Mainil, T. and Stan, S. 2019. Transnational health care. *In* Winnett, R., Furman, R., Epps, D. and Lamphear, G. (eds.) *Health Care Social Work: A Global Perspective*. Oxford: Oxford University Press, pp: 42-57. https://global.oup.com/academic/product/health-care-social-work-9780190942168?cc=us&lang=en&

Transnational health care

Tomas Mainil[1] and Sabina Stan[2]

1. *NHTV Breda University of Applied Sciences, the Netherlands; CELLO, University of Antwerp, Belgium*
2. *School of Nursing and Human Sciences, Dublin City University, Dublin 9, Ireland*

What is transnationalism in health care

How can we define transnationalism in health care? It is certain that in our contemporary world, many patients, medical professionals, organizations and governments are looking beyond national borders to explore options to access health care services. As such, every movement across national borders seeking to provide or receive health care is transnational. When you are transcending the national health system and its borders, you are performing a transnational action. Ormond and Sulianti (2014) position international medical travel as a social force with transformative capacity. And indeed, transnational dynamics more generally changes the life world of patients and health workers who engage in cross-border health care.

If the health system of Romania is of lesser observed quality than its Hungarian counterpart, the resulting patient mobility (Kovacs et al., 2014) will change the lives of cross-border patients, but also have a transformative impact on both health systems. This raises the question of equity of access: not every Romanian patient is able to cross the border in order to receive better health services. Travelling for medical procedures also incorporates bio-value (Whittaker and Heng Leng, 2016). When patients travel and increase their health, this raises the economic value of their bodies in their countries of residence. And transnational spaces and flows also challenge concepts of citizenship (Ong, 2006).

Transnationalism has been defined as sustained linkages between people, places and institutions across the borders of nation states (Pordie, 2013; Faist, 2010). In transnational health care, these linkages are formed through the transnational flows of patients and healthcare providers, but also of technologies, information and policies. Taking into consideration these flows does not mean discarding the nation state, but considering new territorial assemblages in regard to health issues, and thus introducing what Bochaton (2013) calls a new transnational healthcare paradigm.

This paradigm covers not only medical tourists and migrant healthcare workers but also transnational families (Baldasser, 2007), where transnational care ties develop among migrants , aiding grandparents and their grandchildren overseas. According to Stan (2015) transnational health care practices can also lead to inequalities and marketization. This poses the issue which governmental bodies should evaluate these processes within the transnational spaces. Even some analysts have seen transnationalism as being 'globalization from below' (Guarnizo and Smith, 1998), one can counter argue that most of the dynamics in transnational health care is, in essence, informed not so much by grassroots and democratic logics as by contemporary neo-liberal transformations.

In this chapter we will first observe transnational health on three levels. On the micro-level we see that patients go abroad for health care. We also show that medical professionals are working abroad. On a meso-level we trace the influence of transnational health organizations. On a macro-level we highlight the role of governments in this global arena. Finally we present a case study of the EU as a transnational health care space

Transnationalism and patients

There is a vast diversity in the pathways followed by transnational patients and in their motivations to travel abroad for health care. At the core, patients need to be a willing to travel abroad. This willingness has changed because of the changing landscape of international travel, of availability of information and of marketing of health-care facilities.

Medical travel contradicts the fact that health care is generally and originally marked by its high degree of localism (Exworthy and Peckham, 2015). Evidence of such movement has, however, become, in the last decade or so, more and more conspicuous. For example in Thailand, in 2010 104830 medical tourists visited five private hospitals (Noree et al, 2014). A recent UK study (Hanefeld and Horsfall, 2015) on bariatric surgery found out that transnational patients are more likely to be seen as medical migrants rather than just simple tourists. Other authors are pledging for taking into account the ethics of medical tourism. Patients may be unaware of safety concerns, given their lack of familiarity with the destination health system, and language or cultural barriers to adequate communication with health care workers (Penney et al., 2011). However, these patients may also sometimes benefit from more or less formal networks providing information and recommendation on specific providers (Hanefeld and Lunt, 2015). This is confirmed by another Canadian qualitative study (Johnston et al., 2012) where the majority of participants sought advice from other medical tourists. The study also highlighted the importance of the reputation of the surgeon and the facility as opposed to the characteristics of the destination

Transnationalism and medical professionals

Health professionals' mobility is on the global agenda, following the 2010 WHO code of conduct (WHO, 2010). In 2006 the WHO estimated that 57 countries, 36 of which being in

Africa, were facing severe shortages in trained health personnel (WHO, 2006). Health professionals' mobility impacts on the performance of health systems by changing the composition of the health workforce in both sending and receiving countries (Glinos, 2014). According to Hardy et al. (2014) financial incentives induce the migration of health workers not only from low-to high-income economies, but also from weak to strong core economies and from weak to strong peripheral economies.

