University of Strathclyde

Department of Strategy and Organisation

The Internationalisation of Health Care and the Medical Profession: Evidence from Greece

by

Kalliopi Skountridaki

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This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

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ABSTRACT

This thesis brings together two distinct bodies of knowledge, the Sociology of the Professions and literature on International Patient Movement, in order to examine the dynamics of contemporary trends in global health care provision. The thesis suggests that the international movement of patients coincides with symbolic changes in the penetration of commercial practices in health care. The role of states and transnational regulatory bodies in promoting trade in health services directly and indirectly accounts for it to a significant extent. Against the backdrop of accentuated commercialisation and marketisation key actors are reconceptualised as market agents who consequently reinforce marketisation and contribute to the creation of a vicious cycle of commercialisation within health care.

Within this framework the study seeks to shed light on the role of medical professionals in the emergence of the internationalisation health care, through the case of physicians practicing on a solo basis in Greece. It is informed about the perspectives and initiatives of medical professionals on the internationalised market through a qualitative research design based on 32 semi-structured interviews with health professionals.

The research findings provide evidence that medical professionals play a prominent role in the emergence of transnational health care provision. The results extend the literature on commercialised professionalism (Hanlon, 1998) by showcasing professionals who adopt an entrepreneurial self and explore the business opportunities arising from the international patient movement. Displaying an entrepreneurial spirit they employ marketing techniques to attract foreign patients

to their practices; exemplifying a case of contemporary professionalism which may be characterised as enterprising. The omnipresent enterprise culture and the competitive forces forge the emergence of professionalism characterised by lack of disinterestedness (Brint, 1994), individualism, and a strong career focus, as a strategy for adaptation to the changing environment. The effort to perpetuate professional dominance (Freidson, 2006; Larson, 1977) in the emerging internationalised landscape with the subjugation of the new actor, the medical tourism agents, however, gives evidence that elements of continuity and change co-exist and co-shape professionalism (Evetts, 2011).

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CHAPTER 1

INTRODUCTION

This research focuses on the emerging landscape of transnational health care provision. A brand new field for academic exploration, internationalisation of health care is increasingly attracting attention due to its relevance to health policy, business ventures, international trade, and concerns over health equity and equality. It is noteworthy that a number of stakeholders are directly involved, including patients, medical providers, health professionals, the business and public sector, the state, and supranational governmental bodies. Internationalisation of health care is dynamically evolving, however, it remains mostly unexplored. Considering its dynamic impact on a range of stakeholders, advancing an understanding of structures and agency is deemed not only meaningful but also imperative. In light of this, the current thesis critically evaluates existing literature, and aims to shed some light on the practice and theory of international patient travel through empirical research. It employs qualitative methods to explore the perspective and initiatives of a key actor, the medical professionals engaged to the practice. The sociology of the professions, then, serves as the conceptual framework through which collected data are analysed and then synthesised into the research findings.

Internationalisation of Health Care

The body of literature examining the internationalisation of health care and international patient movement is distinguished for its rapid growth and multidisciplinary character. Drawing on law, economics, sociology, anthropology, social policy, and ethics among others, scholars explore theoretically and, to a smaller extent, empirically the emergence and function of the new submarket. It is characteristic that most often patients as individuals serve as the unit of analysis with decision-making (push and pull factors) being at the centre of discussions. Amidst important policy shaping within the European Union (EU Directive on Patient Mobility) and beyond (General Agreement on Trade in Services, World Trade Organisation, WTO) research on various aspects of the development is deemed essential. The literature, after all, captures significant issues in international patient movement that may be of concern. For example, several publications by medical doctors in the UK (Jeevan and Armstrong, 2008), Canada (Birch *et al.*, 2010), Australia (Barrowman *et al.*, 2010), and Germany (Terzi *et al.*, 2008) warn of numerous admissions of malpractice cases from overseas treatment. They also note that treatment abroad may create a misallocation of resources (Jeevan and Armstrong, 2008; Birch *et al.*, 2007), substantial personal financial burdens, or transmission of nosocomial diseases (Miyagi *et al.*, 2011; Hall and James, 2011). In addition, academic scholars explore the development in relation to a range of aspects: the broader trends of privatisation and commercialisation in health care (Chee, 2007), the contradictory nature of commercialisation and health equity (Chee, 2007; Pocock and Phua, 2011; Ledigo-Quigley *et al.*, 2007; Sengupta,

2011); the advantages and disadvantages of patient movement (Smith *et al.*, 2011; MacLean, 2007; Smith 2012), administrative, communication, and information burdens (Groene *et al.*, 2009), the initiatives of states and supranational bodies to encourage international trade in health care (Chee, 2010; Kim *et al.*, 2012; Liu, 2012; Crush *et al.*, 2012) and the necessity for regulation and patient protection (Brady, 2007; Burkett, 2007; Cohen, 2012; Cortez, 2008; Svantesson, 2008).

It becomes obvious that the phenomenon in hand is complex in nature and the moral dilemmas arising are a cause of further concern and debate. Unfortunately, research and findings have still a long way to go. Contributions are valuable but leave much unexplored in terms of depth and variety. For example, business interest and policy making stand in a vacuum of hard data (Chanda and Smith, 2006). Namely, patient flows comprise a grey area; little is known about who travels to where, in what frequency, and for which treatments. Simultaneously, little is known about the *intentions* of patients to travel abroad. Given the anticipated policy changes, intentions will indicate the effect these policies might have. Qualitative insights (soft data) are also scarce. While some ethnographic work on medical travel sites and qualitative work on patient decision making and experiences has been published, little academic research exists on medical providers, the quality of care, communication in a multi-cultural and multi-lingual environment, power relations, and dynamics at play. Of no less significance is the fact that the medical providers, in particular medical professionals, are completely neglected. Some research has been published on patients, agents, governmental initiatives, and supranational

regulation, however, there has been no research to the knowledge of the author that investigates the perspective of medical professionals.

Physicians are key actors in the delivery of health care and simultaneously a key pull factor in patient decision making process in medical travel. Moreover, evidence indicates that medics may play a more important role than providing consultation and treatment; their role seems to be pivotal in the emergence of transnational health care in itself. In light of this, this research places medical professionals in the centre of transnational health care provision as an emerging field. It focuses on physicians as active agents and sets out to explore their perceptions, attitudes and experiences in order to shed light on their role in the development of the internationalisation of health care.

Before moving to the rationale of this research, a short mention of the terminology is deemed appropriate. Namely, the bulk of the literature employs the term 'medical tourism/travel' to refer to the development, which is not particularly favoured here because of its connotations. In contrast, the current thesis prefers transnational health care to refer to the practice and sector; internationalisation of health care to refer to the emerging process, and international patient movement to refer to the travel that people undertake to seek medical treatment far from home[1].

[1] The terminology will be explored in more detail in the literature review.

Context and Rationale: The Role of Medical Professionals in a Highly Commercialised Environment

International patient movement takes place at the centre of multiple forms of commercialisation. Internationalisation of health care is a development endorsed by international regulatory bodies as a form of trade and embraced by some states as an increasing returns business sector. As such it is conceived and inextricably linked to marketisation. In some cases bilateral agreements between countries, as is the case for specific bordering regions in EU (Rosenmöller *et al.*, 2006), form an exception to marketisation. Most often, however, the publicised empirical research on various aspects of the development depicts key actors as market agents; including providers, agents, and patients. In particular, providers are for-profit organisations that employ marketing techniques to reach their potential clients overseas; specialised agencies advertise health services and intermediary between patients and clinics; and patients take health care in their own hands and decide on providers based not only on quality of service but, often, on cost. The resemblance to the market characteristics of any other 'commodity' is striking; quality, price, sales, marketing, international ventures and international trade dominate. The commercialised character of the sub-sector of health care coincides with a wider contemporary trend of enterprise culture in public policy. Closely related to neo-liberalism, state policies prioritise managerial practices and collaborations between the public and private sector in the provision of social goods. As a result, internationalisation of health care takes place in a historical context where private

ventures are intellectually favoured by policy makers as a superior mode of organisation and production. Marketisation is continuously expanding and currently plays out as socially acceptable (Scott, 2008) and the unavoidable final destination of every human interaction. Practice and ideology, private and public sector strongly favour it.

Medical providers delivering care to international patients form no exception. They are often small and medium practices operated by medical doctors on a solo basis or small partnerships. This is evident in Greece, but it seems that in Hungary, Costa Rica, Singapore, South Africa and other destinations, small and medium providers attract a significant part of inbound patient flows. This is actually what captures the attention of the current research and places medical professionals at the centre of discussion; displaying evidence of professional agency within a highly commercialised context. In fact, their attachment to commercialisation can be easily observed. A quick online search is sufficient for the visitor to see a marketing style adopted in their websites, or to identify collaborations with specialised tourism portals promoting providers to patients in an international level. Some doctors also run tourism agencies. It is worth noting here that, even though medical marketing is widespread in the US, in other countries it most often faces substantial legal restrictions. This has been a long-term requirement justified on the grounds that health care provision should not have a commercial character and that, correspondingly, medical doctors are not expected to conduct commerce. How, then, what seems to be substantial business agency is to be analysed and interpreted remains to be explained. The conceptual framework is central in the

research process as an instrument of analysis. At the same time, however, it serves as a lens through which the researcher looks at the research objectives and refines them into well-developed research questions. The next section outlines the basic premises of the Sociology of the Professions as a conceptual framework and introduces the specified research questions the current thesis aspires to address.

Conceptual Framework

The sociology of the professions acknowledges that a narrative of disinterestedness has played out as a legitimacy mechanism for medical professionals, securing a market shelter provided by the state. Entrance restrictions through training and licensure function as closure mechanisms, while advertising restrictions protect medical professionals from competition forces, and endorse fraternity within their community. This is reflected in their identity which bonds professionals to the profession. As such, this distinction between commerce and medicine has been long maintained. Though this is rapidly changing, remnants are still in place, creating conditions for conflict, and, through that, potentially major change.

In light of this, entrepreneurial initiatives undertaken by medical doctors within the internationalisation of health care imply that they play a role in forging commercialisation. The publicised and contrasting opposition of their peers to the practice of international patient movement in countries such as UK, Canada, the US, Germany, and Australia, makes the research objectives even more compelling.

Questions of how MDs who pursue foreign clientele conceptualise the internationalisation of health care, but also what exactly is their agency with respect to the international orientation of their practice arise. A much deeper exploration of how perceptions and agency are reflected on the professional value-system and the professional identity become pressing. Tensions between professional ethics and identity as formulated traditionally within medical communities and the increased commercialisation or the freshly adopted marketing strategies, are anticipated. It is these potential tensions that the current thesis aspires to explore as crucial in understanding the impact of market dynamics on medical professionals. For one thing, the literature on the sociology of the professions examines both tensions and the impact of externally imposed commercial practices; e.g. Stone (1997) and Light (1995) discuss the implications of new organisational arrangements in the US brought along by the rise of insurance companies as third party payers. The subsequent business attitudes of professionals, however, are understood as externally triggered; a consequence of financial incentives to subscribe less medication or therapies and order fewer medical examinations (Stone, 1997). The difference in the case of transnational health care provision seems to lie to the fact that MDs exhibit entrepreneurial attitudes spurred by their own initiatives. Even though international patient movement is growing amidst broader trends, unrelated to medics and their associations, their actions do not seem to be a mere reaction to pressing conditions. How then medics in countries such as Hungary, Costa Rica, Singapore, or Greece among others think and act with respect to this marketised sub-sector treating foreigners remains to be explored.

Contextual Relevance

Despite the ambitions of the current research, it is most suitable to focus on one destination. As a result medical doctors practicing privately in Greece will serve as a case study, keeping in mind that contextual factors (such as professional power in Greece, organisational arrangements in the domestic health care sector, and special characteristics of medics) are influential and need to be analysed too. Greece comprises an interesting case and particularly suitable for exploration for three basic reasons. First, the sub-market is in its infancy, therefore, future events are now being shaped. This increases the potential of understanding the dynamics. Second, the solo-practice model of medical services still dominates in Greece with professionals maintaining power over patients and the overall supply of care. Third, large private hospitals in Greece have not formed a strategy as yet, leaving the first move to those medical doctors who were pioneers in developing foreign clientele already. Contextual parameters are given special attention. The current research focuses on the initiatives and motives of doctors in Greece and how these may be perceived as constrained or enabled by forces such as the state, the function of the markets, and the Greek social reality (political corruption, low social capital, familialism, etc.) and the conjuncture of the debt crisis. It explores the interplay between these forces and professional agency which results in the creation of events. The method employed plays a crucial role in enabling such an inquiry; qualitative interviews allow participants to explain what constrains or facilitates their actions and reflect on how they perceive and realise their choices. It will be demonstrated in the data analysis, for instance, that MDs in Greece pursue their

goals in relation to the emerging market in a disaggregated and individualist way. The interviews give the opportunity to uncover how this comes about; in contrast to the collective agency of medics in the US or UK, research findings suggest that privately practicing MDs in Greece show low trust both in their associations and the state. This inhibits collective action or organised efforts to exercise pressure on the state. In combination with the competitive environment in the private sector, as MDs describe it, leaves little room for collaboration. The central role of contextual factors becomes obvious. Consideration of the insights of the theory of professions, alongside the role of contextual factors, and the research objectives, leads us to the research questions summarised below.

Aims and Objectives

The current research explores the perceptions, attitudes and experiences of medical professionals in order to shed light to their role on the emergence of transnational health care. In particular, it seeks to address how medical professionals conceptualise the internationalisation of health care with respect to themselves as doctors, patients as medical travellers, health care as a national system, Greece as a destination country, and the medical profession itself. In particular, it is interested in the contextual environment, the strategies deployed at an individual and organisational level and the implications for professionalism. The research employs in-depth interviews to explore the perspective of health professionals, and allows them to express themselves in their own words. The explorative nature of this research implies that unanticipated information is expected

to emerge and offer fruitful insights which will improve awareness and understanding of the internationalisation of health care.

Overview

The next chapter (chapter 2) introduces the reader to the topic of international patient movement by presenting two different theoretical approaches that emerge from the literature. This part of the literature is critiqued for its narrow conception and under-theorisation. Thereafter, the ambiguity in terminology employed in the literature is clarified and a critique of the implicit assumptions of the most popular term, 'medical tourism', is presented.

The third chapter outlines the empirical contributions to the literature through an agent-based representation of the sector. Research findings and insights on patients, intermediaries, states and physicians are presented, highlighting the commercialised context within which they operate. It concludes by noting how the sub-market epitomises the advent of market rules in health care with advertising; brokers' involvement; consumerist behaviours; entrepreneurship and competition among providers dominating, in a setting characterised by lack of regulation.

