the research design, there are four key criteria: (i) internal validity, (ii) external validity, (iii) reliability, and (iv) construct validity (Ibid.:34).

Internal validity

Measures the quality of the causal relationship between certain conditions leading to other conditions and whether conclusions are drawn from the actual collected data. The internal validity is weak if conclusions are not supported by the data. Relevant during the data analysis was to use a technique of explanation building, a special type of pattern matching.

External validity

External validity is dependent on the degree to which the findings from this research can be (more broadly) generalized. In this case, the context problem makes it hard to draw general conclusions. Even when the same techniques are used, it might prove to be hard to reproduce a similar result because every case or country is specific. However, the use of multiple sources of evidence used increases the external validity.

Reliability

By having developed a case study protocol and a topic list for the interviews, the operations of the study can be repeated (e.g. data collection procedures) with the same results, which will increase the reliability of this study. However, one should be vigilant that it might prove to be hard to reproduce the exact same results. The research instruments were carefully chosen to assure that they would measure what was needed to be measured. The

last measure to assure reliability was the use of multiple sources of evidence (i.e. literature study, documentation and interviews) (Yin, 2003:97).

Construct Validity

In order to guarantee the construct validity, there are usually several key informants who review the draft case study report. However, because this study is written in the fulfilment of a bachelor degree, the study is conducted by only by one person, and therefore construct validity is relatively harder to guarantee. Nevertheless, the researcher has held an extra-critical position in the execution of the research, by analysing the information from multiple theoretical perspectives. According to Yin (2003:97), using multiple sources of evidence also helps dealing with the problems of establishing the construct validity.

3.4 Research Instruments

During the data collection, the interviews were a great source of evidence. This paragraph will describe how the research instruments were developed and which precautions were undertaken in order to guarantee validity and reliability.

Interviews – Electing Interviewees

Because the attitude of stakeholders involved in the process of trade in health services can tell us a lot about the likelihood or possibilities for current or more trade in the future, interviews were a main source of evidence in explaining how the Netherlands is currently involved in international trade in health services. Interviews are essential because most case studies are about human affairs and trade in healthcare in particular is performed through and for humans (Yin, 2003:92).

The first step was to identify the stakeholders; the second step was to find key informants within these organizations. Since the case here is the Netherlands, most stakeholders were Dutch, except for one healthcare provider located in Spain treating Dutch orthopaedic patients. There were several relevant actors identified in the healthcare market. These were health insurance companies, healthcare providers, patients and regulators. After the initial first contact with a key informant within a health insurer (VGZ), it was clear that brokerage companies play an important role too. The government regulators can be divided between the Dutch Ministries of Economic Affairs, Health, and Foreign Affairs. But because the Dutch Ministry of Health was understaffed, they did not have time for an interview. Patient groups were targeted, since patients' experiences are important as well.

A prerequisite for the key interviewees is that they possess knowledge about the topic and are representative for the actor. The selection of actors, as well as the selection of interviewees within the actors was often accomplished through the snowball effect, i.e. through references.

Actor	Key informant
VGZ	Via Google and news publications on medical tourism to Spain, the key person within the health insurer VGZ was found and contacted by e-mail.
Zorgloket Duitsland	Via the key informant within VGZ, the name and contact details were acquired of the key informant within this brokerage firm. The person was contacted by mail and telephone and asked to be available for an interview as a key informant.
Medical Travel Spain	Via the website of the care provider, the key informant was contacted and asked to be willing for an interview.
Holland Inter Care	Via the key informant within Medical Travel Spain, the name and contact details of the key informant were obtained.
Ministry of Foreign Affairs	Via a general inquiry e-mail a request was made for a key informant within the organization the press officer gave us a name and contact details. The person was asked to be a key informant for an interview on the topic.
Ministry of Economic Affairs	Via the key informant within the Ministry of Foreign Affairs the contact details of the key informant within the Ministry of Economic Affairs were obtained.
CZ	From Medical Travel Spain it was understood the health insurer sometimes could complicate reimbursement. Therefore via Linkedin looked for CZ employees in the department of care procurement. Via Google the e-mail address of one person was found and was asked for the contact details of the key informant on this topic.
~~NPCF~~	NPCF was e-mailed and the subject of this study was explained. However, they responded that there was (not) yet a patient group specialised in medical travel.
~~Ministery Health~~	Same way the Ministry of Foreign Affairs was contacted, the press officer forwarded the topic list for a written interview but due to time constraints and shortage of people within the Ministry they never were able to finish it.
Achmea	Through LinkedIn, looked for Achmea employees in the department of care procurement and via Google the email address was found of the key informant.
Patient	Through the secretary of a patient organization for patients with back issues (Nederlandse Vereniging van Rugpatienten, NVVR) a volunteer from the organization with an experience of two back surgeries in Belgian hospitals was found and contacted.

NB: The NPCF and the Ministry of Health were not interviewed and for that reason have a strikethrough.

All actors were approached as described above. The reactions were varied. Certain key interviewees were more willing to have a conversation because the previous interviewee had already introduced me. For Medical Travel Spain as well as CZ and the patient, these

interviews are in written form, out of convenience due to geographical distance (Spain) and time constraints.

Interviews – Design

In the appendix, the topic list for the interviews can be found. The topics/questions were formulated objectively, without influencing or steering answers in any direction. The interviews started with some questions to understand the role of the interviewee within the organization and his/her relation to the topic. This way it could be verified whether the interviewee indeed was a good key informant.

"*The interviews will appear to be guided conversations rather than structured queries, and fluid rather than rigid*" (Yin, 2003:89). This means that the researcher followed a certain line during the open-ended interview but as well kept an eye on asking questions in an unbiased way (Yin, 2003:90). The emphasis was on questions "how" rather than "why", to avoid creating defensiveness and to maintain a friendly and non-threatening attitude. Open ended questions were asked about facts as well as opinions. As there were multiple interviews with similar stakeholders, it was important to follow the same procedures and line of enquiry. For the written interviews, the interviews were more rigid than the conversations, but it was made explicit that how things evolved was more important than why. Moreover, after the written versions of the interviews were received, there were taped follow-up phone calls where ambiguities were clarified and were the non-threatening attitude was maintained.

3.5 Analytic Strategy

The most preferred strategy is to follow the theoretical propositions that led to the case study (Yin, 2003:111). The theoretical orientation (economic trade theory and socio-cultural theory) that has guided the case study analysis, helped to focus attention on certain data and to ignore other data (Yin, 2003:112).

To analyze the data, there was one specific analytic technique, which is mainly relevant to explanatory and exploratory case studies (Yin, 2003:120). As one of the aims of this study was to explore how the Netherlands is involved in trade in health services and why it is not yet happening on a scale one would expect based on the theory of free trade, the analytic technique to analyze the data was *explanation building*. This is a special type of *pattern matching*. When explaining a phenomenon is an aim, one needs to stipulate a presumed set of causal links (Yin, 2003:120). To explain all complex and difficult relationships of the health sector in the Dutch economy, and the Dutch economy in the Single European Market and Europe in the global market, these had to be described.

Hopefully, the offered insights might lead to (trade and health) policy propositions. Or to the withdrawal of legislation proposed by Ms. Edith Schippers to eliminate worldwide coverage from the basic health insurance policy. The process in the explanation-building technique has an iterative nature and the eventual explanation was the result of a series of iterations (Yin, 2003:121).

After conducting the interviews, these were typed out in full quote. The interview with a healthcare provider in Spain was not taped and only existed out of notes. Another interview with a health insurer did not have a transcript due to time constraints, but based on the notes, the relevant quotes were obtained from the taped version and then fully typed out again.

The results from the interviews were categorized based on the sub-questions asked in this study and the topic list. Both the sub-questions and the topic list had a theoretical orientation. These categories consisted out of paragraphs and loose sentences from the transcripts. The labels were manually appointed. The labels were: (i) the attitude of the different actors towards trade in health services, (ii) the tradability (in terms of calculable goods, calculative economic agencies and calculated exchanges), (iii) opportunities and threats.

The significance of the information in the transcripts was judged by the frequency how often things were mentioned by different actors or the importance an interviewee appointed to a topic. After the coding, it was judged which themes and answers could serve as actual results. To include results, it was important to what extent the results from the literature and documents were supported, rejected or which new information from the interviews was relevant.

CHAPTER 4: Results

In this chapter, the results of the research will be shown. The data will be analyzed from a socio-constructivist view, with a focus on the concepts of calculable goods, calculative economic agents and calculated exchanges. It will zoom in on how things are the result of socially constructed relations. The results will partly be structured in the same sequence as the sub questions; the attitude of actors, the tradability of health services and the opportunities and threats for the (construction of a) global market of health services.