For sources countries healthcare worker migration entails financial costs related to the education and training of health workforce, and leads to gaps in service delivery and access. The phenomenon of brain drain can be regarded as an economic cost, since emigrants usually take with them the value of their training sponsored by the country of origin (Kalipeni et al., 2012). In the Philippines, for example, the perceived high demand for nurses in many developed countries made the nursing degree a popular option for many students (Taguinod, 2013). After decades of Global South to Global North nurse migration, new sources of oil wealth in the middle east have created new circuits of South to South health professional migration (Walton-Roberts, 2015). Of course, in the same time the receiving countries benefit from these professional mobilities, as they make important savings in training and education costs (Martineau et al., 2004).

Transnationalism and organizations

Brown et al. (2004: 332) show that '*the dynamics behind the growth of the corporate hospital sector in Australia are: increased access to international and domestic capital and shifts in investment, the emergence of corporate managerialism with the introduction of private sector management techniques and information systems; and changes to the mode of regulation and role of the state*.' In our view these dynamics are even stronger when they become transnational.

Currently hospitals worldwide have developed strategies to attract transnational patients. These strategies have been accompanied by the rising privatization of hospitals. Privatization also many times entails the development of corporate hospital chains. According to Connell (2015) Asia hosts a number of private international hospital chains, such as the Singapore-based Parkway Holdings chain. Also Fortis health care is mentioned as having 75 hospitals in eleven countries, and linked with Parkway by a purchase of a stake in 2010. Hospitals become more transnational also because of Global North and Global South connections, as shown, for example, by the Singapore and Dubai branches of the American hospital chain Johns Hopkins.

Sometimes hospitals are transformed into health theme parks (Lefevbre, 2008), with emerging linkages to hotels. In Thailand, the advertisement developed by private hospitals reveals a constant mix between medical and recreational areas (Bochaton, 2013). According to Lunt (2015) some large international hospitals aim to integrate services by organising finance, travel, accommodation, full concierge, tours, translation and aftercare. This approach mimics the growth of supermarkets with expansion into additional retail and services.

Transnationalism and governments

Some countries, such as the Philippines, have developed active policies to build a migration regime whereby healthcare professionals are trained mostly for export (Taguinod, 2013). Many others have developed national strategies to attract transnational patients. Thailand, Malaysia and South Africa, for example, have developed strategies to increase their offer of services to transnational patients. Since 2003, the Thai Government has attempted to make Thailand a global center for medical tourism by developing the Asia initiative, a center of excellence in health care (Pachanee et al., 2013). Malaysia is also among the most recognized international medical tourism destinations (Ormond, 2013). But in the private hospitals aimed at medical tourists some 95 % of patients are national patients (Ormond et al., 2014). These results illustrate the myth and relative weight of the medical tourism industry.

South Africa is generally pictured as a medical tourism destination into cosmetic surgery (Crush et al., 2015). But the country is in fact much more active in attracting 'medically disenfranchised' patients form neighboring countries who seek to access basic health care that is unavailable or inaccessible in their own countries. Between 2006 and 2012 an estimated 2.8 million individuals crossed the borders to obtain health care in South Africa. This logic is also valid for other neighboring countries such as Malaysia and Thailand, suggesting the importance of inter-regional medical tourism (Ormond, 2014). However, countries such as Malaysia, Thailand, Singapore, South-Korea and Taiwan are investing in the development of medical tourism, and seeing it as an economical engine for their national income (Ormond and Mainil, 2015). Finally evidence of Libyan patient flows to Tunisia (Rouland, 2016) shows the existence of transnational care networks and bottom-up globalization processes, not driven by governmental policies.