The fourth chapter introduces the professions and professionalism as examined by the Sociology of the Professions, which offers the conceptual framework of the current thesis. It reviews the 'dominance' (or 'conflict') paradigm, largely influential during the 1970s and 1980s, and discusses notions such as professional autonomy, professional ethics, knowledge and expertise, prestige and professional identity. In

addition, it examines the challenges encountered by professionals after the 1970s in a number of countries, including managerialism, consumerism, withdrawal of state, and concentration to large organisations. It then carefully outlines professional agency in an organised and individual level, and strategies deployed to defend professional position. It also describes how new practices infiltrate professionalism, showing tendencies of adaptation to a rapidly changing environment, and concludes by presenting the research questions.

The purpose of the fifth chapter is to engage the reader in the research process by describing the research design and journey. It justifies the choice of qualitative methods, and in-depth semi-structured interviewing in particular, as the most suitable method of inquiry. It then discusses the critical realist philosophical underpinnings of the research approach, reflects on the data analysis process and, last but not least, reflects on ethical issues arising during qualitative research.

The sixth chapter briefly introduces the Greek private health care sector and the professional power of medics. It touches upon the influence over public policy by organised medicine, the autonomy over the content of work and authority in the private sector.

The following three chapters, 7, 8 and 9, continue with a discussion on the research findings. They offer insight on the agency of medical professionals which is infused by entrepreneurial attitudes. This finding enhances the theory of professions with an example of an enterprising profession. The argument is further supported by showing how entrepreneurial attitudes penetrate the value system of professionals

and infiltrate their professional identity, signifying ground-breaking changes in professionalism. At the same time, efforts to maintain professional power amidst the differentiated health care environment, and with regards to a new key actor, highlight the analytical usefulness of the dominance paradigm of the sociology of the professions. It stresses, that alongside substantial change, continuity in professionalism is in place.

The last chapter concludes the thesis. It summarises the main findings, outlines the contribution to knowledge, and finally discusses the implications for future research.

CHAPTER 2

INTERNATIONALISATION OF HEALTH CARE

Introduction

This chapter reviews the existing literature on the development of international patient movement from a critical perspective. In particular, it outlines the theoretical contributions in two distinct parts before it proceeds with the examination of empirical contributions in chapter 3. The first part of this chapter, introduces the reader to the topic by presenting literature that engages in a descriptive style. Scholars examine the development from a micro-perspective. As such analysis is reduced to a consideration of patient movement and remains de-contextualised and under-theorised. The review continues with outlining the contributions of scholars taking a macro-economic perspective to the internationalisation of health care. The phenomenon is presented as a form of trade, and international patient movement is depicted as *consumption of (health) services abroad*. It is argued that this approach is problematic because it fails to capture what it means to reconceptualise health care provision into *trade in services.* It thus remains uncritical to the implications for health care systems or health equity and equality. The second part takes up the task to tackle the definitional fuzziness that prevails in the literature. It clarifies popular terms such as medical tourism, health tourism, and patient mobility and proceeds

with a critique of these terms. These terms are criticised not only for their inadequacy to describe the phenomenon under examination, but also for its biased assumptions and connotations. The critique turns to the critique of the practice itself and paves the way to chapter 3, where the link between commercialisation and internationalisation of health care is explored through the fruitful insights of empirical work conducted on the topic.

The Growth of International Patient Movement:

A Micro-Approach

Medical Travel is not new in the sense of a patient travelling for cure in another region or country (Hall, 2011). Medical travel has taken place since ancient times; during the Roman period; and the 18th and 19th centuries; mostly by individuals and families with the requisite financial means. The nuance in medical travel nowadays is the reversal of this trend (Gray and Poland, 2008). Except for developed countries, patients travel increasingly to developing ones (de Arellano, 2007; 2011). The developing countries no longer lack expertise and technology in many standardised medical procedures and the prices of services are considerably lower than those in developed economies (Svantesson, 2008; Glinos *et al.,* 2010; York, 2008; Abdullah, 2006; Barrowman *et al.,* 2010; Badwe *et al.*, 2012). It is exactly 'North to South' patient movement (Crush *et al.*, 2012) that has captured most recently the attention of the media and thereafter academic scholars. Nevertheless, 'South to South' travel should not be underestimated. As an increasing number of

studies on Asian destinations emerge, the momentum of population movement within developing countries is progressively attracting the attention of analysts and scholars.

Dispersed information on movement of patients gives the reader an idea of the dynamics of the sector given the lack of official hard data. For example, Herrick (2007) reports that next to the 250 thousand people who travelled to the US for health care in 2006, 150 thousand travelled to Costa Rica. Furthermore, according to the 2008 United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP], the number of people who visited Malaysia, India, Singapore, and Thailand during 2005 for medical treatment was over 2.5 million (Heung *et al.*, 2010). It is estimated that 63 thousand UK patients travelled overseas in 2010 (Lunt *et al.*, 2013) and 2 million Americans travelled abroad for health care in 2008 (Bauer, 2009). Within the European Union (EU), data from a Flash Barometer Survey show that as much as 4% of the population receives treatment in another EU member state (Lunt and Carrera, 2010). Abdullah (2006) reports that 10% of patients in EU get treatment in a foreign country with a total spending of 12 billion euro, while a survey of 2,304 Canadians shows that 2% of the sample has been abroad to 'consult with a doctor, undergo a medical test or procedure, or receive treatment' (Johnston *et al.*, 2012: 4). Figures presented here are only a fraction of the estimates circulating in the academic journals and press. These are taken by papers in peer reviewed journals and a research institute policy report (Herrick, 2007). Nevertheless, as there are no official data these figures cannot be

considered reliable. Their importance lays more to the fact that they offer evidence of the flows of patients across the globe.

Driving forces underlying cross-border movement for health care

In the early part of the new millennium, scholars, initially from the US, began to observe a growing trend of patients flowing outside of their home country for medical care. Media reports and internet portals provide evidence, for example, of Americans and Canadians moving to Asian or Latin American countries for cheaper dental care; cosmetic surgery; ophthalmologic care; timely orthopaedic surgery (hip and knee replacement); accessible fertility treatment; diagnosis tests; affordable cardiovascular surgery; or even gender reassignment, and bariatric surgery (Marlowe and Sullivan, 2007; Horowitz, 2009; Beecham, 2002; Carabello, 2008; also see Turner, 2012). Similarly, European citizens travel to Eastern Europe, Southern Europe and Asia for cosmetic procedures such as plastic surgery, but also major medical procedures such as fertility treatment, and organ transplantation (Crush *et al.*, 2012). Whilst elective medical procedures such as aesthetic surgery are attracting wide media coverage, there is a significant, and often under-recognised, diversification in the seriousness of interventions undertaken abroad (Cook, 2008: 4).

Why patients take the decision to travel is perhaps the most discussed topic in the current literature. The vast majority of papers exploring medical travel undertake the effort to answer at least partially this question. Price differences among countries, favourable exchange rates, long waiting time or lack of expertise,

technology, and infrastructure at home, privacy reasons, and the tourism component of the trip are factors commonly cited as inducing international patient movement. These are briefly examined here. To begin with, it is suggested that price differentials comprise a strong motive for people who cannot afford private health care at home (e.g. Svantesson, 2008; Cortez, 2008; Glinos *et al.,* 2010; Connell, 2006; Carrera & Lunt, 2010; Abdullah, 2006; Barrowman *et al.,* 2010; de Arellano, 2007; Carabello, 2008). People commonly demand private services when they are not eligible for a treatment within the national system; when the insurance scheme they belong to does not cover the expenses of the particular treatment; or when they are uninsured. For example, in the US a significant per cent of citizens are deprived of universal coverage and private insurance (Svantesson, 2008), while the prices for private health care are prohibitive. It is indicative that 62% of a random sample of private bankruptcies declared in 2007 in the US is linked to increased medical expenses (Himmelstein *et al.*, 2009). As price differentials among countries vary substantially, some citizens decide to travel abroad and receive health care from a foreign provider. The table below allows price comparisons between providers in different countries for a number of treatments. Favourable exchange rates, sometimes enhanced by currency fluctuations, is an important factor accounting for price differentials, and therefore, patient movement (Connell, 2006; Abdullah, 2006; Barrowman *et al.,* 2010). Except for prices, however, quality of care is of importance and alongside prices quality comprises a pull factor.

Table 1 Price Differentiations among countries for various medical procedures

Procedure	United States	India	Thailand	Singapore
Heart bypass	130,000	10,000	11,000	18,500
Heart valve replacement	160,000	9,000	10,000	12,500
Angioplasty	57,000	11,000	13,000	13,000
Hip replacement	43,000	9,000	12,000	12,000
Hysterectomy	20,000	3,000	4,500	6,000
Knee replacement	40,000	8,500	10,000	13,000
Spinal fusion	62,000	5,500	7,000	9,000
Cost represented in U.S. dollars, excluding travel and convalescence expense				

Source; Mason and Wright, 2011

Quality has to be perceived either as higher or at least not lower by the potential patient (Svantesson, 2008; Glinos *et al.,* 2010; York, 2008; Abdullah, 2006; Barrowman *et al.,* 2010; de Arellano, 2007). Long waiting time in universal coverage systems is another factor which pushes people into private health care domestically and most importantly for our case abroad (Svantesson, 2008; Cortez, 2008; Glinos *et al.,* 2010; Connell, 2006; Carrera & Lunt, 2010; Abdullah, 2006; Barrowman *et al.,* 2010; de Arellano, 2007). Foreign private providers might be preferred over domestic either because they offer the treatment in lower prices; or because the treatment is not offered domestically in the private sector; or because quality of service abroad is perceived as higher. The table below is indicative of waiting times for various medical procedures in UK.

Table 2 Waiting times in UK for various procedures

Admitted Patients Average waiting time in UK	Weeks
Cardiology	5.2
Cardiothoracic Surgery	6.6
General Surgery	7.4
Geriatric Medicine	1
Gynaecology	6.1
Neurology	3.3
Neurosurgery	9.5
Ophthalmology	9.3
Oral Surgery	10.5
Plastic Surgery	7.5
Trauma & Orthopaedics	10.9

Adopted by Altin *et al*. (unpublished)

Historically, the most common reason for medical travel is lack of expertise, technology, or infrastructure at place of residence. Today it remains one of the most important drivers of medical travel. For example, a number of African countries are characterised by severe shortage in medical doctors and lack of adequate infrastructure, leading numerous patients to cross-border movement (Crush *et al*., 2012). UK, Germany, and the US are, on the other hand, renowned destinations for advanced medical knowledge and technology. State regulatory restrictions may also be a cause for lack of expertise or the non-availability of procedures. Difference in the legal framework surrounding specific procedures is, therefore, another factor motivating patients to travel (Hunter and Oultram, 2010; Cortez, 2008; Glinos *et al.,* 2010; Connell, 2006; Higginbotham, 2011). Fertility treatment is another field which accounts for increased international travelling (Bergmann, 2011; Ikemoto, 2009;

Smith *et al.*, 2010) with restrictions basically justified on religious, moral, and medical grounds. For example, the Swedish, British, German and Italian law is more restrictive than the Greek or Spanish one on in-vitro fertilisation cycles, encouraging travel to South Europe. Another example in the field of fertility is the particularly notorious practice of travelling (e.g. to India) in search of surrogate mothers (Ikemoto, 2009) and the law related complications thereafter (Steinbock, 2007; Bognar, 2011). Privacy reasons may also motivate people to travel (Turner, 2007; Carrera & Lunt, 2010; Connell, 2006). Aesthetic interventions or fertility treatment (Inhorn and Shrivastav, 2010) are characteristic examples of procedures undertaken far from social networks or work environment for secrecy. In contrast, familiarity with the foreign country and the local health care system functions as a pull factor to a destination (Glinos *et al.,* 2010; Carrera & Lunt, 2010; Barrowman *et al.,* 2010). A characteristic example is that of expatriates (Inhorn and Shrivastav, 2010) or diaspora communities (Brown, 2008) that undertake treatment during their visit at home. A social network such as family, relatives and friends may also provide a support network for a patient.

There are a number of secondary factors contributing to the growth of medical travel. For example, changes in lifestyle increase the market demand for cosmetic surgeries, dental care, and wellbeing activities (Garcia-Altes, 2011) among the population. These activities may be undertaken abroad for savings or during vacation time. Meanwhile, a number of factors facilitating communication and travel also have positive spill-overs. Ease and affordability of international travel has increased (Abdullah, 2006) while the internet enables unprecedented circulation of