Together, the results from the literature study, the interviews and the documentation will be shown. The results from several sources will be used interchangeably in order to maintain the line of telling. In general, paragraphs will start with literature or documentation findings and will end with findings from the interviews.

4.1 Attitude of the Actors

Because the attitude of actors involved in the (construction of a) global market of health services indicates a lot about how processes and relationships are constructed, it has the ability of giving insight in how relationships or processes might have to be altered for a more efficient market outcome or more transactions.

The results will be divided between first the patients, second the Dutch government, third the Dutch healthcare providers, and last the health insurance companies.

Dutch Patients

Research conducted by NIVEL (2012) showed that half of the population that was asked with the question whether they would be willing to go abroad for medical treatment said that they would do so (58,1% of the 270 person sample). In total, roughly 3% of the respondents in the study ultimately went abroad for medical care (157 persons of the 5,772 person sample). Research performed by Gallup (2007) studied the willingness of European citizens to travel to another EU country to receive medical treatment. They found a relatively different result. Of the Dutch respondents, 77% were willing to receive medical treatment in another EU country. The average percentage of EU citizens that were willing to travel to another EU country for medical treatment was 53%, in a range from 26% (Finns) to 88% (Cypriots). The main conclusion from the outcomes of this report is that geographical distance and cultural differences play a meaningful role in patients' willingness to travel.

The same study conducted by Gallup (2007) explored motives of European citizens to obtain treatment elsewhere in the EU. Motives included medical treatments that were not available at home, a better quality of treatment abroad, a quicker treatment, or a cheaper treatment. Similar motives or attitudes of Dutch patients were found in the interviews. As one of the brokerage firms explained:

> "*It is underestimated how much need / willingness there is for cross-border healthcare. Originally, patients were willing to seek healthcare abroad because of long waiting lists at home, or patients near the border regions were willing to seek care across the border. Now, it is largely due to frustrations with experiences in the Netherlands, where things went badly. Dutch patients get frustrated and say, 'well, let's try seeking healthcare somewhere else'."*

Another broker confirms that:

> "*It's now not only due to long waiting lists. These are still an issue, but not the main issue any longer. It is partly also the interpersonal conduct of doctors. I hear a lot of complaints: 'my doctor does not treat me well, he never has time for me, he does not listen to me and does not communicate well'."*

An important aspect of medical treatment is quality. It is the process which Callon (2002) calls singularization of services. Consumers and patients qualify health services and their judgment depends on the perception of differences against the background of similitude. One of the brokers shows:

> "*Patients are obviously not solely looking for medical treatment. If they have to evaluate their satisfaction, it is about the whole trajectory: the stay, the warmth and empathy of the nurses, the kindness of the doctor. The medical treatment itself is only part of the quality aspect. The pure medical treatment will probably be perfectly fine, on par with say Germany. But the softer aspects will not be comparable. German healthcare scores much better on these aspects."*

But there are some other considerations as well. The government official from the Dutch Ministry of Economic Affairs explained why the United Kingdom (UK), as part of its healthcare expenditure reduction program, is trying to attract international doctors from low wage countries to work in the UK.

"*In the UK, it is much more ingrained in the system. Yesterday, a UK patient was treated by a Chinese doctor, today by an Indian doctor, and tomorrow perhaps by a Russian doctor. UK patients do not really care that much and are already used to doctors from all over the world. In contrast, Dutch patients have a preference for seeing only older, preferably Dutch doctors. Dutch patients are fine with hiring a Polish handy man but they are concerned about being treated by a Polish doctor. They do not trust foreign doctors. Foreign doctors have an image problem and Dutch patients are not yet familiar with being treated by them."*

This same kind of unawareness was mentioned by a broker:
"*There is still some level of arrogance in the Netherlands: 'what we do here in the Netherlands is really good, and we are good at everything'. Foreign doctors are perceived as a bunch of incompetents, willing to conduct surgery without regard for proper levels of hygiene. By contrast, in Germany there are a lot more people, many more hospitals, and many more specializations. For example in Krefeld, Germany, there are cardiologists that do nothing other than Dotter surgeries. It may be boring for the doctors, but they do it for 8 hours a day and become excellent and specialized in the particular surgery. In the Netherlands, doctors may conduct surgeries 3 hours a week. I know German urologists who only operate on prostate cancer; that is their only specialty! This way, they achieve a high degree of specialization."*

The perception of Dutch patients towards foreign medical treatments becomes visible from these examples. In light of Callon's singularization, foreign health service providers could probably gain a lot more market transactions if they know how to singularize their treatments from Dutch treatments and point out the better quality of care (e.g. medical treatments in Thailand or Germany).

Another consideration a broker provided was that consumers are still caught up in routines. They are attached to certain health services. Callon (2002) emphasizes that consumers' preferences are tied to an apparatus of distributed cognition. Patients' socio-cognitive apparatus have to be reconfigured in order to be detached from their routines in choosing a hospital. "*We are used to having a hospital on every corner of the street, where you can get every treatment. But you start seeing that when need is high, willingness to travel increases accordingly. But in general, it is still low*."

This same broker explained that many of the patients for whom he made arrangements in German hospitals come from the Randstad region. It had nothing to do with the lack of supply, because it is one of the most populated regions of the Netherlands and hence has the greatest concentration of doctors in the country. Rather, it has to do with the same issues highlighted above: quality and detachment. In the process where patients re-evaluate their choice between treatments at home or abroad, a common response heard by the broker is: "*Well, where do we need to go in the Randstad? Look at the past few years, the terrible stories you hear. Either the doctors do not perform the surgeries well or the infections post-surgery are horrible. It's a disaster. Dutch patients lose trust in their own hospitals."* These incidents create a certain detachment by patients from regional Dutch health services and patients start re-evaluating and considering treatment abroad.

Dutch Government

Unlike commodities or other products such as clothing, which are often traded goods, health services are different. Healthcare is a public good, and not private. The Dutch government protects / is involved in the (construction of the) healthcare market. As a government official of the Dutch Ministry of Economic Affairs explains:

> "*If the economic models were correct, everyone would always seek the cheapest or the relatively cheapest product or services. Health services are a bit different, because it is a weird market that does not function well. First, because the bulk of the costs are incurred by the government and so the consumer (or patient) does not feel incur the costs of the provided health services. Second, because consumers can not judge what is good or poor quality. Therefore, the government must regulate and control that."*

The attitude of European member states towards international trade in health services shows signs of debate at a wider regional level. Whereas European member states believe that they are able to regulate and take over full responsibility and control over their own health services, the actual degree of oversight is decreasing. On the basis of Article 152 of the Amsterdam Treaty and the recent European Court of Justice ("ECJ") rulings, it is becoming increasingly clear that the Single European Market ("SEM") is having a substantial impact on national health services (markets) (Busse et al., 2002). The attitude of the Dutch government becomes visible:

> "*The reports that healthcare can get cheaper with foreign support are definitely there. But unlike the Brits, we cannot pro-actively do anything about it. Minister Kamp and Minister Schippers made it abundantly clear*

that it is undesirable to bring in foreign doctors. They would rather help as many Dutch doctors get a job and gain experience as they can. Healthcare expenditure is by far the largest expenditure by the Dutch government and they are seeking all types of cost-cutting measures and cheaper solutions. However, internationalization of health services is explicitly excluded."

In the most recent "*Regeerakkoord"* (October 2012), there is a chapter "*Care Nearby*", formulating the desire to deliver care as close as possible to patients' homes. These signs of protectionism can partially be explained by a remark/argument made by an interviewee from the Dutch Ministry of Economic Affairs:

"People are not scared about losing employment, because there is enough demand. But if all the easy and standard patients were to go abroad, there would be no easy cases so that Dutch doctors could practice their skills and generate 'experience hours', which doctors need in order to progress in their careers. There are sufficient complex medical cases but doctors need the simple, routine medical cases to cover the rudimentary overhead costs such as a secretary, a medical office, etc. If those costs had to come from the complex surgeries, those would become even more expensive. Doctors require serial production to cover these daily costs."

One interviewee from a Dutch health insurer added that in the Dutch healthcare system, there is an element of cross-subsidization, whereby low-risk patients contribute to the financing of health services needed by high-risk patients. By losing low-risk patients to foreign health providers, a gap arises in the Dutch healthcare financing system.