Europe as a transnational health care space

Healthcare in Europe has been seen as traditionally being informed by the principle of universal access to services in particular national jurisdictions, a principle translated in the public and/or non-profit delivery of services and a strong involvement of national states in their regulation and funding (Maarse 2006). Since the fall of the Berlin wall, EU integration has both preserved and challenged the strong link between healthcare, public delivery and nation-states in Europe. Indeed, the principle of 'subsidiarity' of last decades' EU treaties sought to keep healthcare policy under national rather than EU jurisdiction. However, in the same period, the increasingly economic, rather than social and political nature of European integration (Greer et al 2016: 264) led to the extension of the common European market and the attendant transnational mobility of people, goods, services and capital into new geographical, economic and social spaces. Despite the Lisbon treaty explicitly excluding healthcare from free movement stipulations (and thus, at least in theory, from the extension of the European common market to the sector), Europe has seen the gradual convergence of rather diverse national healthcare systems towards healthcare services where private actors and interests (including transnational ones) play an increasingly significant role (Hassenteufel et al 2000; Maarse 2006; Andre and Hermann 2009; Schmid et al 2010; Eurofound 2011; Pavolini and Giollen 2013).

An important process that underlies the transnationalisation of European healthcare, namely the diffusion, in Europe and worldwide, of a neo-liberal healthcare governance model seeking to make healthcare services more market than public-sector-like, makes this articulation visible. In Central and Eastern Europe (CEE), the diffusion of the new model has been conducted through transnational policy-making networks with nodes situated in supra-national actors such as the European Commission, international financial organisations (such as the World Bank and the International Monetary Fund) or again international non-governmental organisations (such as Transparency International) (Stan 2007; Deacon and Stubbs 2007). In EU-15 countries, the higher participation of nationally-bred experts in the diffusion of the neoliberal governance model has also been reflected in their relatively greater importance in the transnational networks mobilised in the process (Stamati and Baeten 2015). Finally, 'the EU has [had] an increasing impact on the organization and governance instruments of national healthcare' through a rising 'Europeanized healthcare model' (Marinsen and Vrangbaek 2008: 169). Rooted, especially since the 2008 financial crisis, in 'the EU fiscal governance framework, [and] reinforced by the threat of central bank and market responses' (Greer et al 2016: 278; Erne 2015), the resulting European policy regime is 'more about markets than about individual or aggregate health outcomes' (Greer and Jarman 2012: 260) and has encoded budget austerity goals in EU laws and institutions (Legido-Quigley and Greer 2016: 205).

More generally, the involvement of the EU as 'an extra, albeit thin, layer in organizing, financing and providing healthcare' has led to a 'European healthcare union […] in the making' (Vollaard et al 2016: 171). Indeed, healthcare is 'produced, consumed, and provided across the internal borders of the EU' and member states (MS) can draw on common EU healthcare-related institutions, regulations and financing (Vollaard et al 2016: 171). In the area of cross-border care, examples are legislation on cross-border patient mobility and the recognition of professional qualifications, as well as recently developed institutional designs such as the network of national contact points for information on access and reimbursement for cross-border care in the EU (EC 2015) or European Reference Networks for rare diseases.

The diffusion of a neoliberal healthcare governance model across Europe can be seen as an instance of the transnationalisation of healthcare policy. The process has been uneven, as the model has been introduced at different moments, paces and degrees, and has involved different sets of elements in various national healthcare services. It has permitted, however, the growth of a lucrative market for the corporate, for-profit provision of healthcare services (Lethbridge, 2013: 14).

Significantly, the process of marketisantion of healthcare has been accompanied by the rise in importance and consolidation of a number of European and non-European 'healthcare multinationals' (Andre and Hermann, 2009; Lethbridge, 2013). Notable examples in the area of healthcare provision are Capio (a company based in Sweden and active in several EU countries), Medicover (a Swedish company active in CEE) (Lethbridge, 2013: 16), or again US-owned corporations such as Pacific Health Corporation (already present in 2009 with 56 hospitals in

Germany) or Universal Health Services (already owning 14 hospitals in France in 2009) (Smith et al, 2009: 596).