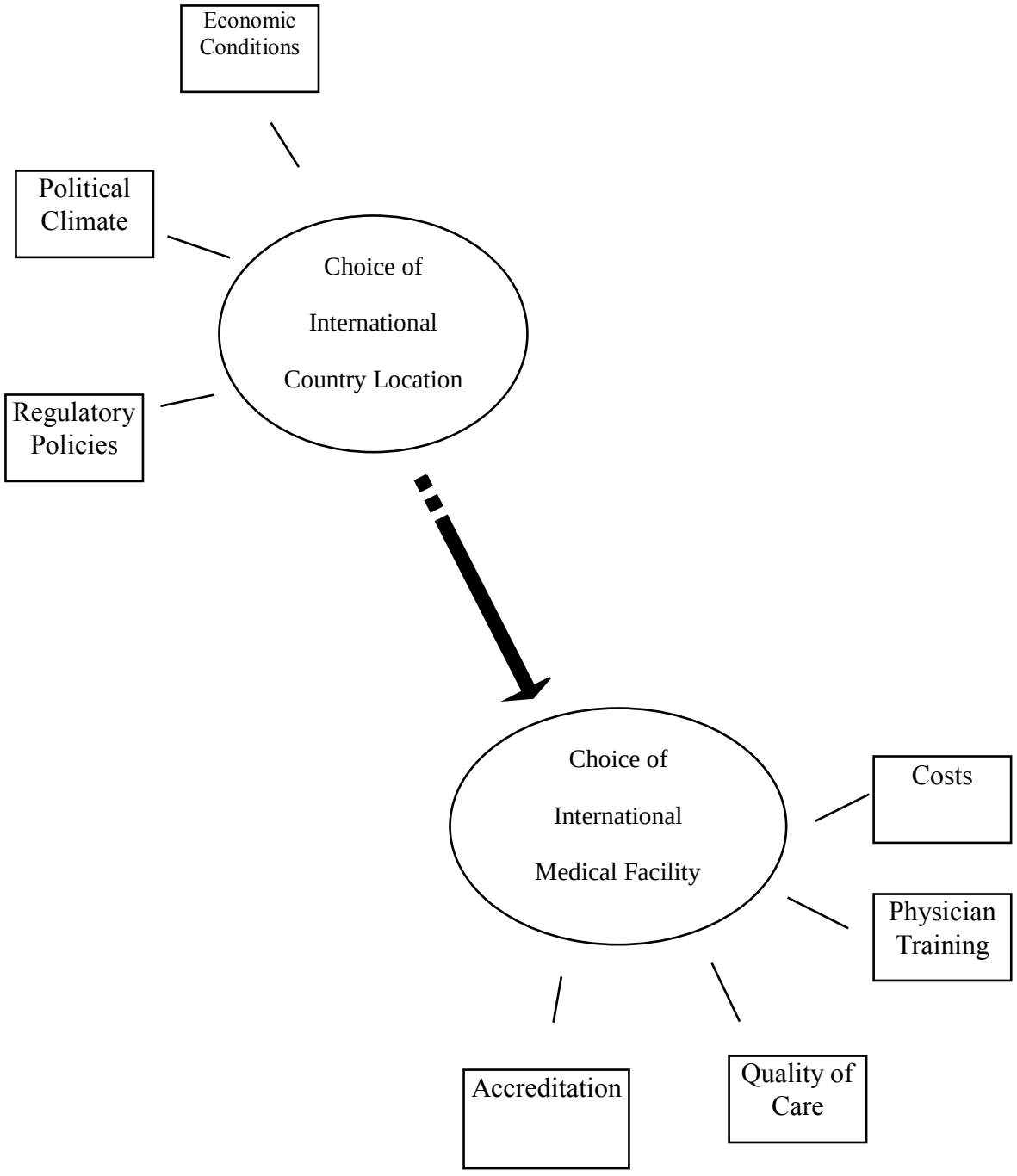
information about providers and procedures (Lunt *et al.*, 2009). It facilitates communication not only between patient and provider but also among patients who may share experiences and offer advice to one another. The internet is recognised as a crucial development in the phenomenon of patient movement (Lunt *et al.*, 2009), also indicated by the popularity of 'medical tourism' portals. The latter play the role of an intermediary and provide information about providers, surgeons and destinations and offer travel services to patients and advertising services to providers. It is suggested elsewhere that people seek health care abroad because they wish to combine it with tourism (Turner, 2007; Carrera & Lunt, 2010; Barrowman *et al.,* 2010; Connell, 2006). The most common term employed to depict the phenomenon is medical tourism and its conception is relevant to the representation of the tourism motive. According to this line of argumentation, better climate conditions, cultural stimulation, a relaxing environment, good diet, and shopping among other activities are evaluated while considering treatment abroad.

Modelling Patient Decision Making

Several scholars have undertaken the effort to model patient decision making. Starting with Smith and Forgione (2007), the models of Heung *et al.* (2010), Altin *et al.* (unpublished) are developed drawing on the literature, while the typology of Glinos *et al.* (2010) and the contribution of Runnels and Carrera (2012) incorporate secondary analysis of empirical information. Pamela C. Smith and Dana A. Forgione present a two-stage framework which models the factors influencing decision to seek medical care abroad. Despite its shortcomings, the model comprises the first

attempt to describe the patient decision making process. The two stages refer to choice of country and facility for medical treatment, respectively. Initially, the patient decides on the destination country taking into consideration the political climate, the regulatory standards and the economic conditions of the country.

Figure 1. Patient Decision Making, Smith & Forgione, 2007

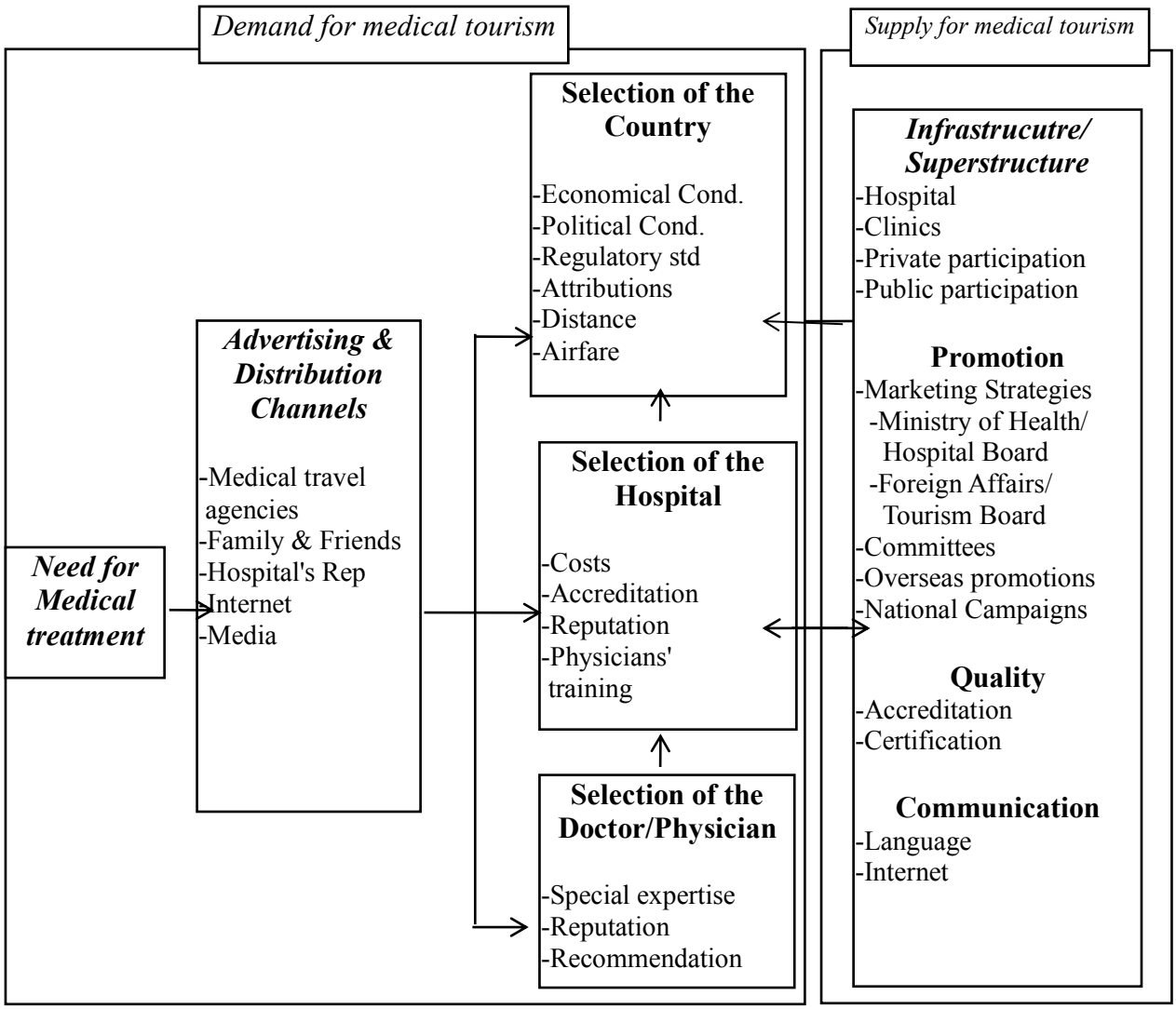


Afterwards, the patient takes into consideration the costs, accreditation, quality of care, and the physicians' training to evaluate medical providers (Figure 1). There are three basic limitations of the model which may be explained from the fact that it is theory laden rather than based on empirical evidence.

First of all, it is assumed that the patient decides first on the country and then the provider, while there is no reason to assume that this is the sequence. In addition, this model attempts to describe the decision-making concerning the place of treatment and not the motivation of patients to leave home. In other words, it is incomplete in that it examines the pull factors without considering the push factors, and focuses on the destination country without any reference to the origin country. At the same time, a number of important factors are omitted from the decision-making process, including distance from home country, familiarity with destination, and the sources of information and advertising that influence providers' choice (such as the internet or word of mouth).

Heung *et al.* (2010) present a richer model on decision making (Figure 2). Even though the model does not examine push factors, it expands the previous model by highlighting the importance of sources of information (medical travel agencies, word of mouth, hospital reputation, internet and media) and the threefold choice over provider, medical doctor and destination country.

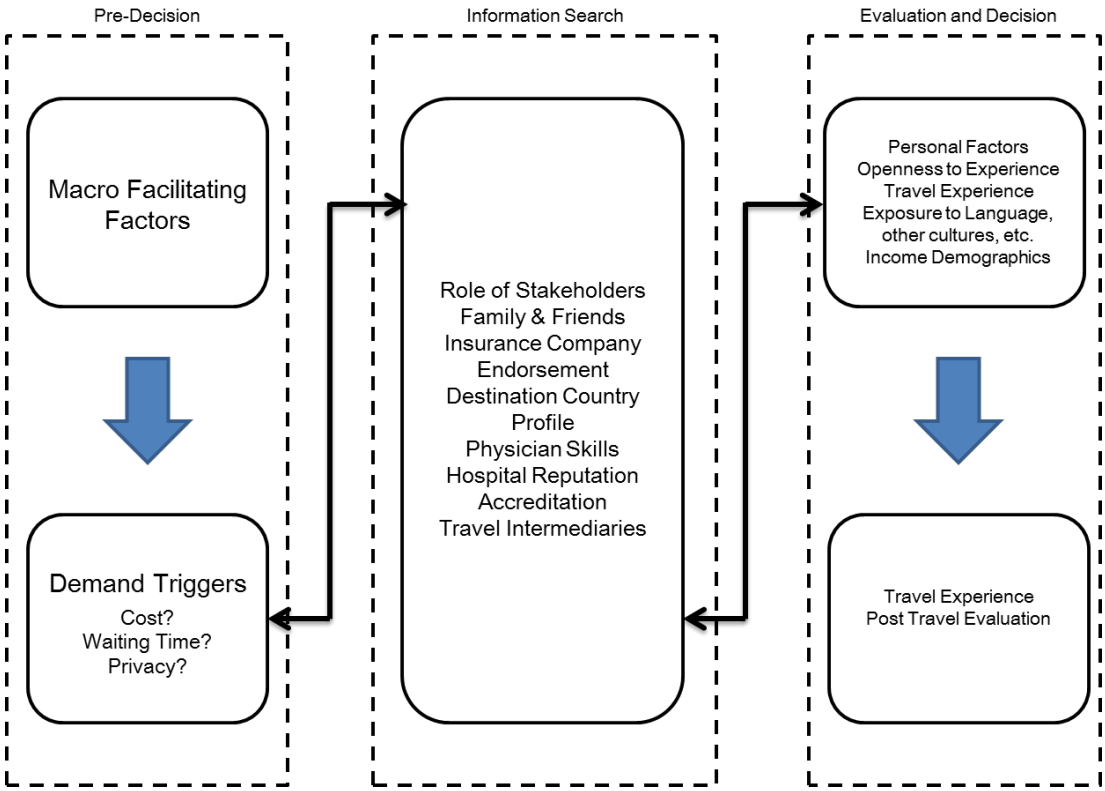
Figure 2. A Conceptual Model of Medical Tourism (Heung *et al.,* 2010)



Another model focusing on patient decision process is that of Altin *et al.* (unpublished). What makes this model special is the fact that it takes into account personal perceptions, influence of family and friends, socioeconomic and demographic factors, and character attributes such as openness to new experiences, and new cultures. The model distinguishes the factors into those affecting first considerations of travelling abroad, the phase of information search,

and finally, evaluation of options and final decision (Figure 3). As such it includes push factors and enriches the range of pull factors; in particular perceptions of other stakeholders and support from family and friends are given weight. The authors emphasise that emotional factors and rational considerations add complexity and have an impact on 'physical and mental wellbeing' (Altin *et al.,* unpublished). As a result, the human aspect and dependence of individuals upon family and society structures is given some consideration.

Figure 3. Consumer Decision Components for Medical Tourism (Altin *et al.*, unpublished)



A noteworthy contribution to the literature is the 'typology' of patient mobility across borders (Glinos *et al.*, 2010). Eight possible scenarios of patient mobility are presented in a matrix, which draws on evidence of patient mobility provided by a research project during 2004-2007 (Rosenmöller *et al.*, 2006). Each of the scenarios

has two dimensions. The first one refers to 'why patients go abroad' with four potential answers (availability in type or quantity of treatment, affordability, familiarity and perceived quality); and the second one refers to 'how the medical treatment abroad is funded' with two potential answers (either by a health insurer or out-of-pocket). Combining the four answers of the first question and the two possible answers of the second question the eight scenarios of the matrix are formed.

Figure 4. Matrix of cross-border patient mobility (Glinos *et al.*, 2010)

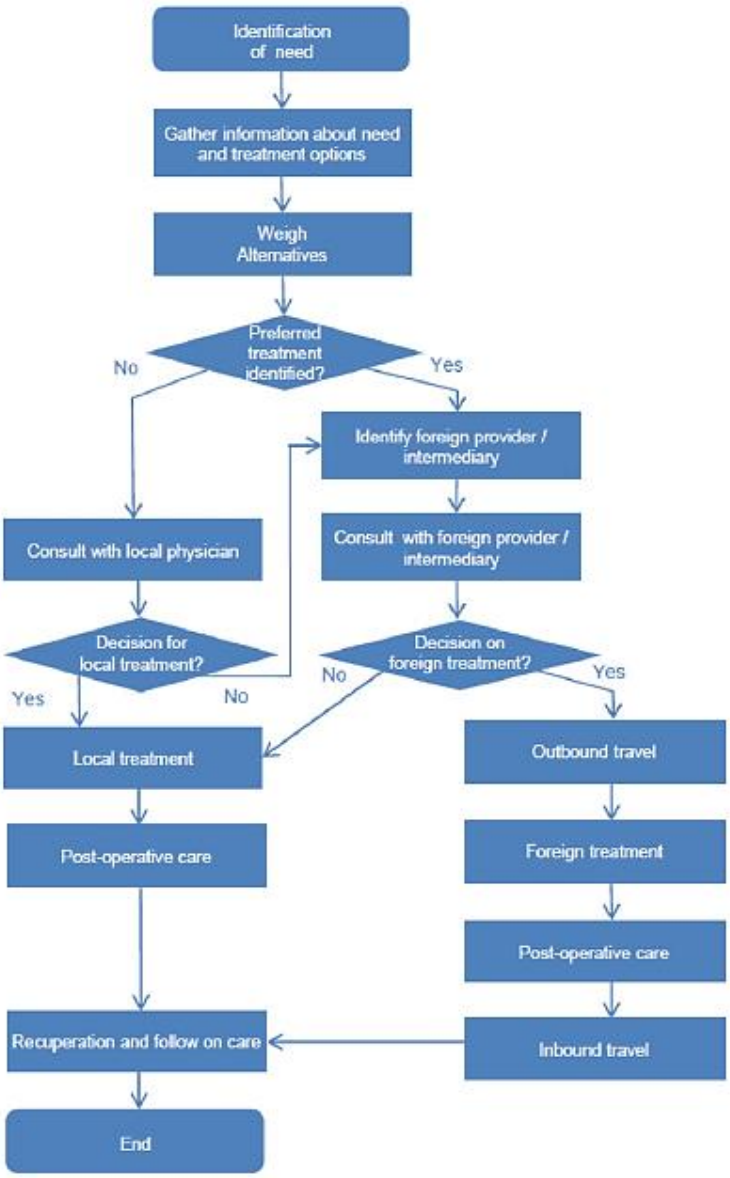
<table>
<tr><td></td><td colspan="3">Types of funding: does the patient have cover for cross-border care?</td></tr>
<tr><td rowspan="5">Types of patient motivations:
Why does the patient travel for care?</td><td></td><td>No cover</td><td>With cover</td></tr>
<tr><td>Availability
• Quantity
• Type</td><td>1</td><td>2</td></tr>
<tr><td>Affordability</td><td>3</td><td>4</td></tr>
<tr><td>Familiarity</td><td>5</td><td>6</td></tr>
<tr><td>Perceived quality</td><td>7</td><td>8</td></tr>
</table>

The last model to be presented is that developed by Runnels and Carrera (2012) (Figure 5). The model identifies as a first step of decision making the decision to pursue treatment in a foreign country. Once treatment abroad is considered as the best option available, identification of foreign providers follows. This is based on consultation with facilitator companies, family and friends and own internet search. What makes this model interesting is that it allows for potential participation of the

local physician in the decision making process.