Dutch Healthcare Providers

In patients' decision making process whether to travel abroad for health services or remain in the Netherlands, a process of attachment and de-attachment by the General Practitioner (GP) plays a key role. Other health service providers (hospitals, specialists, physiotherapists) would likely be open to working in partnership with foreign health service providers on medical treatments. In terms of Callon's mechanisms of encounter, Dutch GPs are economic agencies that are involved in the design of architectures that can organize market encounters between demand (patients) and supply (foreign health service providers). However, GPs' attitudes demonstrate a certain adversity to foreign healthcare. GPs actively try to prevent the process of de-attachment from happening, as an example from one of the brokerage firms will show:

"*There was once a patient with prostate cancer. His urologist did not conduct surgeries on prostates but refused to refer him to a foreign doctor. It happens more often than one may think. Dutch doctors will not tell you to go to abroad for treatment, even if they know that the foreign doctor could treat them effectively. Doctors will simply tell their patients that their treatment is complete, and no further recourse is available. They prefer to simply give up on their patients. This particular patient went to Germany for a second opinion, and the German doctors judged not fully according to the standard protocol, but more according to individual based needs so that they could treat him. That patient was treated and has been cancer-free for over 5 years. However, the Dutch insurer has continued to deny him reimbursement for the health services he received in Germany."*

Doctors also actively discourage Dutch patients from going abroad by emphasizing the risk of complications arising after the treatment. Generally, patients have to go back to the same health service provider where they underwent the initial treatment for after-care treatment. But this may be unfeasible or complicated if the patient is situated far away from the foreign hospital where they received initial treatment and they need urgent care. Sometimes patients may be better served by going abroad for a "core" medical treatment, receiving after-care closer to home. However, Dutch doctors are generally unwilling to cooperate with foreign doctors. The interviewee from the Dutch Ministry of Economic Affairs explains:

"What makes it complicated is the GP's role as a gatekeeper. A Dutch GP is educated and trained in the Netherlands and so will more easily refer a patient to a Dutch specialist. He refers someone with a demand for care to the most convenient supply of care, not necessarily the cheapest care. Therefore, it would be ideal if a health insurance company had the ability to intervene, overrule the GP, and request a referral for healthcare abroad. However, this is complicated due to privacy reasons."

This remark supports the idea that better cooperation between Dutch and foreign doctors would make trade in health services easier. This notion also came to light in an interview with one of the brokers:

"*I have to fight on a regular basis with Dutch doctors and hospitals for good after-care. They have a code. They cannot without reason deny a patient treatment. They have their oath. Sometimes they will not even listen to me.*

I often only get cooperation after I threaten to sue them or bring them before a disciplinary board. They then suddenly start listening to me."

An interviewed patient revealed a fear by fellow patients to go abroad, partly because they were concerned about their relationship with their doctor in the Netherlands if the treatment abroad went poorly. It gave them an awkward feeling. In terms of Callon (2005), Dutch doctors actively try to prevent patients from re-evaluating their need for detachment. They keep patients attached and caught up in their routines by creating a fear of complications from healthcare treatment abroad. The interviewee from one of the four large Dutch health insurers is aware of the trouble with complications. Dutch doctors complain about these complications a lot:

"*Just because this patient wanted to go to Belgium and refuses to go back, I have to clean up the mess!"*

The lack of cooperation between Dutch doctors and foreign doctors leaves room for improvement in the architecture of exchange. The relations between these two agencies seem to have a large influence on the actual transactions to bring demand and supply together as per Callon (2005).

Health Insurers

Consistent with the perceived attitude of health insurers by brokerage firms, the attitude of the interviewed health insurers is to be adverse. In general, there is a tendency to keep trade in health services low by complicating or frustrating the reimbursement process. In terms of Callon (2005:1243), the mechanisms that organize an encounter between calculative agencies are frustrated as health insurers encumber the mechanism. *"Insurers simply should have an easy-to-understand, online tool whereby a patient can input what medical treatment their doctor advises them to undergo and quickly and efficiently know whether costs will be reimbursed or not",* as suggested an interviewee within the Dutch Ministry of Economic Affairs.

One of the brokerage firms describes the attitude of health insurers as follows:

"Generally, the larger the health insurer, the worse the client satisfaction by patients seeking treatment abroad. Larger insurers for the most part do not care much about client satisfaction. They focus on collecting premiums. They do not benefit from treating sick patients. For smaller health insurers, the attitude is different. They rely on good client satisfaction to attract more clients. Therefore, they are more willing to reimburse treatment abroad. Of

course, larger health insurers wish to project the image that they genuinely do care about the well-being and satisfaction of their clients. However, in practice, one can see that patients' needs are less of a priority."

Examples of how patients are denied reimbursement are countless. One of the two brokerage firms explained that reimbursement barriers generally fall into three categories: (i) administrative barriers, (ii) financial barriers, or (iii) direct intermediation. *Administrative barriers* by health insurers include rules that are unclear. It is unclear how patients should complete their claim, where the claims should be sent, who they should reach out to for follow-up. For example, health insurers may inform a patient to make a claim with the department of "Care Abroad", whereby no such department exits. *Financial barriers* by health insurers include denying reimbursement altogether or lowering reimbursement rates for healthcare obtained abroad. They may add further conditions for reimbursement, which by law health insurers are not allowed to do. A last barrier, which does not happen frequently, is *direct intermediation.* In this case, patients are directly contacted by a "care coach" and offered treatment somewhere in the Netherlands quicker than originally communicated to the patient, with the hopes of retaining the patient in the Netherlands. All these barriers are thrown up with the goal of preventing patients from seeking healthcare services abroad.

An example by one of the patient interviewees illustrates the point. After her second back surgery in September 2012, the patient suffered complications and she was asked to return to the same hospital in Hasselt (Belgium) were she underwent her first and second surgeries. Following her first surgery, her health insurer received the bills and paid them directly to the Belgian hospital. Following her second surgery, the patient had to collect the bills from the Belgian hospital and forward them to her health insurer to be paid. After having following the new protocol and believing the issue resolved, she received a payment reminder from the Belgian hospital in November 2012. After contacting the health insurer, she was told that the insurer would look up the relevant documentation and call her back. She asked and received from the hospital an extension to make payment until 31 January 2013. By 14 January 2013, she had not yet heard back from her health insurer and decided to call again. The health insurer promised that they would make payment shortly. On 25 January 2013, she called the health insurer again and was told that her co-payment would have to be €336, with the balance paid for by the health insurer. However, on 29 January 2013, she called the hospital again and they indicated that they had not yet received payment from the health insurer. On the day of the deadline, the health insurer called and told her that her co-payment would increase to €2,931, with the balance paid for by the health insurer. She then filed a complaint against the health insurer and asked and received

from the hospital an extension of payment until 28 February 2013. On 12 February 2013, she received a call from the health insurer, indicating that her reimbursement was denied outright. She then pressed charges with the Complaints and Conflicts Health Insurance Establishment (in Dutch: *Stichting Klachten en Geschillen Zorgverzekeringen*, or SKGZ) and asked and received from the hospital a further extension of payment until 31 March 2013. On 18 March 2013, she came up with the idea of calling a sympathetic representative within the Foreign Care Department of her health insurer with whom she had had previous contact. She explained the whole situation. The representative assured her that she would not have to pay anything in case there were no complications arising three months following the first surgery. The representative sought and received a statement from the neurosurgeon confirming that the complications were indeed caused by the second surgery. Following this statement, the representative notified the neurosurgeon that the health insurer would cover all costs related to the patient's care and requested that the hospital's billing department stop pestering the patient with reminders.

Unfortunately, this is a fairly typical example of how health insurers can frustrate reimbursements and not properly educate / inform their customer-facing personnel.

The interviewees from the Dutch health insurers shared a different perspective, however. One of the interviewees explained the challenge of sending patients abroad for treatments which have long waiting lists in the Netherlands: "*Health insurers are clearly seeking to make a profit and they know that if patients have to wait a long time for treatment, patients often will choose to not pursue treatment after all. Demand vanishes and profitability increases".*

The interviewee also confirmed that health insurers do not like seeing patients going abroad because costs are difficult to control. A study by Mattoo and Rathindran (2006) found the same rationale for insurers discouraging patients seeking health services abroad. Monitoring the costs and quality of health services consumption abroad is extremely difficult. As one of the interviewees from the Dutch health insurers explained:

> "*We cannot monitor quality as easily or readjust it if we want to because we do not know the quality standards of that (foreign) country. We really have to argue with the foreign hospital to either work according to our quality standards or reduce costs according to the actual delivered quality. It is just very challenging to check the costs and quality of healthcare abroad."*

The insurers' argument that it is difficult to control costs is supported by an example provided by one of the brokerage firms.