Several companies active in healthcare now belong to investment funds (Lethbridge, 2013: 25), as private equity investors have become increasingly attracted by 'the historically high returns of the healthcare market [in Europe] – many deals now fetching 10x' (BVCA, 2013: 5). Another indication of the transnationalisation of European healthcare provision is the rise in the international accreditation of healthcare organisations on the continent. 67 (or 20%) of the 329 international accreditations made by Joint Commission International (JCI) between 1999 and 2011 were to hospitals or clinics located in the EU (Woodhead 2013: 697). By 2016, the number of healthcare organisations accredited by JCI in the EU rose to 142, which represents a 112% increase compared to 2011 (JCI 2016).

In the last two decades, the increasing transnationalisation of healthcare policy and provision has also been accompanied by a parallel internationalization (or, we could say, transnationalisation) of higher-level healthcare professional training, and especially medicine. In the last years, an increasing number of higher-level institutions across Europe have started offering medicine and nursing programs in non-national languages, most frequently English but also, albeit more rarely, French. The European University Central Application Support Services (EUNICAS) catering for students looking for cross-border higher-level training in English in Europe (EUNICAS 2016) listed, in 2016, 160 health studies programs (amounting to 16% of the total of 988 programs offered by the platform) spread across 18 countries around the continent.

But not only healthcare policies, services and students are increasingly crossing borders in Europe, healthcare workers have also increasingly done so in the last decade. The transnationalistion of healthcare workforce has been most intense in EU-15 countries, although some CEE MS are also following suite (Maier et al 2011). At the end of 2000s, seven EU-15 countries registered very high (above 20% of the total medical workforce; Ireland and the UK) and high (between 10% and 20%; Belgium, Portugal, Spain, Austria and Sweden) reliance on foreign medical doctors (Maier et al 2011: 26), with one EU-11 country registering very high reliance (Slovenia, 23%) (Maier et al 2011: 27).

While in some EU-15 countries (e.g. the UK and Spain) non-EU workers have been traditionally dominant among foreign healthcare workers, flows of EU healthcare workers, especially from the eastern parts of the continent, have started to grow in importance in the last decades (Maier et al 2011: 35, 43). Mobility of doctors among neighboring MSs has also increased in the last years (Maier et al 2011: 35, 39). As a result, at the end of the 2000a, a number of EU-15 countries (Austria, Belgium, France, Germany and Italy) as well as Slovenia received their foreign healthcare professionals predominantly from the EU (Maier et al 2011: 37, 38). Moreover, the share of medical doctors from other EU countries in the UK medical workforce rose from 6% in 1998 (Maier et al 2011: 39) to 10.8% in 2016 (GMC 2016) following the intensification of inflows from the EU during the financial crisis (Hardy et al 2012: 26).

In parallel with the rising transnationalisation of healthcare in areas of policy, provision, training and workforce, intra-European cross-border patient mobility also increased in the last decade or so. This followed more particularly the formulation of new citizenship rights and the development of new healthcare-related markets in the EU (Mainil, 2012). In addition, health insurers and providers in several EU MSs have started to conclude bilateral arrangements on patient mobility (van Ginneken and Busse 2011: 317-318) and have also been increasingly drawn into cross-border collaborations in e-health and telemedicine (Footman et al, 2014). According to the special Eurobarometer 425 (EC, 2015: 4), the percentage of EU residents who received medical treatment in another MS rose from 4% of the total population in 2007 to 5% in 2014 (EC, 2015: 4). The development of European legislation and of bilateral agreements on cross-border care led to an intensification of frontier cross-border patient mobility (ex. Benelux) but also to thickening flows of east-west and north-south citizenship-based cross-border mobilities (Pacolet and de Wispelaere 2014, a and b; EC, 2015).

In the same time, an already existent health and medical tourism industry expanded its infrastructure and geographical outreach, attracting private patients both to established high-class medical centers in western and northern Europe (Connel, 2015), but also, increasingly, to a developing pool of internationally-oriented medical facilities in Southern and Central and Eastern Europe (Issenberg, 2016). Finally, transnationally mobile Europeans working, studying and living in another EU MS (and most notably in northern and Western Europe, where intra-European migration is concentrated) have displayed strong preferences for recourse to healthcare services in their countries of origins (Stan, 2015; Osipova, 2014; Favell, 2008; Migge and Gilmartin, 2011; Stan, 2016).