Notwithstanding their limitations, the models contribute significantly to the discussion over international patient movement. They are successful in including and grouping a wide range of pull but also push factors, and therefore, in systematically presenting information about the decision making process.

Figure 5. Decision-making Process to engage in Medical Tourism (Runnels and Carrera, 2012)



Concluding Remarks and Discussion

The reader has now been familiarised with demand-driven factors motivating patients to travel abroad. Push and pull factors affecting patient decision making serve as common reference points for scholarly analysis, while to a large extent the literature remains descriptive and under-theorised. A striking exception is the paper of Glinos *et al.*, 2010, which draws insights from the empirical work published in the book of Rosenmöller *et al.* 'Patient Mobility in the European Union: Learning from Experience' (2006). The individual, i.e. the patient, and the corresponding agency serves as the unit of analysis offering a micro-perspective insight into the development, inevitably disconnected from the broader picture. Despite the limitation, however, a number of theoretical concepts are touched upon. For example, there are hints for the need of further examination of the commercialised and unregulated nature of health services; the emergence of new actors; and the issue of equity in accessing health care. These issues will be shortly presented, before moving to a completely different approach in the following section. They will be, however, revisited for a deeper analysis enriched with empirical findings from a wide spectrum of countries and methodological approaches in chapter 3.

The rather descriptive information presented above draws attention to a number of noteworthy observations. First, the emergent sub-sector of health care allows room for new key actors including travel facilitators, transnational regulatory bodies, and foreign providers. This nuance implies the emergence of new rules, mechanisms and structures (Glinos *et al.*, 2010) and comprises the preamble of a

differentiated landscape in terms of power relations. State control could potentially be restrained; local providers may find themselves exposed to international competition; and new actors may gain market power and challenge existing power balances. In addition, it is highlighted that the commercial character of services is strong (Carrera and Lunt, 2010). This implies that involved actors undertake the role of market agents (Carrera and Lunt, 2010). In particular, healthcare providers are typically profit-maximising organisations; advertising and marketing strategies are employed to promote clinics and destinations; while healthcare services are often enhanced and marketed with tourism services. For example, patients are offered an opportunity to spend the rehabilitation period after treatment in 'idyllic' locations by intermediary companies that offer tourism packages including hotel, sightseeing, and transportation. Patients may be also depicted as market agents; comparisons of the quality-price mix to decide upon provider depict consumerist attitudes towards health care (Glinos *et al.*, 2010). MacLean (2007) takes the opportunity to suggest that health care services may be commoditised and elaborates how telemedicine services may be traded in the future exchange market. Finally, a prominent feature of the sector is the lack of regulation (Birch *et al.,* 2010; Barrowman *et al.,* 2010; Cortez, 2008; Cortez, 2010). Combined with an information asymmetry between providers and patients, lack of regulation renders medical travellers vulnerable to malpractice. A solution for better protection of patients would require transnational cooperation and agreement on health standards over a long period. These observations comprise interesting topics for further exploration and pave the way for deeper analysis and theoretical conceptualisation.

The next section presents another framework of analysis, which draws on macro-economic trends to frame international patient movement. It is argued that this approach rests on strong assumptions about the nature of health care provision, which are not explicitly addressed. It is also criticised for remaining uncritical to the real dimensions of the implications for health care systems and health equity and equality.

International Patient Movement as a Form of Trade:

A macro-perspective

Another stream of literature relevant to international patient movement is preoccupied with the developments in the field of international trade in services. Affiliated to economics and international trade, this framework grasps macro-perspectives of the development and place it in the broader context. Nevertheless, one would argue that it depicts somewhat uncritically, health care as a commodity and, thus, international patient movement as a form of 'consumption'. Developments in the EU also address the increased health care provision to foreign nationals from a market perspective. The directive on patient mobility of the EU Commission (2010) introduces the common market rulings in health care, which, in the name of broadening EU citizens' rights, is accordingly reconceptualised as a commercial service. It is notable that except for the implicit assumptions about health care, these approaches draw methodologically on a cost-benefit analysis for policy prescription. This section examines, first, the contributions of this stream of thought in the

discussion of patient movement, and then attempts to show that both conceptually and methodologically the scope of such a framework is limited in addressing the development in its full social and moral dimensions.

Consumption Abroad

Cross-border health care provision is represented in the General Agreement on Trade in Services (GATS) of World Trade Organisation (WTO) as a form of trade, and is coded as “mode two” of Trade in Health Services. According to the GATS nomenclature trade in health services is distinguished in four modes of supply, as follows:

Mode 1. Cross-border delivery of trade: it includes e-health services and shipment of laboratory samples. E-health includes a vast range of services such as diagnosis and consultations, telepathology, teleradiology and telepsychiatry. Electronic means, systems and devices used to transfer the medical information include among others, emails, health information networks, electronic health records, telemedicine services, wearable and portable systems which communicate, health portals, etc.

Mode 2. Consumption of health services abroad: it refers to the movement of patients to another country for medical examinations and treatment. The flow of people have many directions, including affluent people from developing countries travelling to developed countries, middle and low income citizens travelling to developing countries, affluent people moving to developed countries as well as patients moving from developing countries to developing countries. Reasons such

as superior quality or expertise and low cost or privacy are reasons accounting for the movement of patients.

Mode 3. Commercial presence: it refers to the establishment of hospitals, clinics, medical centres etc. by foreigner companies. Foreign Direct Investments can take place in various modes such as acquisitions, mergers or building of new facilities.

Mode 4. Movement of health personnel: it refers to movement of health professionals for short or longer periods with different social, economic and legal consequences for source and host countries. It includes movement of physicians, specialists, nurses, paramedics, midwives, technicians, consultants, trainers, health management personnel, and other professionals.

Proponents of trade liberalisation generally suggest that trade fosters growth, which in turn fights poverty; stimulating thus a virtuous growth cycle. Trade in health services is no exception to the rule; the health status of the general population has the opportunity to improve due to wealth generation which, in turn, has positive externalities on development (Labonte-Gagnon 2010: 9). Caution, however, is necessary. Some scholars urge that health care services are characterised by high complexity as issues of data protection, litigation, quality standards, and public opinion arise and play out as substantial constraints to trade (Chanda, 2011). In light of this, it is pointed out that regulation initiatives in international trade are advanced without collection of empirical evidence (Chanda, 2002) both in a national or an international level. This lack of data is problematic;

'the high degree of heterogeneity of these national sources renders it impossible to make comparisons between countries or to figure out the global value of health services exports on the world market' (Lautier, 2008: 103).

Evaluation of the potential impact of trade on health-care systems and populations would therefore, be essential for informing policy (Arunanondchai and Fink, 2007).

Cost-Benefit Analysis

In face of risks involved in opening up trade, scholars note that state policy should be carefully planned. It is suggested that governments should take research informed decisions (Chanda and Smith, 2006) and consult health experts and economic analysts so as to estimate the impact of each one of the four modes on the country and society. In light of this, Smith suggests that trade volume indicators, benefits and losses from trade, as well as the allocation of benefits should be measured (2012: 187). This need mandates cooperation among ministries of trade and health within each country (Smith, 2012). But international trade is not only a matter of internal coordination; official data collection on the movement of patients (Arunanondchai and Fink, 2007; Smith, 2012) calls for international cooperation. The role of international and national regulatory bodies is considered pivotal (Smith, 2012). In light of this, OECD (Organisation for Economic Cooperation and Development) has taken initiatives to coordinate international data collection on patient movement under the system of Health Accounts (Glinos *et al.*, 2010).

Evaluation of the trade-off between benefits and costs from opening-up trade for each country is conducted by several scholars (Arunanondchai and Fink, 2007; Smith *et al.* 2009; MacLean, 2007; Smith, 2012). Benefits commonly cited include greater choice of services for patients (Smith *et al.,* 2009); considerable cost savings for patients and hospitals and, at the same time, increases in efficiency and specialisation for hospitals as the outcome of trade and competition (Smith *et al.,* 2009; Smith, 2012; Arunanondchai and Fink, 2007). Another important implication of trade is the transfer of medical knowledge and equipment; which would increase the availability and quality of therapies provided in a region. Further than this, export revenues for specific countries would increase while remittances could potentially strengthen the economy, as is the case of Philippine nurses (Smith, 2012; Arunanondchai and Fink, 2007). Destination country insurance schemes can achieve considerable savings by outsourcing patients (MacLean, 2007), while national systems could achieve shorter waiting lists. In contrast, trade in health services could cause inequality in access to healthcare since well-off citizens and the population of urban areas will be privileged (Arunanondchai and Fink, 2007). Smith (2012) suggests that a two-tier system may be developed, demarcating locals from foreign patients, while export benefits may benefit only the most affluent and worsen the situation of the poor (Sengupta, 2007). Perhaps the most discussed negative impact on specific countries is the internal and external brain drain. Except for the external brain drain that many developing countries suffer from for decades, an internal brain drain may be observed where medical staff are attracted to private clinics due to a high inflow of foreign patients (Smith, 2012). An example given by

Arunanondchai and Fink (2007: 63) is an estimate concerning medical doctors in Thailand, where 'an extra 100,000 patients seeking medical treatment in Thailand leads to an internal brain drain of between 240 and 700 medical doctors'.

Smith (2012: 186-187) concludes that the positive elements should be kept while the negative should be minimised through state regulation. Considering the pitfalls involved in opening up to trade, Chanda and Smith (2006) propose a trade in health services framework for policy makers. The three basic factors to be taken under consideration according to this framework are the general macroeconomic environment and trade; the health care system; and the mode of trade (Chanda and Smith, 2006: 253). Elsewhere, Chanda (2011) examines the opportunities and constraints in trade in health care services between India and the European Union and concludes that bilateral agreements could be considered by policy makers as a way to tackle challenges (data protection, litigation, quality standards). Similarly, Álvarez *et al.*, (2011), Smith (2012) and Smith *et al.* (2011) suggest that trade in health care services will be better served through regional in addition to bilateral agreements rather than the GATS.

Discussion

These frameworks are, however, heavily skewed towards economic analysis leaving little room for real consideration of the impact on societal issues. After all, the greatest consequences are relevant to health equity and a cost-benefit analysis is too narrow to capture the implications. Equity is a principle irreducible to a

parameter to be 'weighted' against the benefits of trade. As such, policies promoting opening up trade in health services are recognised as inherently contradictory:

> 'Trade objectives of increased liberalisation, less government intervention and economic growth generally do not emphasize equity, whereas health sector objectives like universal coverage do. […] Reconciling the aims of economic growth with equitable health service provision and access makes governance of medical tourism within a country's health system challenging at best and contradictory at worst' (Pocock and Phua, 2011: 4).

A well-targeted critique to policies promoting trade comes from the literature analysing the European Union case. The European Union Commission has been taking initiatives in opening up trade in health services, and has worked on the EU Directive on Patient Mobility. According to Jarman and Greer (2009) liberalization of health services is recognised as a common denominator both within EU and the members of WTO, and concerns on EU '*patient mobility*' are closely related to these referring to Trade in Health Services. It is notable that regulation of patient movement within EU is framed as a citizen 'right' and is actually more advanced in comparison to World Trade Organisation agreements (Jarman and Greer, 2009). Scepticism is expressed over the application of internal market rules to health services in EU by a number of scholars (Greer, 2008; Legido-Quigley *et al.*, 2007; Jarman and Greer, 2009; Forchielli *et al.*, 2008; Földes, 2009). Specifically, Legido-Quigley *et al.* express concern about the future of the healthcare systems as the creation of a market for health care carries the danger of opening the sector to competition law. Subsequently, the potential entrance of large multinational

corporations might challenge the national health care systems; and might lead to deregulation of the market. Földes (2009) also suggests that states' ability to control the planning and financing of the domestic system is restrained. At the same time, the fact that the reimbursement obligation within EU stops at the level of the equivalent domestic amount, means that citizens of countries with more expensive treatment costs can benefit from travelling to countries with lower treatment costs; whereas the reverse is not possible. Equity concerns are considerable. At the same time, the problem of policy irreversibility is emphasised. Jarman and Greer (2009) and Forchielli *et al*. (2008) speak about a "ratchet effect" as the steps taken towards patient mobility within the EU now cannot easily (if at all) be reversed. The very sequence of the decisions will determine the future of the policy with institutional inertia accounting for future irreversibility. In light of this, the imperative over informed, careful and enlightened policy making is advocated by most scholars.