> "*One of the big four health insurers established open contracts with 12 Belgian hospitals to allow their clients to go there for medical treatment. The health insurer agreed to reimburse all costs so long as the patients obtained a proper GP referral. Thereafter, costs exploded because these hospitals were savvy: they were used to working within a budget but following the establishment of the contracts, they had free rein to start billing the insurer. Seeing costs spiral, the insurer terminated the contracts."*

In the construction of a mechanism organizing market encounters, these results show certain barriers put up by Dutch health insurers to deny reimbursement. In terms of Callon, one could say that the architecture of exchange is not clear to most patients, which frustrates reimbursement and thus the transaction from happening. One last comment from an interviewee within one of the big four health insurance companies in the Netherlands supports these findings. She explained that a colleague of hers needed a neurological surgery and decided to go abroad: "*She worked here and had arranged everything before she left. Yes, of course, she knew her way around here to get her costs reimbursed. Most of our clients do not have that insider knowledge and can get frustrated by the process."*

4.1.1 Conclusion

The results from the interviews demonstrate a large degree of ignorance of the opportunities available to patients and unfamiliarity with the topic by the general public as well as by Dutch health service providers. Most patients are caught-up in routines and are attached to their Dutch doctors. Those few patients who were aware of the opportunities demonstrated a certain aversion to harming their relationship with their Dutch doctors by seeking treatment abroad. Dutch doctors demonstrated an adverse and almost hostile attitude towards patients returning with complications following treatment abroad and were frustrated by their need to provide after-care to these patients. Moreover, health insurers made active efforts to discourage patients from seeking care abroad by complicating or obfuscating the reimbursement process. A final key finding was that despite the proven cost saving benefits of internationalizing healthcare services, the Dutch government does not encourage healthcare abroad for Dutch patients because of concerns regarding knock-on effects to the Dutch medical care system, with Dutch doctors losing relevant experience.

4.2 Tradability of Health Services

In order to find out how health services actually become tradable, this section will go into the research findings on how social processes create this "liquidity". The findings will be ordered in a sequence: (i) the process of making goods tradable, (ii) the economic agencies that help create this tradability; (iii) and finally the calculated exchanges needed for a tradable or liquid health service market. According to Callon (2005), these three constitutive elements are required so to create a global market for health services that can calculate and compromise on the value of goods / services.

Calculable Health Services

In socio-constructivist terms, health services have to be objectified before they can be the objects of market transactions. By defining a combination of characteristics, a system of differences and similarities, singularity is established. When asked for which health services patients are most likely to go abroad, most interviewees concluded that patients would go abroad mostly for basic and standard surgeries. A broker explained:

> "*What we see happening is that people mostly go abroad for the standard procedures (i.e., an orthopedic back surgery). For these types of specializations, you see a lot of demand and hence the most supply and competition by doctors. Surgeries which can be standardized can be executed cheaply. Highly specialized procedures can often only be performed at academic hospitals or specialized institutions, as these procedures need significant resources (financial and material) and highly-skilled doctors with a high degree of expertise and knowledge. There are only a handful of these academic hospitals or specialized institutions in Europe."*

One way German doctors differentiate themselves from Dutch doctors and why certain health services in Germany are more competitive and tradable is that German medicine is less controlled by established protocols. "*In the Netherlands, there is a strong fixation by doctors on protocols. If a patient falls outside the definition set by the doctor, there are no longer any options. In Germany, doctors will follow an established protocol but if the patient in some way does not fit the standard definition, the doctor will look for an alternative solution."* According to one of the brokers, Germany focuses less on the definition of a certain health service. In Germany, there is a process whereby the doctor will attempt to re-qualify a patient until they fit some category. Therefore, Germany offers a more tradable or liquid market for medical treatments.

In terms of Callon's singularizing health services, German hospitals have a different system of working, explains a brokerage firm:

> "*In the Netherlands, doctors are very much used to conducting a lot of poli-clinical diagnoses. For example, a cardiac patient first has to come in to a hospital for an ECG, then for a cycling-test, then for an echography of the heart. Between each of these separate procedures, there a 3 to 4 week delay, minimum. In Germany, a cardiac patient would be admitted into a hospital for 2 days and all tests are conducted back-to-back. The ability to diagnose and treat quickly is highly valued."*

These advantages of getting a diagnosis rather quickly (once aware of the opportunity of going abroad) makes patients re-qualify the quality of Dutch hospitals. This way, foreign health service providers can try to detach patients from their routines. They reconfigure the socio-cognitive apparatus of patients and reattach them to their hospital and medical services.

Calculative Economic Agencies

The market makers that create liquidity in medical treatments are acting forces. An example of such a market maker was given by a brokerage firm: he explained how language was a barrier to trade. In order to make health services tradable, he had to adjust the properties of German health services to the Dutch patients' world:

> "*Dutch patients do not always speak German. We bridged this language barrier by having a Dutch-speaking interlocutor in the most frequently-used German hospitals. This could be a nurse or an administrative employee. At minimum, it had to be an agent who understood the medical topic that had to be discussed."*

A small example such as this demonstrates how a simple solution can increase trade and liquidity in health services.

Other economic agencies that make health services more tradable are brokerage firms. The first broker explained that he sees himself as an agent, while the other broker sees himself as a byproduct of health insurers. However, both brokers were responsible for facilitating the interaction between demand (patients) and supply (foreign health service providers) and thereby making health services more tradable. Brokers would make all arrangements for patients, guide the patients through the insurers' reimbursement processes,

and contact foreign health service providers. Brokers play an important, often critical role in the infrastructure facilitating the trade in health services.

One of the Dutch health insurers explained the need for such economic agencies: "*There is space for such actions and negotiations with foreign health service providers, but the market needs entrepreneurs willing to fill in the gap between demand and supply."* As a study by Lunt et al. (2011) showed, most medical tourism is currently driven by commercial interests and not by state-run health policy-making. These commercial interests should be better understood and documented. Multiple business models have emerged and in order to uphold quality and ethical standards, an accreditation system may prove useful.

An essential instrument of such economic agencies is the contracts between health insurers and brokers with foreign hospitals. These contracts make health services tradable in a sense that there are limited barriers for patients who wish to seek care at these hospitals. As one of the health insurers explains:

> "*The patient will be treated quicker if there are contracts. Everything from A to Z is taken care off. The patient does not have to worry about making a request with us. The patient does not have to worry whether or not he / she will be reimbursed or not. The hospital has all the right information and knows what, how much, and where they can make the claims. All the relevant information is in the contract."*

Contracts with foreign health service providers are an essential element in making health services tradable, because without such contracts, patients face greater uncertainty. This same Dutch health insurer uses the contracts to make treatments in the contracted German hospitals tradable to their Dutch insured. The insurer simply requires that the insured patient brings an "International Health Card" with them to the contracted German hospitals. Thereafter, the German hospitals can make claims directly to the Dutch health insurer. However, feedback from the interviews indicates that obtaining such a card does not always come easy. As one of the brokers explains:

> "*There was a patient who had breast cancer. She called us because she wished to be treated in Germany. She heard that a Germany hospital nearby provided good care. So we asked her which insurer she was with and explained her how her insurer works. I asked her to obtain the International Health Card to facilitate the process. The patient called her insurer to make the request, and the insurer informed her that she did not qualify for the card. She read the fine print of her insurance contract, called*

her insurer again, and insisted that she had the right to it. The insurer finally relented and agreed to prepare one for her, but required that she pick it up herself, which would require a 3-hour drive! When she arrived at the insurer, the card was not there. They had made a "mistake". It was at one of their other offices, another full hour drive. When she arrived, the insurer apologized again because the card had not yet arrived by mail. The insurer could have perfectly well mailed the card directly to her but they chose to throw up unnecessary obstacles. This happens all of the time."

With these barriers, health services become less tradable. By raising these three types of barriers (administrative, financial and direct intermediation), health services become less liquid. Insurers make it more complicated to go abroad for health services and thus prevent transactions from occurring.