Conclusion

Several complementary, but not necessarily always opposing, processes thus drive the transnationalisation of healthcare in Europe. The EU has developed legislation and initiatives that foster the transnationalisation of healthcare based on citizenship rights and members states' commitment to the public/non-profit provision of healthcare. Significantly, the rising marketization of healthcare has been triggered by the transnationalisation of healthcare policy, by the extension of the single market to new sectors and by the increasing cost pressures on healthcare policy following the 2008 financial crisis. In all these processes the EU has played an important role, making thus the union an actor that fosters both citizenship and market-based healthcare transnationalisation on the continent. However, while free movement of people is under serious pressure in the EU following the UK referendum on Brexit and the refugee crisis, the larger forces that drive the transnationalisation of healthcare on the continent are here to stay. Although transnational forces are also present in other regions around the globe, the EU can be perceived as an engine for the sustainable development of transnational health policies.

Funding

This work was supported in part by the European Research Council grant 'Labour Politics and the EU's New Economic Governance Regime (European Unions)', grant agreement ERC 725240**.**

References:

Ormond, M. & Sulianti, D.(2014): More than medical tourism: lessons from Indonesia and Malaysia on South–South intra-regional medical travel, *Current Issues in Tourism.* http://dx.doi.org/10.1080/13683500.2014.937324

Betty Rouland, B., Fleuret, S.and Jarraya, M. (2016, June). Emergence of a transnational care network: Private services and Libyan migrants in Sfax, Tunisia. Paper presented at the academic conference IMTJ summit Retrieved from https://summit.imtj.com/academic-abstracts/

Kovacs E, Szocska G, Knai, C. (2014). International Patients onOperation Vacation – Perspectives of Patients Travelling to Hungary for Orthopaedic Treatments. *Int J Health Policy Manag*; 3: 333-40. doi: 10.15171/ijhpm.2014.113.

Ong, A. (2006). Neoliberalism as Exception. Duke University Press, Durham.

Whittaker,A. Leng, C.H. (2016). Flexible bio-citizenship' and international medical travel: Transnational mobilities for care in Asia. *International Sociology*; Volume: 31 Issue: 3 Pages: 286-304 DOI: 10.1177/0268580916629623.

Taguinod, F. (2013). Licensed to Care: Inhabiting the Transnational Economy of "Global Pinoy", PhD Thesis. Dublin Technology Institute. http://arrow.dit.ie/appadoc/38/

Pordié, L. (2013). Spaces of Connectivity, Shifting Temporality. Enquiries in Transnational Health. *European Journal of Transnational Studi*es; 5 (1), 6-26.

Faist, T. (2010). Towards transnational studies: world theories, transnationalisation and changing institutions. *Journal of Ethnic and Migration Studies* 36(10), 1665-1687.

Bochaton, A. (2013). The rise of a transnational healthcare paradigm : Thai hospitals at the crossroads of new patient flows, *European journal of transnational studies*; 5 (1), 54-80.

World Health Report (2006) Working Together for Health. World Health Organization.

Baldassar, L. (2007). Transnational families and aged care: The mobility of care and the migrancy of ageing. Journal of Ethnic and Migration Studies. 33 (2), 275-297.

Stan, S. (2015). Transnational healthcare practices of Romanian migrants in Ireland: inequalities of access and the privatisation of healthcare services in Europe. *Social Science and Medicine*, 124: 346-355.

Woodhead, A. (2013). Scoping medical tourism and international hospital accreditation growth. *International Journal of Health Care Quality Assurance*, 26, 8L 688-702 http://www.emeraldinsight.com.dcu.idm.oclc.org/doi/pdfplus/10.1108/IJHCQA-10-2011-0060

Guarnizo, E. and Smith, M.P. (1998). The Locations of Transnationalism in Guarnizo, E. and Smith, M.P. (eds.) Transnationalism From Below. Comparative Urban and Community Research V6 – 1998 New Brunswick: Transaction Publishers.

Exworthy, M. and Peckham, S. (2015). Patients' willingness to travel .in Hanefeld, J., Horsfall, D., Lunt, N.; Handbook on Medical Tourism and Patient Mobility, Cheltenham, Edward Elgar Publishing.

Noree, T. Hanefeld, J. and Smith, R.(2014). UK medical tourists in Thailand: they are not who you think they are. *Global Health*; 10: 29.doi: 10.1186/1744-8603-10-29.