The literature on EU patient mobility as presented here offers richer insights towards the potential impact of trade liberalisation in comparison to the literature on international trade agreements. In effect, it escapes the calculative narrative of a cost-benefit analysis to inform policy, which suggests a quantification of economic and social factors for comparison reasons. It is argued here that a meticulous comparison between 'costs' and 'benefits' with subsequent policy prescriptions such as '*minimization* of risks to equity' (Lipson, 2001: 1140) is an oversimplification of the implications of market dynamics on health care provision and social justice. In the same way that health care is not just another commodity, the international patient movement cannot be reduced to just another form of trade. In light of this,

scholars highlight that commercialisation is inherent in trade (Smith, 2004); trade and growth are indifferent to health equity issues (Pocock and Phua, 2011); while the competition law promotes de-regulation and downgrades nation-states' control over policy (Legido-Quigley *et al.*, 2007; Földes, 2009). Simultaneously, it is recognised that opening-up trade is a policy that may trap states into an irreversible decision (Jarman and Greer, 2009; Forchielli *et al.*, 2008). Arguably, employing a cost-benefit analysis to inform such a policy decision for a nation state (or a number of them as in EU) is considered too technical to capture the scope or essence of health care for people. Considering the argument that *issues of equity, efficiency, access and quality in health need to be accessed before reducing trade barriers* (Lipson, 2001) it still remains questionable whether weighing them against benefits is an appropriate approach. It is argued that quantification of principles and values such as health equity appears to be a fictitious endeavour of limited scope.

Conclusion

Contributions to the literature that offer descriptive insights into the phenomenon of medical travel have been presented. Even though important concepts relating to health care provision are briefly mentioned, this part of the literature is characterised overall by a lack of a broader conceptualisation of the development that would potentially surpass the borders of a micro-analytical framework. For example, a widely discussed topic in the current literature concerning health travel is why patients take the decision to travel. It is notable how, most commonly, the individual is taken as the unit of analysis. Often, trips for medical reasons may be for minor

cosmetic procedures or diagnosis tests in which health risks are relatively low. Frequently, however, procedures undertaken abroad include major interventions. Whatever the treatment required, receiving health care abroad is complex; requiring orchestrated coordination of a range of services. For the patient, commitment to travel to satisfy health care needs involves high levels of emotional engagement combined with a rational-consumerist problem solving approach. The discussion is expanded by the perspective of another body of literature, focusing on trade in health services. Despite its macro-perspective, this framework, given its emphasis on health care as a market and tradable service, does not recognise the essence of health care for people; the importance of the principle of equity, and its contribution to the cohesion of society. Arguably, framing the development as a form of international trade surrenders aspects which are crucial for the people involved and the societies as a whole to oblivion.

The next section will focus on critical perspectives concerning the practice of internationalisation of health care. With the starting point the definitional fuzziness that prevails, clarification of terms' implicit assumptions from a critical perspective will open up discussion to a reconceptualization of the internationalisation of health care. The latter develops into to a critique of the practice in itself.

Medical Tourism: Critique of the Term, Critique of the Practice[2]

The multi-disciplinary interest in the internationalisation of health care accounts for the existence of a number of terms including: medical tourism/travel, medical outsourcing, cross-border care, consumption of health services abroad, patient mobility, patient movement, transnational health care, and health tourism. This section focuses on three of these, namely health tourism, patient mobility and medical tourism. The choice is justified by their popularity but also by a need for clarification due to an observed variation in the way they are used. The current section offers a review of alternative definitions and attempts to clarify these differences. It also takes the opportunity to review the growing critique of the most popular term, namely medical tourism, which in the last section escalates to a critique over the practice in itself.

Medical Tourism and its interrelatedness to Health Tourism

Health tourism is often related both as a term and phenomenon to international patient movement. Garcia-Altes (2011, p. 262) defines it broadly 'as people travelling from their place of residence for health reasons' and Kim *et al.* (2009: 2) as a visit 'from one residential place to another for the purpose of health care and tourism'. From the perspective of a number of tourism scholars, but also governments of established destinations, international movement of patients is perceived as a niche market of the tourism industry. The same holds for medical

[2] The analysis is part of the working paper titled 'The Medical Tourist and a Theory of Dependency', co-authored by Professor Sharon C. Bolton.

tourism which is perceived as a sub-section of health tourism (Garcia-Altes, 2005; Connell, 2006). Medical tourism refers to patients' movement to a foreign country with the purpose of receiving medical treatment (Balaban and Marano, 2010: e135). Frequently, it is defined with respect to health tourism. Several scholars note that medical tourism is distinguished from health tourism for its emphasis on improvement or restoration of health (Carrera and Bridges, 2006; Connell, 2006) or for its curative focus (Hall, 2011: 7). According to Carrera and Lunt (2010) it puts 'an emphasis on clinical, surgical, and hospital provision'.

One of the first studies referring to medical while exploring health tourism is the study of Goodrich (1993) on Cuba. The author examines the relationship between tourism and health services and the scope of activities, which is summarised in the following definition.

> 'Health tourism is defined as the deliberate attempt on the part of a tourist facility (e.g., hotel) or destination (e.g., Baden, Switzerland or Bath, England) to attract tourists by promoting health-care services and facilities in addition to regular tourist amenities. These health-care services may include medical examinations by qualified doctors and nurses at the resort or hotel, special diets, acupuncture, transvital injections, vitamin-complex intakes, special medical treatments for various diseases such as arthritis, and herbal remedies' (Goodrich, 1993).

According to Goodrich, one form of health tourism in Cuba is related to governmental efforts to attract people from the Caribbean and Latin America who typically visit the US for medical examination and treatment. As such medical travel

emerges as a subcategory of health tourism; and even though Goodrich's definition has been criticised for emphasizing the supply side (Heung and Kurukusta, 2012) and for having a narrow conception of the development (Hall, 2011), Goodrich's critics also perceive medical travel as a subcategory of health tourism. For example, Hall (2011) defines health tourism as

> 'a commercial phenomena of industrial society which involves a person travelling overnight away from the normal home environment for the express benefit of maintaining or improving health, and the supply and promotion of facilities and destinations which seek to provide such benefits' (Hall, 2003: 274).

The definition highlights a commercial character, puts an emphasis on health and the travelling component, but it also refers to both demand (person) and supply (facilities and destinations). The importance of clarifying the boundaries of medical travel within health tourism is emphasised. Hall examines the interrelatedness of health and medical tourism domains and suggests that the latter relates to *curing illness* instead of *preventing ailments* (health tourism) or *promoting wellness* (wellness tourism). Carrera and Lunt (2010) make a similar distinction between medical and health tourism with regards to three parameters; the kind of intervention (Bio-medicine as opposed to complementary medicine); the setting (hospital/clinic as opposed to non-medical facility); and the supportive inputs (medicaments and medical devices as opposed to anything else). They draw thus a line between the notion of medical and non-medical and give a negative definition of health tourism as encompassing non-medical activities.

At last, according to Carrera and Bridges (2006 in Lunt *et al.*, 2011: 7), health tourism is the

> ‘organised travel outside one‘s local environment for the maintenance, enhancement or restoration of an individual‘s well-being in mind and body’,

while medical tourism is specified as

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

In the latter, the medical component is emphasised, maintenance as an aim is de-emphasised and a clear distinction between *one’s jurisdiction* (medical tourism definition) and the *environment* (health tourism definition) is made. Health care *jurisdiction* is a term loaded with political underpinnings and puts an emphasis on civil rights and obligations of the individual. The distinction is also related to increased risks in the medical procedures; the consequences of malpractice are not as perplex and as a result, ethical or legal concerns are milder in health related activities.

Before reviewing the critique of the term medical tourism, the following section will briefly present another term often employed in the related literature, *patient mobility.*

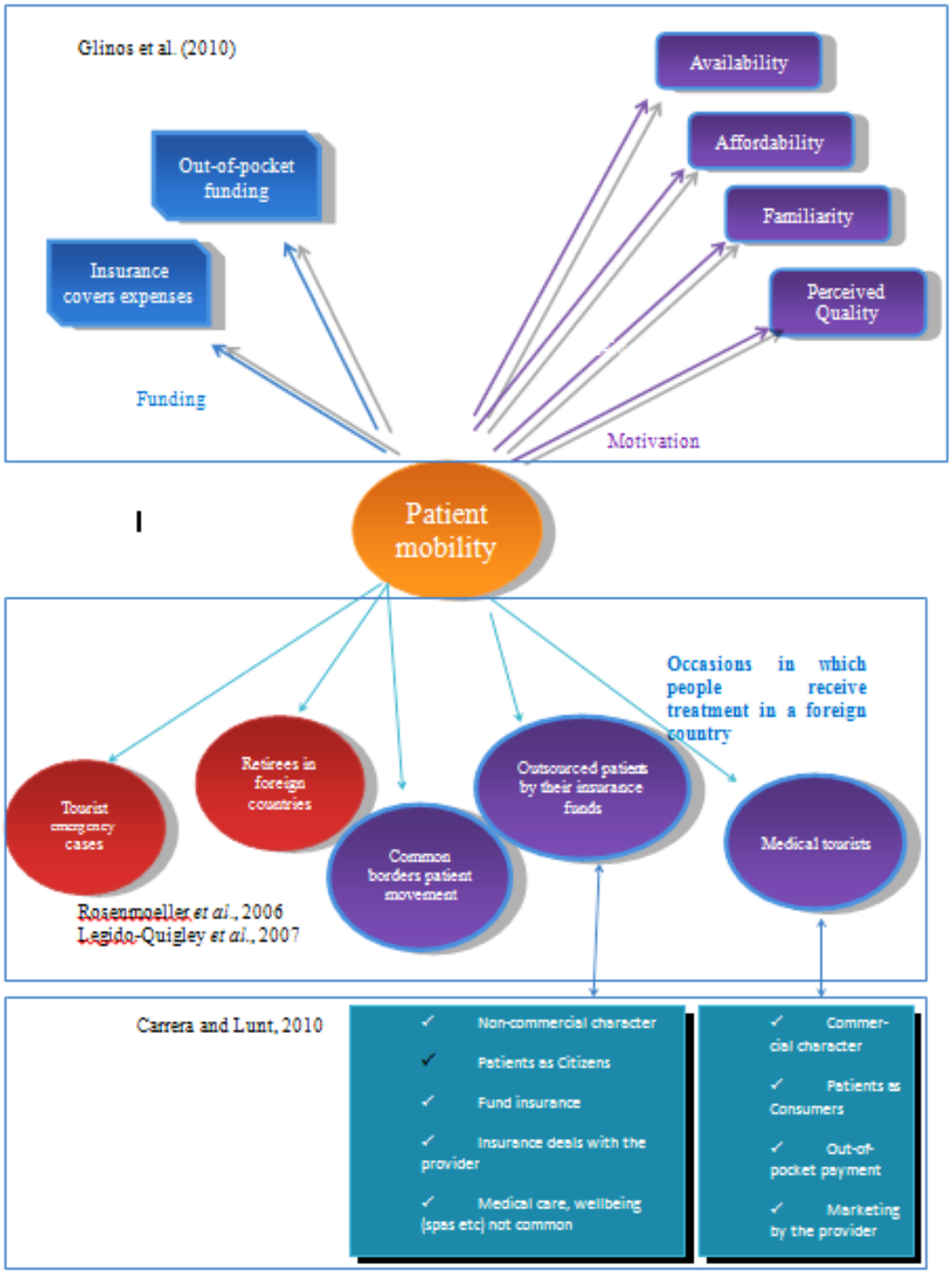
Patient Mobility

Patient Mobility is the term adopted by the European Union to describe the

movement of patients. As it has been already mentioned, the right of EU citizens to be treated in another member state and have related medical costs reimbursed by their insurance is now recognised. After the 1998 rulings on two cases of EU citizens by the European Court of Justice, the right is linked to the principle of free movement within EU and health care is accepted as a service (Healy, 2009: 125). Definitions of patient mobility are basically 'taxonomic', like the typology of Glinos et el. (2010) presented above. It is worthy of mention, however, that there are small, albeit significant, differences between the categories falling under patient mobility in different publications (Figure 6). For example, two criteria are employed to describe patient mobility concerning i) *the motives of patients travelling abroad* and ii) *the way patients fund the medical expenses* in Glinos *et al.* (2010). In an earlier paper which Glinos co-authors, however, patient mobility is distinguished into five categories according to a different criterion (Legido-Quigley *et al.*, 2007). The categories describe the occasions in which people receive healthcare treatment in a foreign country. These are tourists' emergency cases; retirement migration; common border patient movement; outsourced patients; and 'medical tourism'. In Legido-Quigley *et al.*, health care in itself is not necessarily the basic incentive to travel. This is a striking difference with Glinos *et al.*'s work where travelling is 'planned' specifically for health care. Instead, planned care is relevant only to the last two categories of Quigley's *et al.* taxonomy. As a term officially employed by the EU, it also does not presuppose health care as the basic motive for the trip; in fact, most writings employing the term, all five categories of patients are included. For example, the book *Patient mobility in the European Union Learning from experience*, which is

prepared within the framework of an EU research project (Rosenmöller *et al.*, 2006), is rich in case study material of patient mobility as defined in Legido-Quigley *et al.* (2007). Lunt and Carrera (2010) employ the same categorisation and focus on the last two categories so as to highlight differences between outsourced patients and medical tourists.

Figure 6. Differentiation in categorisation of cases falling under the term patient mobility



Critique of the Term Medical Tourism

The emergence of the term

'Medical tourism' has been adopted by various practitioner stakeholders and academic scholars and is particularly relevant to the academic and business field of tourism and hospitality. It has been elaborated that writers from the tourism sector and discipline have approached medical travel as a new facet of tourism and the term medical tourism has become a dominant descriptive term (Connell, 2006: 1093) so that health care providers, travel facilitators, as well as whole states whose governments support the development of the sector as strategic for the national economy, employ the same descriptive phrase.

The term and nature of medical tourism

What emerges from the varied literature that covers the topic is that the term *medical tourism* successfully represents the practice of marketing commercial health services (Lunt *et al.,* 2011) whilst also implying mobility and choice for the patient (Gilmartin and White, 2011). Requiring medical care in a marketised healthcare sector equates to profit making for health care providers and facilitators. When health care goes international the beneficiaries are not only providers from the health care sector but also agencies and companies from the supporting tourism industry. At the same time, patients are mobilised and also able to take decisions on their health care with limited or no assistance (Gilmartin and White, 2011: 276). The decision making process can be compared with and simulated to tourism decision

making, where the individual decides on destination and provider without any type of professional assistance as a necessary prerequisite.