Another tool used by health insurers to make health services less tradable is by directing clients to preferred or contracted providers:

"*Of course, insurers want to have the means to control which hospitals patients go to. Within the Netherlands, one can see more and more examples of this. It goes very slowly. Hospitals have to get used to it. Insurers are gradually picking up that role of managing care paths for patients. Previously, it was very common for patients to choose their provider. Patients were not required to go to a specific provider because it was cheaper or better."*

Managing care paths is a tool by health insurers to make foreign health services less tradable. But in the construction of this tool, it is interesting to see that this role is still small. Health insurers are trying to differentiate insurance policies, so that patients will indirectly choose their medical care paths and certain health service providers. An interviewee at one of the big four health insurers explains:

"*We are trying to differentiate policies. The student policy in Nijmegen, Take Care Now, is booming. For a very low student-friendly rate, we control the patients' medical care paths. They cannot go to any hospital. We will tell them which hospital to go to, what pharmacy to use. It reinforces our procurement power."*

In the creation of the instrument of controlling medical care paths and providers, health insurers use insurance policies as an instrument. In terms of Callon (2005), these are

non-human entities that have the ability to steer behavior in certain directions. A study by the Dutch Ministry of Health shows that managing care paths and navigating patients to preferred providers is the most effective tool to control costs. However, health insurers currently use these instruments only in a limited manner. In many of their insurance policies, they do reduce reimbursement for non-contracted providers.

Whereas patients previously were able to go to any hospital or any provider, health insurers are increasing their influence in the care process. Given the ability of health insurers to differentiate policies and gain control over medical care paths, it was interesting to look at the construction of this patient as a calculating economic agency demanding treatment anywhere, anytime. In the interview with one of the brokers, he says:

> "*In the 1990s, a 3 to 6 month waiting period was very usual. We had a budget system. But at some point, patients became more aware and empowered and demanded faster service times. The 'Treek' norms changed care a lot. There now were norms for patients to indicate a maximum appropriate waiting time. In 10 years, things changed dramatically."*

In the construction of an empowered patient, these norms as calculating devices have probably helped empower patients. This phenomenon is what Friedson (2001) calls "consumerism". Whereas previously doctors determined medical care paths (professionalism), patients now took over.

Calculated Exchanges

An example of a calculated exchange was found in the results of an interview with a patient. The economic agencies that were involved in the architecture of an organized market encounter were a Belgian health service provider and a Dutch health service provider. "*My physiotherapist recommended that I visit a neurosurgeon in Hasselt, Belgium. The neurosurgeon had given a lecture in my physiotherapist's clinic about his work and their services."* Through this lecture, the Belgian neurosurgeon was able to increase cooperation with the Dutch physiotherapist. The Belgian doctor was able to design an architecture for a market encounter. Because Dutch patients see a direct link between their Dutch physiotherapist and a Belgian neurosurgeon, they are more willing to go to Belgium for their surgery. This relationship between two health service providers is essential for patients and the liquidity of transactions between demand and supply. Another way this lecture made Belgian health services more tradable or liquid is because it can as well be explained as a

process of detachment by a Belgian surgeon from Dutch hospitals. Patients are confronted with the opportunity to re-evaluate their routines, and this increases competition.

Results from the interview with the person within the Dutch Ministry of Economic Affairs showed how the GP could be involved in the architecture of organizing market encounters between demand and supply. Patients in the Dutch healthcare system have to always first see a GP. If necessary, the GP can then refer his patients to a specialist for medical treatment. Because of this central role, the GP holds a lot of power. If Dutch GPs were more aware of opportunities abroad, they could design market encounters between patients and foreign health service providers. "*At the moment a GP refers a patient, you should actually want the health insurer to intervene, because they know where health services are cheaper. And if that is abroad, the GP should refer them there.*" In the design of an exchange, it is clear that a GP plays a significant role.

4.2.1 Conclusion

Simple basic and standard procedures (e.g., hip and knee replacements) were identified as the most tradable health services. Patients evaluate and compare differences in treatments against the background of similitude in order to singularize treatments. For example, German doctors distinguish themselves by being more time efficient in diagnoses and are less focused on protocols and more focused on finding solutions. A translator was a instrument that overcome language barriers and facilitated German medical health services for Dutch patients. Contracts with foreign providers are crucial to making health services tradable because these remove issues / risks regarding reimbursement. The central role of health insurers in managing medical care paths and referring patients to preferred providers is an important instrument to control costs. A similar crucial role in designing market encounters was found in the role of GPs as gatekeepers in the referral process. Finally, via lectures, seminars or conferences, foreign health services providers could increase awareness and better collaboration with Dutch health providers and thereby make their services more tradable.

4.3 Opportunities and Threats

This section will show the results from the interviews about opportunities and threats to trade in health services and the construction of a global market for health services. The threats and opportunities will be evaluated for health service providers, health insurers, and the Dutch public healthcare system. Similar to the previous sections, the results will be discussed in terms of calculable health services, economic agencies, and exchanges.

Health Service Providers

In the previous sections about tradability and singularization of health services and the attitude of stakeholders, some of the opportunities for and threats from health service providers have already been indirectly highlighted. The threats from Dutch providers which prevent transactions from happening are the exact same opportunities to address in order to develop an architecture for calculated exchanges.

In order to make health services more liquid to trade, patients must first be able to perceive and evaluate differences between foreign and Dutch services. An example provided by an interviewee from one of the big health insurers, illustrates how Dutch specialists discourage their patients from going abroad. "*Neurologists do not want to give permission. I told the patient, why do you even need permission? You don't need the neurologist's permission, just do it. Go get a surgery done in Germany. This insecurity is probably some cultural limitation – the unwillingness of patients to go against an authority figure."*

By denying permission, which a patient does not technically need, the Dutch doctor prevents a patient from considering treatment abroad. For foreign competitors, it becomes harder to re-attach patients to their services due to the fear and insecurity of Dutch patients. The interviewed patient who sought medical care in Belgium expressed those same sentiments and heard these from a lot of other patients she met through her volunteer work at a patient-advocacy organization.

The lack of collaboration between foreign and Dutch health service providers makes health services illiquid. There are limited interactions between Dutch health services providers and foreign counterparts. However, the interviewed patient explained how she became aware of the possibility of going to Belgium for treatment: through a lecture offered by the Belgian neurosurgeon at her local physiotherapist's clinic. Using such an instrument to inform Dutch doctors about alternatives for the patients, the Belgian doctor is able to detach Dutch patients from their routines and make them re-qualify their choices. Moreover, because the physiotherapist has met and knows the neurosurgeon in question, the collaboration makes after-care easier and the total treatment more liquid. However, the interviewed patient cautioned that there is still more progress to be made: "*Cooperation between Dutch and Belgian doctors could be a lot better."*

The interviewee within the Ministry of Economic Affairs acknowledges this lack of collaboration and views it as a barrier to trade in foreign health services. He sees an important opportunity in making the link between foreign and Dutch healthcare providers.

"*There should be more health service providers who offer a package deal. In combination with a foreign provider, they could offer a combined treatment. Because they sees the link with the Dutch provider, it becomes easier for the health insurer and for the patient."*

It is understandable that Dutch doctors would rather not see their patients go abroad. However, in the architecture of the calculated encounter with a foreign provider, they could be more actively involved in designing the encounter in a way that patients benefit the most, especially in cases where a Dutch doctor is not able to perform a certain surgery. By working together with a foreign provider, they have a larger influence on the process of designing the encounter, resulting in a larger variety of choice for patients in a global market.

Dutch Healthcare System

Although health service consumption abroad could ease burdens on health systems because of more competitive prices, there are serious concerns about the sustainability of public health insurance schemes. This concern was shown in a working paper by Olivier Cattaneo (2009) for the World Bank and is supported by a document from the Dutch Ministry of Health. The interviewee from the Dutch Ministry of Economic Affairs explains:

> "*Foreign health services are all well and good. However, they should not lead to higher healthcare costs for the Netherlands, or to another possibly more significant problem: the lack of patients in the Netherlands requiring routine care, which would take away opportunities for Dutch doctors to practice and improve."*

In a Dutch government study titled "*Borderless Care*" (in Dutch: *Grenze(n)loze zorg*), the government can take measures that deviate from the European Directive of Free Movement of Services when the public interest is harmed. The public interest can include a serious burden on the financial structure of the social security system or the conservation of a special treatment facility with expert medical knowledge on national territory. The unit cost of hospital care depends to a large degree on the volume and overall capacity utilization of a facility. Cattaneo's (2009) theorem is outlined by an interviewee from a Dutch health insurer:

> "*Yes of course a patient can go abroad, but the Netherlands has a complete health infrastructure. These infrastructure costs are an integral part of the Dutch healthcare system and are part of the macro-framework*

that require cross-subsidization. Any healthcare infrastructure that is built in the Netherlands and is not used is empty capacity that goes to waste and still needs to be paid for."