Hanefeld, J. and Horsfall, D.(2015). Journey without end: travelling overseas for bariatric surgery: a qualitative study of UK patients travelling for bariatric surgery in Hanefeld, J., Horsfall, D. and Lunt, N. (eds.) Handbook on Medical Tourism and Patient Mobility, Cheltenham, Edward Elgar Publishing.

Penney, K.,Snyder,J., Crooks, V.A. and Johnston, R. (2011). Risk communication and informed consent in the medical tourism industry: A thematic content analysis of Canadian broker websites. *BMC Medical Ethics*. 2011; 12: 17. doi: 10.1186/1472-6939-12-17.

Hanefeld, J., Lunt, N.,Smith, R., Horsfall, D. (2015). Why do medical tourists travel to where they do? The role of networks in determining medical travel. *Social Science & Medicine* 124 (2015) 356e363.

Johnston, R., Crooks, V.A. and Snyder, J. (2012). "I didn't even know what I was looking for": A qualitative study of the decision-making processes of Canadian medical tourists. *Globalization and Health*; 8:23.

Glinos, I.A. (2014). The Possible Effects of Health Professional Mobility on Access to Care for Patients in R. Levaggi and M. Montefiori (eds.), Health Care Provision and Patient Mobility, Developments in Health Economics and Public Policy 12.

WHO. WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva, World Health Organization(63rd World Health Assembly, WHA63.16); 2010. Available at:http://www.who.int/hrh/migration/code/WHO global code ofpractice EN.pdf

Hardy, J., Shelley, S. and Calveley, M., Kubisa, J. and Zahn, R. (2016). Scaling the mobility of health workers in an enlarged Europe: An open political-economy perspective. *European Urban and Regional Studies* 1–18.

Walton-Roberts, M. (2015). International migration of health professionals and the marketization and privatization of health education in India: From push-pull to global political economy. *Social Science & Medicine* 124 (2015) 374e382.

Martineau, T., Decker, K., Bundred, P. (2004). "Brain drain" of health professionals: from rhetoric to responsible action. *Health Policy*; 70, 1–10.

Kalipeni, E. Semu, L.L., Asalele Mbilizi, M.(2012). The brain drain of health care professionals from sub-Saharan Africa: A geographic perspective. *Progress in Development Studies* 12, 2&3, 153–171.

Brown, L., Barnett, J.R. (2004). Is the corporate transformation of hospitals creatinga new hybrid health care space? A case study of the impact of co-location of public and private hospitals in Australia. *Social Science & Medicine* 58 427–444.

Connell, J. (2015). Transnational Health Care: Global Markets and Local Marginalisation in Medical Tourism. In Parry,P.,Greenhough,B., Brown, T. Dyck, I. (Eds.), Bodies Across Borders: The Global Circulation of Body Parts, Medical Tourists and Professionals, (pp. 75-93). Farnham: Ashgate.

Lefebvre, B. (2008): The Indian corporate hospitals: touching middle class lives. In Jaffrelot, C. and van der Veer, P., (eds.), Patterns of middle class consumption in India and China. Los Angeles: Sage, 88- 109.

Pachanee, C.A., Wibulpolprasert, S. (2006). Incoherent policies on universal coverage of health insurance and promotion of international trade in health services in Thailand. *Health Policy & Planning;* July;21(4):310–8. 10.1093

Ormond, M. (2013). Neoliberal Governance and International Medical Travel in Malaysia. London, Routledge.

Crush, J. Chikanda, A. Sanders, D. and Maswikwa, B. (2015). The rise of medical tourism to South Africa , in Hanefeld, J., Horsfall, D., Lunt, N (eds.) Handbook on Medical Tourism and Patient Mobility, Cheltenham, Edward Elgar Publishing.

Ormond, M. and Mainil, T. (2015). Government and governance strategies in medical tourism, in Hanefeld, J., Horsfall, D., Lunt, N (eds.) Handbook on Medical Tourism and Patient Mobility, Cheltenham, Edward Elgar Publishing.

André, C. and Hermann, C. 2009. Privatisation and marketisation of health care systems in Europe. In Frangakis, M., Hermann, C., Huffschmid, J., Lóránt, K. (eds.). Privatisation against the European Social Model. A Critique of European Policies and Proposals for Alternative. Palgrave Macmillan: 129-144.