What emerges from the growing literature and the prominence of the concept of the medical tourist is an emphasis on patient choice fuelled by potential, and possibly combined, pull and push factors that result in a similar scenario. First, people with a positive outlook take a trip to a foreign country to receive medical treatment, benefit from lower prices, better quality of care, speedier provision, etc. *and* enjoy a vacation. Second, patients, frustrated by personal health problem/s and lack of response from locally provided services feel the need to leave their home and familiar environment to take a trip at the moment they are most vulnerable. Both are worthy of further examination. In terms of combining a decision to travel for medical treatment with a wish to also experience relaxation, recreation, cultural stimulation and joy, i.e. acting as a medical tourist, research indicates that aspiration does not always match outcome and there is evidence to suggest both positive and negative personal experience. Ackerman (2010), for example, tells us how post-operative patients, who have undergone plastic surgery in Costa Rica and stay in the same lodge, create small communities and offer strong psychological support to one another. On the other hand, other patients in the same study express high levels of anxiety about post-operative pain, feel uncomfortable, and regret having the procedure and recovery period far from home and loved ones (Ackerman, 2010). Arguably, medical travellers experience stress and fear and encounter personal and highly sensitive situations that tourists (generally) do not. Anxiety stems largely from being in a foreign environment, often of a developing country (Johnston et el., 2012;

Eissler, 2010). The situation in the latter becomes more frustrating when patients face financial constraints or other difficulties but have no other option. Eissler (2010: 42) notes that all 15 patients she interviewed had unsatisfied medical needs that caused discomfort and had an impact on their ability to work and enjoy life. As Kangas (2011) suggests, travelling for health care involves hardships, even for the most minor of medical interventions. Characterising the practice as a form of tourism would mean that surgical interventions and at least some medical treatments are simple and commonplace so that the medical element loses its meaning. Nevertheless, cases of medical malpractice in presumably simple procedures such as hair transplantation would support the claim that even the simplest of procedures involve medical risk and potential harm for the patient.

Medical tourism and its discontents

What becomes apparent is that the term tourism can be misleading; distorting the real nature of medical travel in the eyes of patients and potential patients and travellers. Despite the positive attention the concept has received, a number of scholars have expressed discontent with the term and its connotations. For example, focusing on patient choice, Bergmann (2011) and Glinos *et al.* (2010) suggest that the term medical tourism is inadequate to refer to the scope for which patients travel abroad. Whilst Bergmann (2011: 282) highlights how the term tourism 'masks the fact that (…) there is a wide range of motives for travelling to another country for treatment'. Similarly, Glinos *et al.* (2010) propose that medical tourism as a term is too narrow to capture all situations under which patients are provided

health care in another country. Rather, they recommend the term patient mobility. An additional dimension of this critique is added with the observation of Gilmartin and White who highlight that,

> 'the use of the term "tourism" to describe this international movement in search of health care emphasizes individual agency, choice, and possibility, […] and celebrates the emancipatory potential of mobility' (Gilmartin and White, 2011: 276).

In that context the citizen becomes mobile and is emancipated from state intervention/regulation; and 'passive patients' are transformed into 'empowered educated consumers' (Ormond and Sothern, 2012: 935). Thus, the savvy patient-consumer is presented as an informed individual that compares providers' services and prices in a number of locations and purchases the best deal for health care. This critique is particularly relevant to 'patient mobility', as a term, for similar reasons; it stresses an ability to travel and celebrates the emancipatory potential of patients' movement.

Other scholars express concern for the patient experience and dispute the validity of the concept of the medical tourist, irrespective of the motivation to travel, as it implies 'a leisurely, pleasurable activity undertaken by people, often with their families, on a vacation' (Garud, 2005: 318). Kangas highlights that the term obscures the hardships involved in the trip for the patients (Kangas, 2011: 328). She also emphasises the elevation of the commercial over care in the way medical tourism 'prioritizes the (…) destinations and facilitators over the patients' (Kangas,

2011: 328) as entire countries seek to market themselves as medical tourism destinations. Niechajev and Frame (2012), for example, suggest that facilitators bundle medical and tourism services together, referring to the practice as tourism, and cultivate the impression that patients travelling for health care combine their treatment with vacation. Nevertheless, the authors argue, most often the trip is short and patients 'see only a glimpse of the country of destination' (Niechajev and Frame, 2012: 203). Therefore, the touristic component of the trip is marginal (Cohen, 2012: 169).

Travelling to another country, health care included, involves the function of the hospitality sector of this country by default; travel costs, accommodation of the patient, in addition to goods consumed, boosts the tourism sector of the economy. That does not mean, however, that tourism becomes the dominant feature of the activity. With some irony, Mattoras (2005: 3571) notes that no one (as yet) refers to immigration as labour tourism. Repeatedly, the function of the tourism sector in medical travel is implicitly overstated. Based on qualitative interviews with patients travelling from the US abroad for health care, Eissler concludes that

> 'the use of the term "medical tourism" deemphasizes the significance that the study participants placed on the basic health care needs, economic considerations, and dissatisfaction with the ability to obtain health in the US that motivated these health 'seekers to travel internationally for medical care' (Eissler, 2010: 108-9).

It is notable that the critique does not directly address the underlying market based assumptions attached to the term medical tourism. According to an analysis of selected newspaper articles conducted by Mainil *et al.* (2011), during the last decade a market discourse dominated over the medical, patient and ethical discourses. The implicit assumption of the term medical tourism and its derivative medical tourist is the view of the patient as autonomous; a person with the ability to take decisions on health care and freedom to realise them (Bolton and Skountridaki, forthcoming).

In light of this, scholars suggest alternative terms such as medical migration (Crush *et al.*, 2012), medical outsourcing (MacReady, 2007), international medical journeys (Kangas, 2011), medical pilgrims (Song, 2010) and health seeking travel (Eissler, 2010), medical exile (Inhorn and Patrizio, 2009), even patient mobility (Glinos *et al.*, 2010). As it has been noted in the introduction, the current thesis prefers and employs phrases such as international patient movement, internationalisation of healthcare, and transnational health care.

The Internationalisation of Health care

Fewer arguments are examined from a wider perspective, where most of the basic drivers suggested in the literature are framed as weaknesses of the national health care systems (Garcia-Altes, 2005). This in itself is not a new phenomenon; limitations of local health care providers have always led patients with the means to travel to seek health care abroad. However, within a context of diminishing state support for health services in the wealthier west, more citizens decide to travel

around the world to satisfy health needs. Considering the future, continuation of this trend is anticipated. The rising medical costs alongside demographic pressures (Glinos *et al.*, 2010) of an ageing population in leading economies causes a financial headache for the insurance and pension funding schemes. This is accentuated by the fact that increased corporate taxation is not considered a viable solution to funding problems. As Freund and Smeeding suggest,

> 'there is great concern that modern rich nations will not be able to afford the future health care costs of ageing societies' (Freund and Smeeding, 2010: 173).

At the same time, in response to increasing international demand for cross-border care, a number of governments see an opportunity in developing a 'medical tourism' sector. The circle of commercialisation reinforcing internationalisation and the reverse is then accentuated. In order to successfully internationalise, measures which strengthen the commercial character of health care provision are implemented (Chee, 2007). For example, Malaysia relaxed the advertising restrictions imposed upon health care providers, set quality benchmarks for clinics, promoted health care services to foreigners and directed attention to 'consumer choice' (Chee, 2007: 23-24). Private medical providers employ commercial practices and marketing techniques to advertise their services overseas. Crooks *et al.* (2011), for instance, focus on the promotional efforts of Indian hospitals targeting Canadian citizens in a 2009 trade show organised in Canada. At the same time, new public management theories have been implemented in the healthcare sector of western

countries, giving to healthcare a commercial character. This is connected to the transformation of the patient into a consumer and the internationalisation of healthcare:

> 'Linked to the previous but also to other pressures for 'patient-empowerment' is the choice rhetoric according to which patients are expected to behave as consumers who decide what services and products to consume / buy in the healthcare market- place (Newman and Kuhlmann, 2007; Tritter *et al.*, 2010). Commercialisation is partly a prerequisite for the globalisation (or internationalisation) of healthcare by which actors increasingly function beyond national borders' (Glinos *et al.,* 2010).

It becomes clear that the internationalisation of health care is realised within a market framework where principles of universal access to health care and state responsibility are increasingly put aside. At the same time, Arnold (2005) suggests that international trade is not occurring by the international demand of patients from various countries but is deliberately fostered by actors such as multinational corporations and industry trade lobbies through international regulatory bodies and trade agreements. For example, the General Agreement on Trade in Services and specifically the Trade in Health Services agreement is part of the World Trade Organisation's agenda promoting global health care markets. Similarly, the European Union (EU) encourages cross border care within member states under the logic of a common market. Legido-Quigley *et al.* (2007) express concern about the

future of the health care systems of EU countries given the current regulatory initiatives on 'patient mobility'. As seen in the previous section, the negative consequences of opening the health sector to competition law are emphasised. Arguably, the internationalisation of health care provides fertile ground for the transformation of health into a commodity; of health care provision into trade in services; of hospitals into commercial organisations focused on exports; of medical professionals into entrepreneurs; and patients into consumers (Ormond and Sothern, 2012: 935). From a neo-colonialism perspective, within this neo-liberal framework, destination (often periphery) countries are represented as 'therapeutic landscapes' to citizens from core countries (Buzinde and Yarnal, 2012).

The next chapter will draw on existing empirical research to examine closer the link between commercialisation and internationalisation of health care. It brings together research findings on the role and initiatives of key actors including patients, intermediary companies, states and physicians. The picture drawn depicts these actors as market agents and the practice of transnational health care as an exemplary sector of marketised health care provision. Issues of equity, safety, misleading information, and bad practice raise concerns over the increased commercialisation especially when it coincides with lack of regulation.

CHAPTER 3

INTERNATIONALISATION & COMMERCIALISATION:

STATES, PATIENTS, AGENTS, AND PHYSICIANS AS

MARKET AGENTS

Introduction

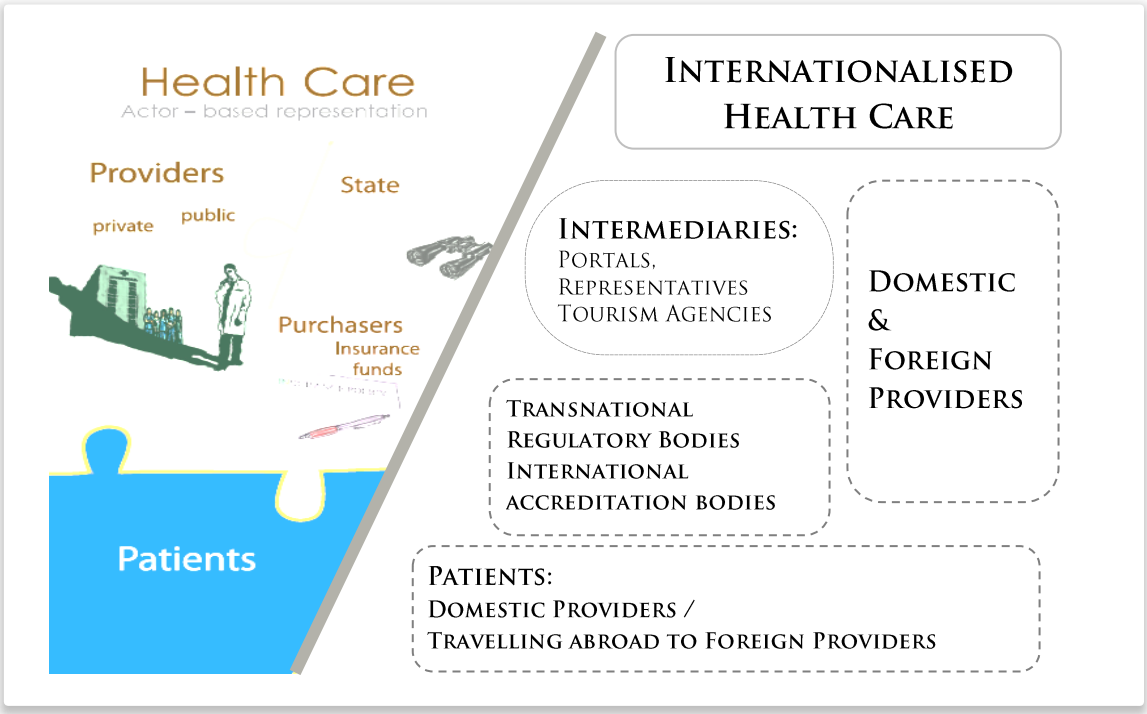
Empirical data have a special weight in the field of transnational health care where much written is based on smoke and mirrors[3]. This chapter presents research outcomes of fieldwork conducted in a number of countries; employing a range of methods; and falling within the sphere of diverse academic fields. Given the geographic dispersion, disciplinary and methodological pluralism, the findings are organised according to the object under investigation. An agent-based approach is employed; each section outlines research outcomes that refer to one of the key actors in transnational health care. In particular, patients or citizens, intermediating companies, states that promote health services' exports, and physicians are included. The last section is of particular interest for the current thesis, which sets out to empirically explore the role of medics within internationalised health care.

[3] Dan Horsefall, 2011, Presentation at Medical Tourism/Travel Post-Graduate Forum, University of York, 8th Sep.

Based on the fact that it comprises a particularly under-researched actor, it introduces the existing information on medics' prominent role and establishes the need for further research.

The representation in Figure 7 shows that noteworthy differences exist between a national and an internationalised conceptualisation of health care. Foreign medical providers appear with local ones; patients travel abroad; insurers may need to cover medical expenses in foreign jurisdictions, transnational regulatory bodies have significant role in setting the rules and overseeing the health care sector, and a new key actor facilitating communication between providers and patients emerges. Accreditation organisations also play a facilitating role in transnational health care by certifying internationally recognised quality standards. Alongside transnational regulatory bodies, it substitutes an important function of national states.

Figure 7. Actor-Based Representation of Internationalised Health Care



Patients

The decision making process of patients has been central in discussions exploring medical travel. As described in the second chapter, push and pull-factors determining patient decision making dominate conceptual contributions. This section presents empirical work on decision making including: experiences, profile, and spending behaviours of patients travelling in foreign countries. In addition, it presents an overview of the existing literature on intentions of individuals to receive treatment abroad. Light is shed by quantitative (questionnaires and surveys) as much as qualitative (ethnographic studies and in-depth semi-structured interviews) studies, while research spans geographically from Northern America to South East Asia. The focus is basically on patients leaving countries of the wealthier west, while contributions to south to south movements are scarcer and consequently misrepresented in this account.

Patient Decision Making

Decision making on medical travel is complex in nature (Wallace *et al.*, 2009). It involves high levels of emotional engagement, rational-consumerist problem solving (price and provider choice) (Altin *et al.,* unpublished), online research, and travel arrangements. Socioeconomic factors are also influential, causing further complication to both patients and the development as a whole (Wallace *et al.*, 2009: 2). Often more than one factor influences decision making; as Johnston *et al.* (2012: 13) note, in practice motivation is 'layered'. Push and pull factors as represented in qualitative research findings will be presented here.