Therefore, health services are tradable only to a certain extent. The Dutch government has the right to intervene if the public interest is endangered. Regulation of this kind shows the limits of tradability in health services. Regulations are instruments that can be used by economic agencies to prevent too many transactions from happening. Unlike the clothing industry where all production can theoretically be offshored to Mauritius or Bangladesh, the production / services of the healthcare industry cannot be wholly outsourced for reasons of public interest.

Another threat to the construction of a global market for health services is the risk of complications post-treatment. If patients decide to go abroad for a medical treatment because it is more convenient / appropriate for them, suffer from complications post-treatment, and have to be re-admitted to a Dutch hospital for emergency care, those (extra) costs are paid for with public funds. The interviewee from the Dutch Ministry of Economic Affairs explains:

"*The number of cases of medical malpractice is limited. However, in dental care, where barely any care is covered by health insurers, there is a sizeable number of Dutch patients who go abroad to Turkey for care. There are Dutch dentists who rely for 10-15% of their income from repairing malpractice by foreign dentists. Therefore, it is not a de minimis cost. Dutch healthcare expenditure goes up simply because people go abroad to cheaper clinics for non-urgent care and return to the Netherlands needing urgent care, which is very expensive."*

The upcoming legislation to withdraw reimbursement for elective non-emergency care outside Europe is another threat to Dutch involvement in the construction of a global market for health services. The Minister of Health, Ms. Edith Schippers, announced in early August 2013 that the government would seek to cut €60 million of healthcare costs outside Europe by 1 January 2015. Therefore, treaties with foreign countries such as Turkey and Morocco would have to be re-adjusted. Both countries have resisted these measures, as the Turkish and Moroccan medical industries earn approximately €10 million and €5 million, respectively, from Dutch patients. The measure would affect at least 1.5 million patients and would make a significant dent on foreign health services and would go

directly against the comparative advantage theory.

In terms of Callon (2005), there are some who view the construction of a global market for health services as the final step in the deconstruction of national social-health system (Smith, 2009:593). However, others view it as a means to develop and expand the range of quality of health services offered to their population. However it is perceived, the drive towards specialization is a significant trend and as the interviewee within the Dutch Ministry of Economic Affairs explained: "*In time, it will happen. You already see it happening in countries in the European Union, such as Luxembourg. Luxembourg is just too small to keep offering all these medical specializations. Luxembourgers are being asked by their government to seek medical care abroad, in particular in Belgium, France, or Germany."*

Dutch Health Insurers

Last but not least, there are threats and opportunities by health insurers. Because of their growing importance in the Dutch healthcare system, there are threats to the tradability of health services. The results are divided into opportunities and threats related to the quality of medical services and to the financial structure of health insurers. All the results will be explained in terms of calculable goods, calculated economic agencies, and calculated encounters.

Quality

There exists a major concern about the quality of foreign health services. Mattoo and Rathindran (2006:364) show that the risk of worsening health problems as a consequence of foreign treatment remains a problem. All of the interviewed health insurers shared this concern. One of the big health insurers supports and explains this: "*As a health insurer, it is just challenging to monitor everything. We lose control if we allow patients to go anywhere. If we wish to further internationalize healthcare, the burden falls on the European Union to establish a framework and international agreement related to prices and quality standards throughout Europe."* The construction of a global market for health insurers would require a European-wide prices and quality standards. The working paper by Cattaneo (2009) underscores the need for international quality standards and reports several voluntary initiatives. For example, the Joint International Commission (JIC) has accredited over 120 hospitals worldwide, and several other organizations, such as the International Society for Quality in Healthcare (ISQUA), the National Committee for Quality Assurance (NCQA), the International Organization for Standardization (ISO), and the European Society for Quality in

Healthcare (ESQH). These are initiatives to ensure that patients receive the highest-quality care. By having a European or global quality standard for medical treatment, the process of qualification becomes easier. Because when quality requirements for medical services are standardized, patients can make new judgments about the combination of differences and similarities, of distinct and yet connected categories of health services. Health insurers therefore have certainty about the quality of treatments and can issue reimbursements, making health services more tradable and the market more liquid.

One of the interviewees at a small Dutch insurer acknowledged the quality problem, and cautions about the possibility of fraud:

"*The two key problems will always remain quality and fraud. Of course, each system creates its own abuses. Thai hospitals know exactly how much Dutch health insurers reimburse and that is usually 100% of whatever they'll put on the bill. That is why the Spanish hospitals have to declare on DBCs."*

The risk for fraud was underscored by a representative from a small Dutch health insurer (20:00 NOS Journaal, 1 August 2013). "*Indeed, the perception is that foreign claims are much more fraudulent than Dutch claims. Of course, is very challenging to trace whether the claims are valid or not."* In terms of Callon (2005) international quality standards or diagnose related (cost) groups could be instruments to overcome fraud. Preventing fraud and singularizing medical treatments better would make them more likely to be a product of a transaction. By creating such international standards to which all stakeholders would conform, the performance and quality of foreign health service providers would be more easily controlled and benchmarked.

Finance Structure

In healthcare, the health insurer is the third-party payer. Insurers do not consume or produce health services. They simply procure health services for their clients and clients ideally go to contracted service providers. Because not all health service providers are contracted, the tradability of health services is reduced. As previously noted, the interviews demonstrate how health insurers complicate reimbursement. The following comments illustrate why. An interviewee from a large Dutch health insurer explains why foreign health services could actually increase costs.

"We have budgets and make agreements with Dutch healthcare providers. If we allocate our full budget to the Netherlands, any healthcare services consumed abroad generate supplemental costs. Because they are not calculated in the price arrangements we make in the Netherlands, patients seeking health services abroad simply fall outside these

contracts."

One of the brokers adds an example for illustration: "*Currently, foreign health services increase costs for one simple reason. Let's say you have 1,000 patients and they all are being treated in the Netherlands. They all get a budget and stay in the Netherlands. If 20 of those 1,000 patients go to Germany, the health insurer has to pay for them. But they keep making price arrangements for 1,000 patients with Dutch hospitals. So in fact, they are paying roughly for 1,020 instead of 1,000 patients. Because the amounts are still so low, they are not deducted from the price arrangements. They should actually contract less in the Netherlands. But for an individual this should not play a role."*

In terms of Callon (2005) markets calculate the compromise on the value of a medical service. In this calculation by economic agencies, the health insurers obtain a quantity discount from service providers. This was explained by the interviewee from within the Dutch Ministry of Economic Affairs.

"*The margins for Dutch health insurers originate from economies of scale. They purchase bulk contracts. So even if a small minority of their clients goes abroad, they receive a smaller discount on these bulk contracts. Therefore, all clients should go abroad for it to make economic sense. Or at least the cost-benefit should be large enough to make up for the difference in discount."*

In terms of attachment and detachment, it seems that health insurers are caught up in routines and are attached to certain Dutch health service providers. Health service provider might do well to reconfigure the socio-cognitive apparatus of health insurers and detach themselves.

4.3.1 Conclusion

To improve Dutch involvement in constructing a global market for health services and to give Dutch patients a wider variety of choice for treatments, doctors could be more cooperative towards their foreign colleagues. Thereby, patients are able to make or see a link with their doctors, and they do not need to concern themselves with harming the relationship with their Dutch doctor. A threat to further trade in health services are broader concerns related to the sustainability of public health insurance schemes and a possible impairment of the financial balance of the social security system. It is believed, although not quantified yet, that trade in health services drives up prices of (specialized) treatment costs in the Netherlands. An opportunity for health insurers is to globally develop uniform DRG's and corresponding quality standards as a means to create a framework for medical claims

and prevent fraud. A last opportunity for health insurers is to make more use of their purchasing power to manage medical care paths and send patients to preferred providers. This way they can benefit from economies of scale by buying bulk contracts from foreign hospitals and save money.

CHAPTER 5: Review and Conclusions

5.1 Review

This chapter will report on the used research method, the process of data collection and the data analysis process.

At the start of this study, several relevant stakeholders were identified. Initially the Dutch Ministry of Health was identified as an important source of information and was approached for an interview. The Ministry agreed to a written interview but ultimately was unable to answer any of the questions due to staff shortages. The perspective of the Dutch regulator would certainly have been a valuable contribution. The Ministry's unwillingness to cooperate with this study might possibly be interpreted as a confirmation of their opposition to the internationalization of health services. A contact later confided that the Ministry was currently working on a similar study to explore alternatives to the status quo. This underscores the increasing importance for more research on this topic.