BVCA (British Private Equity and Venture Capital Association). 2013. Guide to Investing in European Healthcare. Available at http://www.bvca.co.uk/portals/0/library/documents/bvca per cent20guide per cent20to per cent20investing per cent20in per cent20european per cent20healthcare.pdf

Connel, J. 2015. From medical tourism to transnational health care? An epilogue for the future. Social Science and Medicine. 124: 398-401.

Deacon, B. and Stubbs, P. (2007). Social Policy and International Interventions in South East Europe. Cheltenham, UK: Edward Elgar.

Erne, R. (2015) A supranational regime that nationalizes social conflict. Explaining European trade unions' difficulties in politicizing European economic governance. Labor History. 56, 3: 345-368.

European Foundation for the Improvement of Living and Working Conditions (Eurofound). (2011). Employment and Industrial Relations in the Healthcare Sector. Dublin: Eurofound. Available at «http://www.eurofound.europa.eu/eiro/studies/tn1008022s/tn1008022s.htm».

European Commission (EC). (2015). Commission Report on the Operation of Directive 2011/24/EU on the Application of Patients’ Rights in Cross-border Healthcare. Brussels: European Commission.
file:///Users/sabinastan/Downloads/2015_operation_report_dir201124eu_en.pdf

European Union (EU). (2015). Special Eurobarometer 425. Patients’ Rights in Cross-border Healthcare in the European Union. EC: Directorate General for Health and Consumers.

European University Central Application Support Services (EUNICAS). 2016. Health sciences programmes. Available:

http://eunicas.ie/index.php/eunicas/search.html?discipline=82&ordering=&searchphrase=all&searchword=

Eurostat. (2016). Self-reported Consultation of a Medical Professional by Sex, Age and Educational Attainment Level (%). EC: Eurostat. http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_hc5&lang=en

Favell, A. (2008). Eurostars and Eurocities. Free Movement and Mobility in an Integrating Europe. Oxford: Blackwell Publishing.

Footman, K., Knai, C., Baeten, R., Glonti, K. and McKee, M. (2014). Cross-border Health Care in Europe. World Health Organization: European Observatory on Health Systems and Policies.

Galotti, M. (2015). Migrant Domestic Workers Across the World: Global and Regional Estimates. Geneva: International Labour Organisation. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/briefingnote/wcms_490162.pdf

General Medical Council (GMC). (2016). List of Registered Medical Practitioners – Statistics. GMC. Available: http://www.gmc-uk.org/doctors/register/search_stats.asp.

Greer, S. and Jarman, H. (2012). Managing risks in EU health services policy: Spot markets, legal certainty and bureaucratic resistance. Journal of European Social Policy. 22, 3: 259–72.

Greer, S., Jarman, H. and Baeten, R. (2016). The new political economy of healthcare in the European Union: The impact of fiscal governance. International Journal of Health Services. 46, 2: 262-282.

Hardy, J., Calveley, M., Shelley, S., and Zahn, R. (2012). Opportunities and Challenges Related to Cross Border Mobility and Recruitment of he Healthcare Workforce. European Public Services Union. http://www.epsu.org/sites/default/files/article/files/EPSU-Report-Migration-Health-Workers-Final-Version_Appendices-EN.pdf

Hassenteufel, P., Delaye, S., Pierru, F., Robelet, M., and Serré. M. (2000). La libéralisation des systèmes de protection maladie européens. Convergence, Européanisation et adaptations nationales. Politique Européenne. 2: 29-48

Issenberg, S. (2016). Outpatients : The Astonishing New World of Medical Tourism. New York : Columbia Global Report.

Joint Commission International (JCI). (2016). JCI-Accredited Organizations. http://www.jointcommissioninternational.org/

Legido-Qigley, H. and Greer, S. (2016). Austerity, health and the eurozone. International Journal of Health Services. 46, 2: 203-207.

Lethbridge, J. (2013). ‘Expansion and consolidation? Major Trends and Eligibility for European Work Councils’. European Federation of Public Service Unions: Public services International Research Unit. Lunt, N., Horsfall, D., and Hanefeld, J. 2016. Medical tourism: A snapshot of evidence on treatment abroad. Maturitas. 88. 37–44.