Push Factors: Accessibility, Cost and Privacy

The most important driving force of medical travel appears to be patients' inability to access health care at home. It is indicative that out of 32 participants in a qualitative research study in Canada, six travelled for procedures which are not approved in Canada; 11 travelled for procedures not available domestically; and four participants were not eligible for treatment (Johnston *et al.*, 2012: 8). Similarly, Mexican immigrants report that their inability to access services in the US is a basic motive to travel for health services to Mexico (Bergmark *et al.,* 2010: 610). Eissler (2010: 42) also stresses that all 15 patients she interviewed in Alaska had unsatisfied medical needs which affected their ability to work and run a normal life. For example, a patient who travelled to Thailand for hip replacement explains the difficulties he faced prior to his trip.

> '…the pain was getting worse and worse…progressively over the years…It had gotten to my point in life where I had to do something because I was just dealing with pain a lot and I didn't want to live that way anymore' (Eissler, 2010: 43).

Frustration drives many patients to look for alternative solutions, and treatment abroad appears in some cases as a deus ex machina opportunity. Song (2010: 389) describes that the first American to receive stem cell therapy in China 'refused' to accept his paralysis could not be cured and started looking through the internet for a solution. He soon discovered a patient forum where people facing similar problems talked over experimental treatment provided in China, and decided to participate (Song, 2010: 390). In addition, Inhorn and Shrivastav (2010: 72) explain that British

couples visit UAE for fertility treatment due to long waiting lists at home; and that at the same time couples living in UAE make a trip out of the country as a result of similar delays in state provision (coupled with unaffordable private care). Lack of treatment locally also accounts for the most part of patient movement between developing countries as well. According to Crush *et al.* (2012), neighbouring countries with serious disruptions in public health care provision account for the increasing patient flows to South Africa.

Very often financial constraints account for non-accessibility to domestic health care. According to Eissler (2010: 42), all interviewees faced financial constrains in covering their treatment locally. They said it was a happy surprise to realise they could save money by travelling abroad. Findings of another study on 45 travel facilitators in US confirm that cost is the most significant driver for patients travelling abroad (Alleman *et al.*, 2010). For instance, Ackerman's (2010) ethnographic work highlights that financial constraints create dilemmas and generate a consumer like behaviour linked to cross border care. People not only compare price and quality among providers but also perceive (cosmetic) surgery as an expense in their shopping checklist. 'Instead of a new deck, I got a new rack' an American visiting Costa Rica for cosmetic surgery confesses (Ackerman, 2010: 410). Nonetheless, finance is not always the main driver. Most Canadian citizens do not refer to cost benefits in Johnston *et al.*'s work (2012), while middle class Africans visiting South Africa for treatment do not raise concerns over medical expenses (Crush *et al.*, 2012).

Privacy concerns may also prompt a patient to seek health care abroad. Inhorn and Shrivastav (2010: 73) explain, for example, that fertility treatment might stigmatise couples in their working environment and therefore they often try to keep their trip abroad for fertility secret. Apparently, cosmetic surgery may also provoke social criticism. In Costa Rica visitors sometimes decide on the spot to undertake aesthetic operations; they are relieved from the social pressure of their familial environment while at the same time they find themselves within an environment supportive of plastic surgery (Ackerman, 2010).

As the phenomenon is popularly called medical tourism and a number of theoretical papers suggest that people combine tourism with health care, the question of the tourism component of the trip remains. Empirical evidence suggests that some patients take the opportunity to travel for recreation after their treatment or in between consultations (Eissler, 2010). Their purpose is to see family and friends, be culturally stimulated or see the destination country; nonetheless, tourism activities are not part of the decision to travel for treatment (Eissler, 2010). Similarly, the national tourism survey in South Africa shows that foreign patients engage in activities like shopping and some nightlife (Crush *et al.*, 2012: 15). Usual activities of conventional vacationers such as seeing wildlife, going to the beach or visiting cultural monuments, however, are not reported. In addition, Song (2010) suggests that patients and their families interviewed in China during their trip for stem cell therapy did not engage in sight-seeing.

‘some of them never ventured beyond the hospital grounds during their month-long treatment course in Beijing. They made their arduous trips for a very specific objective: to obtain an experimental treatment unavailable elsewhere in the world’ (Song, 2010: 386).

Similarly, Middle Eastern families visiting Bangkok appear disengaged from tourism activities, other than shopping in close reach to their hotel (Cohen and Neal, 2012: 23). Cohen and Neal narrate that they behave and interact as they would at home and do not seem to have an interest in Thailand as a tourism destination. Current empirical studies, thus, confirm that travelling for health care abroad does not necessarily involve a tourism component (Cohen, 2012). More so, they emphasise that patient decision making is unrelated to tourism, a fact which will become more obvious in the overview of pull factors to a destination country.

Pull Factors and Sources of Information

How patients choose destination and provider is a significant component of decision making. Important aspects are providers’ choice and third-party recommendation; the first is perhaps the most important aspect of decision making. This decision in itself consists of the criteria used to evaluate providers and the trusted sources which inform evaluation. As far as the first component is concerned, most studies suggest that a basic criterion is the doctor’s reputation and quality of facilities. For example, according to a qualitative research study in Canada, the most important factor is the reputation of the surgeon (Johnston *et al.*, 2012: 10). Credentials, experience and testimonials are the criteria of evaluation, and internet

or word of mouth are the means to get to know the surgeon. Specifically, out of the 32 interviewees, only patients seeking CCSVI (Chronic Cerebrospinal Venous Insufficiency) treatment and members of migrant communities would not prioritise the surgeon. Overall the dominant source of information appears to be word-of-mouth. Information provided by acquaintances, family or friends includes opinion about hospitals, medical doctors, and narration of past experiences (Ye *et al.*, 2011). For example, a research study in Malaysia based on (approximatey) 400 questionnaires distributed to foreign patients, shows that 60% of the patients decided to go to Malaysia after family and friends' recommendation (Musa *et al.*, 2012: 539). In addition, Eissler explains that talking to the doctor, other health care professionals and former patients gave confidence to the patients in their final decision to go abroad. Some visited a number of clinics before taking the treatment after they reached their destination. Recommendation functions often as a means to counterbalance information asymmetry in the doctor-patient relation. In order to understand its special meaning in an internationalised context it should be born in mind that patients are called to take unprecedented decisions over their health that they would normally delegate to professionals or other institutions.

Finally, culture and religion of the destination country appears to play a role in decision making, but not for all patients or groups of patients. For example, evidence shows that Western visitors in Malaysia do not place importance on cultural and religious (dis)similarities whereas populations of neighbouring countries do (Musa *et al.*, 2011). In addition, Muslim couples visiting Iran for fertility treatment are most possibly attracted by a religious sentiment (Moghimehfara, and Nasr-Esfahanib,

2011). In contrast, Johnston *et al.* (2012) conclude that Canadian interviewees did not consider the destination in itself prior to choosing country, with the exception of members of diaspora/immigrant communities. Therefore, nationality seems to influence the desire for a culturally sensitive destination.

Emotions and Experiences

It has already become obvious that international travel for health reasons is, more often than not, a complicated decision. This section emphasises the link between dissatisfaction at home and the decision to undertake an 'unconventional' trip. It also takes the opportunity to present patient experiences of being treated abroad.

Dissatisfaction at home

Dissatisfaction with the organisation of local provision is a theme that continuously reoccurs in the literature. For example, in Canada, the vast majority of interviewed patients express dissatisfaction with the quality of care.

> 'I had had so little care here [in Canada] I figured it couldn't be any worse over there. Maybe it could, I knew it was a third world country, but after I researched the hospital on the Internet and I talked to four or five different people who went over there I had no concerns whatsoever' (Johnston, 2012: 9).

Eissler suggests that interviewed patients in Alaska are unsatisfied with the length of the procedures, the lack of organisational efficiency but also the difficulties in having a scheduled appointment. A patient who travelled to Mexico for dental care

explains she was postponing treatment due to a difficult and lengthy procedure which she could speed up in Mexico.

> 'I'm sure it would take like six months of going in [the dental practice] regularly and I just didn't want to face it' (Eissler, 2010: 53).

There are also accounts of complaints over MDs' behaviour at home. The complaints refer to physicians' short consultation time or little attention paid to patients and lack of sensitivity in explaining the costs and consequences of the services promptly (Ackerman, 2010; Eissler, 2010). That patients who travel abroad often do not inform their family doctors, thinking that they will be dismissive of their decision (Johnston *et al.*, 2012), indicates bad communication between patients and physicians. Furthermore, in the US in particular, the health care system is perceived as complicated, expensive and inefficient because of the role that insurance companies play. Similar concerns are revealed by psychological pressures often felt by Canadian patients, as the narration that follows indicates.

> 'I didn't leave voluntarily, I didn't go for a tourist trip, this is not like plastic surgery where I was doing something voluntarily and looking for the best environment to . . . do this, I needed remediation, I was in pain. . . . So I left not for any reason other than Canada and BC [British Columbia] in particular didn't offer me appropriate care' (Snyder *et al.*, 2012: 41).

Since inaccessibility of health care at home is a main driver in decision making, the psychological pressure felt by patients should not come as a surprise. It logically follows that patients invest emotionally in the trip as they hope it will improve the

quality of their life. First, they have to overcome initial hesitation but also anxiety and stress related to uncertainty and the disruption of the trip for themselves and their family.

An 'Unconventional' Trip

The experience of treatment abroad entails anxiety for many patients. Prior to their trip, patients mention that they are stressed and nervous due to the imminent care to be received in a foreign environment. Anxiety stems often from being in a developing country (Johnston et el., 2012; Eissler, 2010), or the complication and expenses (Inhorn and Shrivastav, 2010). Visa procedures, travel arrangements, communication and miscommunication, extended periods off work under an effort to maintain secrecy are emotionally exhausting for working couples that travel for fertility treatment (Inhorn and Shrivastav, 2010). It is indicative how some patients reflect on travel anxieties by framing the experience as 'adventurous' and 'unconventional' (Eissler, 2010). For some, it is experienced positively. The American yoga teacher below expresses excitement over undertaking cosmetic surgery in Costa Rica,

> '…it was so gentle and loving. It wasn't like going to the hospital; it was like going on an adventure' (Ackerman, 2010: 409).

In contrast, other patients frame the trip as 'exile' (Inhorn and Schrivastav, 2010) and renounce the term (medical) tourism as disrespectful and insulting. It is interesting to note that travelling for treatment creates ties among people taking the 'unconventional' trip, which become evident by strong support networks

developed among them. For example, former travellers appear willing to contact prospective travellers so as to offer support and encouragement (Johnston *et al.*, 2012). In addition, Ackerman reveals how patients psychologically support one another in the lodge where they spent their recovery period. Similarly, Song (2010) provides an account of the importance of communication and encouragement between the potential and actual patients that takes place in an online patient forum. Qualitative research findings tend to describe expressions of strong solidarity.

The Lived Experience

Despite initial frustration, in the aftermath of the trip the overall experience is reported as positive by most interviewees from N. America (Ackerman, 2010; Johnston, *et al.* 2012; Eissler, 2010). Patients regularly highlight feelings of trust towards the providers; the MDs and nursing staff; and the organisational efficiency; including timely scheduling and articulate explanations over illness and procedures. Ease of transportation and communication; 24-hour email correspondence; medical test results readily available, enhance the experience of patients. Often in low cost destinations patients from leading economies may enjoy the standards of service that the local elite does. In essence, these patients do not simply change country but simultaneously change social class.

‘ ‘You feel like someone special here’, a recovery hotel guest said about the comfortable, affordable amenities and the friendly attention of local caregivers’ (Ackerman, 2010: 411).

Excitement is not expressed by all patients, however. Quality standards are not as high in all destinations and providers, or hardships are sometimes not anticipated prior to the trip. Some mention that medical equipment in Mexico is not as modern as at home (Eissler, 2010) or that they feel vulnerable in the absence of their familiar environment (Ackerman, 2010). According to Ye *et al.* (2011), Chinese women travelling to Hong Kong to give birth report discriminatory behaviour by local MDs and nurses which contributes to an overall negative experience (Ye *et al.*, 2011).

> 'When I ask the nurse to teach me how to feed the baby in Mandarin, the nurse seems impatient. It seems that I make troubles for her' (Ye *et al.*, 2011: 1126).

The experience therefore, though in general reported as positive, appears situation specific. Qualitative research samples comprise of volunteers and do not aim at representativeness, therefore selection bias of people reporting positive experiences may be strong. Empirical data are still quite scarce, while the media is full of reports on overseas malpractice cases. As it will be elaborated further, medical doctors in Australia, US, Canada, UK and Germany express concerns about cross border care based on malpractice incidents they come across after patients return home. It would be, therefore, too soon to draw conclusions as possibly there is great diversion in quality standards among providers. Obviously, it is this variation that raises concerns among law scholars and medical doctors as it is closely related to the high risks involved in medical travel.

Empowered patients or medically disenfranchised citizens?

It has been suggested above that patients sometimes avoid discussing their decision to travel with friends, family or their doctor and perceive treatment abroad as an unconventional way to deal with their health problems. Bristow *et al.* (2011: 114) suggest that neither prior visit to the destination country nor earlier international tourism experience more generally is a pre-requisite for medical travel. Empirical research corroborates that patients may receive treatment in a country they visit for the first time, or even that they may take their first international trip for medical reasons (Eissler, 2010). This contrasts with observed behaviours of populations such as immigrants, diaspora groups, ex-patriates, and people living close to borders. The latter groups are typically familiar with two countries' health care systems, culture and language and may feel quite comfortable with cross-border care. The question then of why the rest choose an 'unconventional solution' to their health problems remains.

Altin *et al.* (unpublished) suggest that 'dispositions like openness to experience' characterise people travelling abroad for treatment, while this initiative is at times related to 'savvy' patients; well-informed and empowered people who do not hesitate to take their health in their own hands. Ormond and Sothern (2012: 935) describe the transformation of 'passive patients' to 'empowered educated consumers' who take responsibility of their choices. This interpretation, however, merits a more careful examination. On the one hand, there is indication that patients who cross the borders are relatively sophisticated. They search extensively for

providers on the internet and prepare their trip for months in advance (Johnston *et al.*, 2012). They try to get information from pervious patients and depend a lot on a surgeon's reputation, word-of-mouth, and testimonials, as has been demonstrated above. Foss (2012), for example, remarks as a sign of sophistication the fact that patients increasingly crosscheck (ISAP) surgeon credentials. On the other hand, there is the evidence of patient high stress levels, hardships and dissatisfaction; in fact, treatment abroad often caters for patients' inability to access health care domestically. Crush *et al.* (2012: 9) characteristically observe that people seeking treatment abroad are, at home, 'medically disenfranchised'; citizens deprived of their right to health care and the right for health equity. There is, therefore, a tension created between the two interpretations. Is it about medically disenfranchised citizens or is it about empowered patients? Possibly there is some truth in both conceptualisations and Kumar *et al.* (2012) partly bridge the gap when they suggest that in the US, for example, insurance contracts foster consumerism among citizens who take a more active role in their health care and at an increasing level leave the country for health treatment. It is suggested here, therefore, that patients find themselves in adverse conditions and are incentivised by their environment to discover deus ex machina solutions.