The Dutch government does not yet account for medical tourism, either with the European Union or globally as per the European Directive (2011/24/EU d.d. 9 March 2011) on the application of patients' rights in cross-border healthcare. Initially, this study intended to estimate and quantify possible financial gains for the Dutch healthcare system and for Dutch health insurers. But because there were no records on the number of medical tourists, it was impossible to quantify possible savings. The interviews did show the increasing role of cross-border care to Dutch patients. A Belgian observatory report showed that 26.452 Dutch patients went to Belgium for medical treatment in 2007, and this figure increased to 30.152 patients by 2010. Even though this study has an explorative nature and does not quantify potential savings, it might be advisable for the government to collect data on medical tourism to do this analysis. The topic of medical tourism has gained much importance in the last 10-15 years. This is due to the increased jurisdiction by the European Court of Justice and increasing media attention on the topic. By identifying the key treatments for which patients seek to go abroad, the government could better quantify and qualify the potential impact of Dutch medical tourists on the country's healthcare system.

In the process of selecting stakeholders, Dutch health service providers were not included. It was presumed that Dutch doctors would be adverse / hostile towards the topic because of the perception that foreign doctors are seen as competitors that take away their clients, Dutch patients. However, following the interviews, the study could have benefitted

from first-hand accounts and views from Dutch specialist doctors as well as from Dutch GPs. GPs would have added particularly valuable insights because of their crucial role in the referral of Dutch patients to specialist doctors. These interviews might have offered a more well-rounded perspective on the topic and provided alternative structures / frameworks for cooperation and alternative solutions.

Because there is no organization representing / advocating for these patients, it proved difficult to identify patients who had sought care abroad and would be willing to undergo an interview. Only one patient was found to share her personal story. There might have been a privacy threshold for patients because of the sensitive nature of the topic. However, the anecdotes and information gathered from this one interview was particularly interesting and informative. The interviewed patient trusted me with her story and thought that the research could improve conditions for patients seeking care abroad. Most of the other anecdotes came from second-hand sources, such as brokers, but were nonetheless valuable as they revealed the attitudes and behaviors of Dutch health insurers. As far as I am aware, this is one of the first studies of its kind revealing misconduct by health insurers, frustrating reimbursement of their clients.

Obtaining interviews from health insurers was challenging. Most insurers were hesitant to speak and required a very cautious and professional attitude by the researcher towards the interviewees to make them feel comfortable and open up. By being unbiased and maintaining a very open attitude, initial hostility was overcome. But it might have influenced certain outcomes because they might have not felt comfortable speaking openly about the topic.

A drawback during the data collection was the interview with the Dutch Ministry of Foreign Affairs. In selecting stakeholders for the interviews, the Dutch Ministry of Foreign Affairs was included, based on the comparative advantage theory and examples from the United States of America. The Dutch Ministry of Economic Affairs mainly concentrates on the SEM and on international multilateral and bilateral trade agreements (i.e. outside Europe, such as the General Agreement on Trade in Services (GATS) by the WTO). These agreements are instruments to promote trade and can be used to remove obstacles to trade and/or harmonize domestic rules. They vary in content and can have different legal attributes that can be binding or not.

The interviewee from the Dutch Ministry of Economic Affairs explained how they negotiate on behalf of other ministries. However, due to its sensitive nature, healthcare is a

much protected policy domain and hardly ever discussed or negotiated. In a sense, the interview did not add much incremental information. However, the interview did acknowledge that the Netherlands is not actively negotiating in this field, not seeking to open up the healthcare system or gain access to healthcare systems from low-income countries. The interview was helpful in that it supported findings from other interviews. Most trade occurs in the EU and not with low cost, high-quality destinations such as the Philippines or Thailand. In the conclusion, I will go into further detail on this topic.

5.2 Conclusions

This section will analyse the empirical material in light of the used theories. During the study, two theoretical perspectives were used to analyze the data, the socio-constructivist perspective and the economic perspective. The socio-constructivist perspective shows its value by illustrating the complexity of networks of social processes and relationships between humans, organizations and non-human entities that create a global market for health services. It also shows how market attachment is produced or rendered through hybrid socio-technical devices (McFall, 2009:268).

As a consequence of analyzing the findings from two different perspectives, I will answer the explorative problem statement that was central to this study: "*How is the Netherlands involved in (the construction of) a global market for health services, and will this change in the future*?" in terms of both perspectives. However, the theoretical perspectives determine the emphasis in the conclusions. First I will conclude how tradability can be achieved, by focusing on socio-technical devices.

Tradability

In terms of Callon (2002, 2005), patients evaluate and compare differences between products, in this case medical treatments. Callon suggested the existence of a complex socio-technical device that supports patients in their evaluation work. In order to be able to singularize medical treatments, patients are guided and assisted by material devices which can act as a point of reference and which distribute information.

The findings of this study confirm the existence of and need for such a device because the current lack of information is probably the cause for relative low levels of trade in health services. If more information can cause more trade, then what are these material devices that increase awareness and the opportunity to perceive differences between foreign and Dutch treatments? One finding of such a socio-technical device was the lecture offered by a Belgian neurosurgeon in a Dutch physiotherapist clinic. The lecture assisted the

patients that came to the lecture and built links between the neurosurgeon and physiotherapists in the clinic to increase collaboration for the after care of the patients. This lecture as a socio-technical device made health services offered by the Belgian neurosurgeon more tradable. It influenced the ability of people to perceive the differences of foreign treatments against the background of similar Dutch treatments. That way he detached these patients and Dutch physiotherapists from their routines.

This lack of awareness and consequent negative or cautious attitude towards the phenomenon was found not only among patients, but also among Dutch health service providers, Dutch health insurers, and the Dutch government. Many examples of their attitude and unawareness showed threats to and a decrease in the tradability of health services.

Contracts between health insurers and foreign health service providers proved to be similar socio-technical devices that gave health service providers all the necessary and required information to assist them in making claims. Contracts seemed crucial to make health services tradable because patients were not bothered with reimbursement and it gave health insurers the required information to properly process the claims.

One last concluding remark addressed the central role of GPs as gatekeepers in the referral process, and making health services more tradable. In making health services more tradable, it is essential for GPs to have the right information to assist and guide them in the advice they offer their patients. Currently, the vast majority of patients still follow their GPs' advice. For foreign health service providers or health insurers who wish to increase awareness of foreign treatment possibilities, material devices such as seminars, conferences, or other presentations through advertisement are required to increase the knowledge and awareness of GPs.

Information is crucial in creating awareness and increasing trust. Trust as a shared infrastructure is needed for a well-functioning market. It is something in which Callon seems rather uninterested (Fligstein and Dauter, 2007:118). Trust can be seen as the belief or expectation of competence, integrity or predictability in relationships between social actors. During the interviews, trust was a recurring theme. Foreign doctors were perceived as incompetent and unreliable because there was a lack of knowledge and trust. Trust is the product of long-term engagement, familiarity and historical interactions. What socio-technical devices could create then trust? – perhaps the same devices that disseminate information. In the example of the Belgian neurosurgeon, the lecture created trust because patients had met and could relate to the doctor who would do the surgery. However, this does not yet

explain the differences between a Belgian and a Thai doctor, which will be discussed next.

How is the Netherlands involved?

The problem statement that guided this study was how the Netherlands was involved and whether this would change. In answering this question, I concluded that there seems to be a discrepancy between theoretical expectations from economic theory on comparative advantage and reality derived from data results in the study.

Comparative advantage explains how one should expect much more trade with low-cost but high-quality countries like Thailand or Singapore. However, for health services this is not the case. Patients that chose to seek health services in Thailand were mentioned once by a health insurer and once by a broker. They are not common. The interview with the Dutch Ministry of Foreign Affairs further supported this because there are currently no negotiations in the field of healthcare on a multi- or bilateral level. On the other hand, Germany, Belgium, and Spain were mentioned countless times as destinations for medical tourists. The economic literature explains this as a consequence of scale effects which create incentives to trade with similar countries. Germany, for example, has a larger market for health services because of its larger population. Therefore, health service providers have the opportunity to develop specialized and innovative treatments, which would not be possible in a small market or country such as the Netherlands. In a larger market, it is easier to cover the large fixed costs required to establish a specialization.

However, from a socio-constructivist, view this might be explained as a lack of shared infrastructure of information and trust. Trust in foreign doctors from Asian countries with high-quality healthcare systems is lower than trust in German or Belgian doctors. This can be explained because trust is the product of long-term patterns of associations and interactions. Because globalization is a relatively new phenomenon and travel and knowledge exchanges with Asia exist for a shorter period of time than with Germany or Belgium, it is likely that this trust will need time to develop. Due to the advent of air travel and technological advances, these differences will diminish over time. The socio-technical devices that create information or trust are probably similar but need more time to get used to for Dutch patients and health insurers. This study has shown that at this time, the Netherlands is involved in the (construction of a) global market of health services on a European rather than a global level.