Maarse, H. (2006). The privatization of health care in Europe: An eight-country analysis. Journal of Health Politics, Policy and Law. 31, 5: 981–1014.

Maier, C., Glinos, I., Wismar, M., Bremner, J., Dussault, G. and Figueras, J. (2011). Cross-country analysis of health professional mobility in Europe: the results. In Wismar, M, Maier, C., Glinos, I., Dussault, G. and Figueras, J. (eds.) Health Professional Mobility and Health Systems. Evidence from 17 European Countries. Copenhagen: European Observatory on Health Systems and Policies.

Mainil, T. (2012). Transnational Healthcare and Medical Tourism: Understanding 21st Century Patient Mobility. Towards a Rationale of Transnational Health Region Development. PhD thesis, NHTV Breda University of Applied Sciences, University of Antwerp, Belgium.

Marinsen, D. S. and Vrangbaek, K. (2008). The Europeanisation of health care governance: Implementing the market imperatives in Europe. Public Administration. 86, 1: 169–84.

Migge, B. and Gilmartin, M. (2011). Migrants and healthcare: investigating patient mobility in Ireland. Health and Place. 17, 5: 1144–1149.

Osipovic, D; (2013) 'If I get ill, it's onto the plane, and off to Poland.' Use of health care services by Polish migrants in London. Central and Eastern European Migration Review. 2, 2: 98-114.

Pacolet, F. and F. de Wispelaere. (2014a). Planned cross-border care. PD S2 Questionnaire. European Commission: Network Statistics FMSSFE.

Pacolet, J and de Wispelaere, F. (2014b). The European Health Insurance Card. EHIC Questionnaire. European Commission: Network Statistics FMSSFE.

Pavolini, E. and Gillen, A. 2013. Health Care Systems in Europe under Austerity Institutional Reforms and Performance. Palgrave McMillan.

Schmid, A., Cacace, M., Gotze, R. and Rothgang, H. (2010). Explaining health care system change: problem pressure and the emergence of “hybrid” health care systems. Journal of Health Politics, Policy and Law. 35, 4: 455–86.

Smith, R., Chanda, R. and Tangcharoensathien, V. (2009). Trade in health-related services. Lancet. 373, 9663: 593-601.

Stamati, F. and Baeten, R. (2015). Varieties of healthcare reform: understanding EU leverage. In Natali, N. and Vanhercke, B. (eds.) Social Policy in the European Union: State of Play 2015. Sixteenth Annual Report. Brussels: ETUI, OSE: 183- 214.

Stan, S. (2016). Transnational patient mobility and healthcare mobilities and governance processes in Europe: towards a rising European healthcare system? Paper presented at the IMTJ Academic Conference 'Medical tourism: Time for a check-up?' Madrid, Spain, 25-26 May.

Stan, S. (2015). Transnational healthcare practices of Romanian migrants in Ireland: inequalities of access and the privatisation of healthcare services in Europe. Social Science and Medicine, 124: 346-355.

Stan, S. (2007). Transparency: Seeing, Counting and Experiencing the System. Anthropologica. 49, 2: 257-273.

Van Ginniken, E. and Busse, R. (2011). Cross-border health care data. In Wismar, Matthias, Palm, Willy, Figueras, Josep, Ernst and van Ginneken, Ewout (eds.) Cross-border Healthcare in the European Union. Mapping and Analysing Practices and Policies. World Health Organization: European Observatory on Health Systems and Policies: 287-344.

Vollaard, H., van de Bovenkamp, H., Martinsen, D. (2016). The making of a European healthcare union: a federalist perspective. Journal of European Public Policy. 23, 2: 157-176.

Wismar, M., Palm, W., Figueras, J., Ernst, K., van Ginneken, E. (2011). Cross-border healthcare in the European Union. Mapping and analysing practices and policies. World Health Organization: European Observatory on Health Systems and Policies.

Woodhead, A. (2013). Scoping medical tourism and international hospital accreditation growth, International Journal of Health Care Quality Assurance, 26, 8: 688 – 702.

http://www.emeraldinsight.com.dcu.idm.oclc.org/doi/pdfplus/10.1108/IJHCQA-10-2011-0060