Will it change?

The increasing media attention, the jurisdiction of the European Court of Justice, and

the increasing number of medical tourists cannot be ignored. In order to address the concerns regarding the sustainability of public health insurance schemes and the financial balance of the Dutch social security system, the Dutch government should conduct further research on the topic and undertake the right measures in order to create more choice and competition in the global market without impairing the financial balance of the social security system.

5.3 Recommendations

This section will contain several recommendations for future research. An element that received fairly little attention by Callon in his socio-constructivist work and is not particularly well explained in economic trade theory is the element of historically situated relationships. This study showed that patients have long-term relationships with their doctors and fear that their relationships could be impaired if they go abroad for care and return with complications. There exists a shared responsibility to maintain the relationship. Similarly, health insurers have a shared responsibility to maintain a national health care system and sustain good relations with Dutch care providers. This sort of responsibility is part of a shared infrastructure for the national health care market. The example provided by the Belgian hospital showed that they do not share that sense of shared responsibility when they received an open contract from one of the Dutch health insurers. They started to file as many claims as possible and did not feel any sense of commitment towards their client, the Dutch health insurer. Further research into this historical situated-ness will be useful to explain part of the low levels of trade in health services and low levels of detachment by patients and health insurers from Dutch health service providers.

Another topic that should receive further attention is the concept of trust. Trust by Dutch patients, healthcare providers, health insurers in foreign doctors and the quality of their work is critical to develop a global market and tradable health services. It remains unclear why patients in the UK have no issues with being treated by a foreign doctor and why Dutch patients do? How is trust created? If more information can result in greater trust, then which socio-technical devices could generate this type of information? What role could global diagnose related cost-groups (DRGs) and corresponding quality standards play? Further research into opportunities for such socio-technical devices in order to create trust would be useful, as well as more research on their effects and their ability to create trust in foreign (e.g. Asian) doctors. And what other socio-technical devices could directly create trust? In economic theory, trust is explained as a form of social capital, but it remains unclear how that social capital is developed. More socio-constructivist research in this field can be useful to clarify these ambiguities.

Bibliography

Arunanondchai, J., Fink, C. (2007), 'Trade in Health Services in the ASEAN Region', *working paper 4147,* Policy Research, World Bank.

Baumol, W.J., Blinder, A.S., (2006), *'Economics: Principles and Policy'*, Thomson South-Western, Mason, USA.

Bhagwati, J. (2004), 'The muddles over outsourcing', *Journal of Economic Perspectives,* 18 (4): 93–114.

Busse, R., (2002), 'The European Union and Health Services', IOS Press.

Busse, R., (2006), 'Mapping Health Services Access: National and Cross Border Issues', *Health ACCESS, Final Report.*

Blouin, C., Drager, N., Smith, R. (2006), '*International Trade in Health Services and the GATS, current issues and debates',* The World Bank, Washington DC.

Callon, M., Méadel, C., Rabeharisoa, V. (2002), 'The Economy of Qualities', *Economy and Society,* 31(2): 194-217.

Callon, M., Muniesa, F. (2005), 'Economic Markets as Calculative Collective Devices', *Organization Studies,* 28(8): 1229-50.

Carruthers, B.G. (1999), 'The social structure of liquidity: Flexibility, markets and states', *Theory and Society,* Vol. 28, No. 3, 353-382.

Cattaneo, P. (2009), 'Trade in Health Services: What's in it for Developing Countries', International Trade Department, The World Bank.

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

Fligstein, N., Dauter, L. (2007). 'The Sociology of Markets', The *Annual Review of Sociology*, 33 105-28.

Freidon, E., (2001), '*Professionalism, the third logic*', University of Chicago Press.

Gallup, (2007), 'Cross-border health services in the EU', Flash Eurobarometer 210.

Hindley, B., Smith, A. (1984), 'Comparative Advantage and Trade in Services', *The World Economy*, Volume 7, Issue 4, 369–390.

Irwin, D.A. (1991), 'Mercantalism as Strategic Trade Policy: The Anglo-Dutch Rivalry for the East India Trade', *Journal of Political Economy,* vol. 99, no.6.

Israel, J.I. (1989). 'Dutch Primacy In World Trade, 1585-1740', Oxford University Press, USA.

José, R., Sachdeva, S. (2010). 'Keeping an Eye on Future: Medical Tourism', *Indian Journal of Community Medicine,* July; 35(3): 376-378.

Krugman, P. (1998), "Ricardo's Difficult Idea: Why Intellectuals Don't Understand Comparative Advantage." In Gart Cook (ed.), *The Economics and Policits of International Trade,* Vol. 2 of Freedom and Trade. London: Routledge.

Latour, B. (1987), 'Science in action: How to follow scientists and engineers through society. Cambridge, MA: Harvard University Press.

Lunt, N. (2011), 'Medical Tourism: Treatments, Markets and Health System Implications: A scoping review'.

Mackintosh, M., Koivusalo, M. (2004), 'Health Systems and Commercialisation - In Search of Good Sense', UNRISD international conference March 2004, Geneva.

Marel, E., van der. (2011), 'Determinants of Comparative Advantage in Services', *working paper*, Groupe d'Economie Mondiale (GEM), Sciences Po.

Markusen, J., Rutherford, T., Tarr, D. (2005), 'Trade and direct investment in producer services and the domestic market for expertise', *Canadian Journal of Economics*, Vol. 38, N° 3, 758-777(20).

Mattoo, A,. Rathindran, R. (2006), 'How Health Insurance Inhibits Trade in Healthcare', *Health Affairs*, vol. 25, n°2.

Mattoo, A. (2008) 'A Handbook of International Trade in Service', Oxford University Press, New York.

McFall, L. (2009). 'Devices and Desires: How useful is the 'new' new economic sociology for understanding market attachment', *Sociology Compass,* 3(2), 267-282.

NIVEL, Bes, R., Wendel, S., Curfs, E., de Jong, J. (2012), 'Ervaringen met zorg in het buitenland positief', Factsheet. Utrecht: NIVEL.

NZA, (2007), '*Richting geven aan keuzes',* visiedocument, Utrecht.

Paton, C., (2002), 'The European Union and Health Services: Summary', in R. Busse, *The European Union and Health Services* (Amsterdam, IOS Press): 1-16.

Smith, R., (2006), 'Measuring the globalization of health services: a possible index of openness of country health sectors to trade', *Health Economics, Policy and Law,* 1:323-342.

Smith, R., (2009), 'Trade in health-related services', *Lancet,* 373: 593-601.

Snyder, J., Crooks, V.A., Johnston, R., Kingsbury, P. (2011), 'What do we know about Canadian involvement in medical tourism? A scoping review', *Open Medicine*, 5(3).

Stuiveling, S. (2011), 'Uitgavenbeheersing in de Zorg', Brief aan de Tweede Kamer van de Algemene Reken Kamer, Den Haag.

Yin, R.K. (2003), 'Case Study Research – Design and Methods', Sage Publications, In., Thousand Oaks, California, 3rd edition.

Websites:
[OECD, URL:
http://www.oecd.org/document/8/0,3746,en_2649_37407_2742536_1_1_1_37407,00.html, visited May 2012]

Appendix A: Top List Interviews

Topic list, Interviews
Onderzoek: Internationaal Zorggebruik
Erasmus Universiteit Rotterdam
(t) 06 – 300 43 855
(e) soeskehartjes@hotmail.com

· Hoe betrokken bij internationaal zorggebruik/medisch toerisme/patiënt mobiliteit/ de handel in zorg 'diensten' ?
· Wat is de functie/rol van uw organisatie bij (totstandkoming) vh onderwerp?
· Hoe betrokken? Belang/beweegreden?

· Verloop/Historie zorggebruik over de grens?
· Visie op het verloop/historie?
· Doelstellingen van uw organisatie mbt... ?
· VB casuïstiek of iets opvallends/nieuws/baanbrekends? + Hoe was dat zo?

· Hoe kwaliteit van zorg bepaald? Gewaarborgd?
· Hoe wordt er omgegaan mbt. nazorg? Complicaties/heropnames?

· Heeft u idee dat het bijdraagt aan betere patiënten zorg?
· Heeft u idee dat het bijdraagt aan efficiëntere verdeling van de publieke middelen?
· Wat zou nog moeten/kunnen gebeuren/veranderen mbt. toekomst?