Consumerism is also a concept that needs deeper consideration when employed for patients travelling abroad, for similar reasons. Patients often look for a better price and compare the price / quality mix offered by various foreign providers before they make their decision (Musa *et al.*, 2012), so, at least on the surface, they exhibit consumerist behaviour. But the connotations of such a characterisation should be

given some deeper thought. If one takes under consideration that the decision making is externally conditioned by financial constraints, then the term 'consumer' may carry connotations that bear little relevance to dilemmas and pressures encountered. Song (2010: 387) among others emphasises that "framing patients as individualized tourist consumers hunting globally for the cheapest deal" is a very narrow conception.

Intention to Travel Abroad

In addition to empirical work on patients seeking health care abroad, a number of studies investigate the *intention* to travel abroad for medical reasons. Questionnaires, surveys and polls are employed to capture university students'; citizens'; and tourists' intention to travel abroad in general or to a specific destination. The latter often aims to collect information for marketing purposes of country-destinations.

To begin with, a nationwide poll in UK in 2002 with 2000 participants shows that more than 40 percent of respondents would go abroad for treatment covered by the National Health care System to avoid long waiting lists (Beecham, 2002). In addition, according to a questionnaire distributed to the general public in UK in 2010, 97% of people who have considered cosmetic surgery (92 individuals) would consider travelling abroad for the operation (Nassab *et al.*, 2010). A survey conducted on 2,304 Canadians indicates that 20% of the respondents would travel in a foreign country for out-of-pocket health care procedures. (Johnston *et al.*, 2012: 4). Results of a questionnaire distributed to university students in US shed light to

more important aspects of medical travel than just intention to travel. The questionnaire examines the likelihood of travelling abroad for health care and the attitude towards medical tourism. Results of a sample of 336 undergraduate students of ‘a large Midwestern university' studying Psychology show that students are not willing to learn more about medical travel to a developing country (Reddy *et al.*, 2010). Another study conducted in the US examines the factors influencing destination choice among students when considering medical treatment abroad (Gill and Singh, 2011). Results show that competent doctors, high quality medical treatment facility and ‘prompt medical treatment when needed’ were most influential factors. In addition, students indicate that online research would be a most preferred way to search for information, followed by recommendations of the family physician and then of family and friends. It is interesting to note that most participants show preference to developed over developing countries (in descending order they choose Japan, South Korea, Singapore, Mexico and finally India). Both researches on students show that when cost is not of concern, highest quality of care and developed countries as destinations are the mostly appreciated, reinforcing the argument that medical travel comes to a large extent as the outcome of need and not choice.

In addition, a number of studies examining decision making process of individuals have been conducted recently in Asia. They are mostly inspired by the perceived opportunity of a ‘medical tourism’ sector development and are often supported by governmental initiatives. As such, their goal is to examine factors influencing decision making given that people consider travelling abroad. For

example, Chinese tourists participated in a survey in Macao examining perceptions on 'medical tourism products' (Lam *et al.*, 2011). Results indicate that most influential factors in the evaluation of medical services are the cost of treatment, cleanness, and the quality of medical equipment and service. In addition, most significant information sources for respondents are considered to be friends, the internet and relatives. Magazines of general content, conferences, exhibitions and medical institutions are least preferred, with less than ten percent of respondents showing preference. Another research focusing on Chinese people was conducted in Taiwan (Wang, 2012). Middle class employees of a Chinese company visiting Taipei for an event responded in a questionnaire examining intentions for medical travel. Results indicate that quality in medical treatments and quality in services may influence positively intentions to travel to Taiwan for health care. Entertainment appears also important, while Chinese citizens may be attracted by language and cultural similarities. In addition, perceptions of low risk would have positive effects on intentions. Based on the results, Wang emphasizes that high standards medical facilities, well trained medical staff and accreditation bundled with vacation opportunities would contribute significantly to an attractive medical product for Chinese middle class citizens in Taiwan.

Two more exploratory research studies focus on Korea as a destination country. The first one focuses exclusively on Japanese visitors' intentions while the second one compares preferences of Chinese, Japanese and Koreans. According to 237 responses in a questionnaire distributed during 2010, Japanese would consider the possibility of visiting Korea for health care services but intentions are conditioned by

perceptions over quality of care (Lee *et al.*, 2012). Of these respondents, 1% reported they have had treatment in Korea in the past. The results indicate that participants place importance on word-of-mouth for informing their decisions; recommendations from family, friends, acquaintances, and their doctor but also from travel agents are reported as most influential. For non-elective medical procedures factors such as cost, adequate information, good communication, and safety are indicated as most influential, while for cosmetic interventions cost, information and communication, but also the difficulties involved in terms of time and effort and the location of the provider in Korea are indicated. The other study that focuses on Korea's potential as a medical destination examines the case of Jeju Island, south of Korea (Yu and Ko, 2012). It investigates which factors may influence positively Chinese, Japanese and Korean visitors through a structured questionnaire distributed. The findings indicate that Japanese are more interested in rehabilitation care and major surgeries and are less sensitive to price changes. Chinese on the other hand are more interested in invasive care and cosmetic procedures where demand elasticity appears to be high.

The overall emphasis on quality and safety, doctors' reputation but also reliance on family and friends, or else on word of mouth, corroborates the research findings on decision making of patients who have travelled abroad for treatment, as presented earlier in this section. The conclusion to be drawn is that health care is a field that even when perceived as a service, 'consumers' are unwilling to compromise quality. Patient travel, thus, is severely restrained by concerns over health outcomes. Notwithstanding the limitation of focusing on *hypothetical* decision

making process, the value of research findings on intentions lie to the conclusion that high quality of care is emphasised. Research findings may be interesting, from a marketing perspective, for medical providers that target at inbound flows of foreign patients.

Conclusion

It becomes obvious that empirical work adds another dimension to the development by highlighting ignored aspects of the practice. First of all, it sheds light on patients' decision making process which was only theoretically approximated; it expands knowledge on pull factors such as the weight that surgeon's reputation has on providers' choice and the importance of word of mouth; or it informs about the lengthy period of travel preparation. Second significant contribution is the opportunity to voice patients' experience and concerns which highlight strong dissatisfaction with health care at home; the emotional situation of stress and the feeling of unconventionality; or the complication that the trip involves. Especially the expressed dissatisfaction with local provision underlines the perceived responsibility of states in providing health care; and, at the same time, the fact that states' failure to do so encourages the practice of medical travel. At last, empirical work shows that the tourism component of the trip is minimal; rendering the term 'medical tourism' as irrelevant and misleading or at times even disturbing. Overall, instead of a dry and technical account of factors, empirical work offers rich information and places peoples' narrations in the centre of discussion; as such it allows a better

understanding of the conditions and circumstances under which the phenomenon in hand develops, but also opens up new venues for debates in public policy issues.

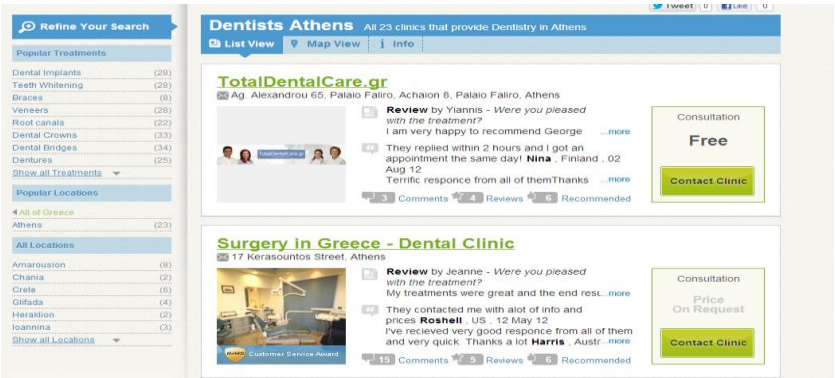
Intermediary Companies

Brokerage Companies in Transnational Health Care

Medical tourism web portals and agencies are synonymous to the internationalisation of health care. They appeared when growing numbers of patients searching for information online and seeking treatment abroad signalled a new opportunity for business. Soon they became a key actor. Crush *et al.* (2012: 28) mention that at least 16 such companies are now operating in South Africa mainly promoting cosmetic surgery alongside vacation packages. Commonly known as medical tourism facilitators, these companies offer services to both patients and medical providers. In particular, they may offer services to patients related to the medical component of the trip, such as medical provider recommendation, first screening of medical history and preparation of documents for hospitalisation, and/or services related to travelling arrangements, such as lodge recommendation, airfare tickets, and visa application. A research study on 66 specialised websites in the US has shown that actually only 14.5% of these provide services for the travel component, with the majority referring patients to general tourism agencies for related assistance (Mason and Wright, 2011). Agents offer services to medical providers as well, which include advertising and patient reference for a fee.

There are quite a few types of agents across the continents. Often, agents are web portals including information about providers in one or multiple destinations, and, sometimes, information about medical procedures. Lunt *et al.*, 2009 distinguish web portals in English language in five categories; the national (country specific); governmental (supported by the state); open (including for multiple destinations); treatment (specialised on one treatment such as fertility treatment or stem cell therapy); and provider (supported by a group of medical providers) websites. It is not uncommon for an intermediating portal to function similarly to hotel booking portals where the patient types in a search engine the type of treatment and/or location she has an interest in. Patients may also comment on services or inquiry replies by overseas' providers and rate them. The captures below are an example of the home page of a website as such, followed by research results of the terms 'Dentist Athens' (WhatClinic.com, last retrieved 15/03/13).

Capture 1



Capture 2

Even though it is typical for such portals patients to make the arrangements directly with a provider, at other instances, agents' services have a more personal character and greater involvement in provider choice. Some intermediary companies maintain offices in origin countries where potential patients meet a representative and perhaps the medical doctor prior to their trip. Others are destination based. Table 1 provides an example of a detailed plan followed by a medical tourism operator based in S. Africa (South Link Consulting) after a patient inquiry from abroad is received. The facilitator in this case, takes over a significant part of decision making on behalf of the patient and act as the representative of the patient to the provider.

Table 3 Patient Inquiry Management Plan, South Link Consulting

STEP 1: Completion of the Enquiry form
STEP 2: Assignment of Clients to a Medical Practitioner
STEP 3: Approval of Medical Procedure
STEP 4: Finalisation of the Quotation
STEP 5: Confirmation of the Booking, Payment and Communication
STEP 6: Client Arrival

STEP 7: Consultation and Physician payment
STEP 8: Medical Procedure
STEP 9: The “Care-Bubble”
STEP 10: Departure and Post-Operation Contact

Source: Crush et al. (2012)

It becomes clear that agents gain momentum in cross-border care. Their growth stems from the need of patients to be informed about providers in foreign countries and the effort of medical providers to become known to foreign nationals. They emerge as a key actor with significant influence on patients and providers but also on the function of the sector more broadly. Their impact on the decision making of patients and the information asymmetry in health care provision will be more closely examined now. It will be highlighted that largely unregulated, the operation of these companies raises policy concerns over the medical information they provide, and the liability they carry towards their clients (Lunt *et al.*, 2009; Penney *et al.*, 2011).

Emphasising benefits, Downplaying Risks

Medical tourism websites have a strong commercial character which is related to commercialisation in the health care sector (Lunt *et al.*, 2009). There is a tendency to emphasise benefits of treatment overseas and downplay negative aspects and risks (Mason and Wright, 2011). For example, Mason and Wright (2011) observe that low cost, high-quality services, and doctors’ expertise are factors most commonly emphasised among 66 reviewed sites, with exotic destinations also highlighting the tourism component of the trip (Mason and Wright, 2011); e.g. beautiful scenery and safari is commonly promoted in South Africa along with

cosmetic surgery advertisements (Crush *et al.*, 2012: 26). Similarly, Medical Tourism Agencies in the US (i.e. arranging both travel and treatment on behalf of the patient) emphasize factors such as easiness, 24/7 services, friendly health care personnel, medical services of at least as high standards as these of local providers, and assignment of a personal assistant in destination country (Sobo *et al.*, 2011). More abstract notions are also touched upon by agents. For example, the US agencies not only emphasise hedonistic aspects of the trip such as tourism activities, but also highlight the concept of patient empowerment (Sobo *et al.*, 2011). Under this narrative, the individual is liberated from gate-keepers or social pressure to decide for their health care based on freely available information (Sobo *et al.*, 2011). In addition, website content among Canadian sites appears carefully worded. Intermediaries avoid the term 'broker' and any negative connotation that may be associated with the word (Penney *et al.*, 2011). Instead, the preferred term 'facilitator' allows emphasis on servicing patients. Notable are also the efforts of specialised travel agencies to legitimise the practice of seeking and offering health care abroad; medical travel is promoted both as a modern and trendy behaviour and, at the same time, as a conventional initiative re-occurring through centuries (Sobo *et al.*, 2011). Furthermore, several agencies take the opportunity to explain that lower cost of living abroad, currency differentiations, and lower physician fees account for price differences (Sobo *et al.*, 2011). In this way they try to tackle the moral concerns of individual responsibility that clients may feel towards local populations at destination countries; their own national health care system; and their choice to 'jump' the waiting list. The evidence, therefore, shows a targeted effort

from the side of intermediaries to embellish the practice of medical travel and its impact, and minimize patients' hesitations. Intermediary sites, in addition, downplay health risks involved in treatment abroad. For example, the content analysis of 66 websites in English indicates that just a minority includes information on malpractice, complications, post-operative care, legal liability, and involved risks (Mason and Wright, 2011: 170). The study highlights that medical providers' sites actually include less information on risks in comparison to non-medical sites (Mason and Wright, 2011: 170). Similarly, another study on Canadian travel agencies reveals that almost half of the examined cases made no reference to risks (Penney *et al.*, 2011). The rest mentioned them briefly, while positive messages were numerically surpassing messages on risks**,** cultivating, thus, positive impressions.

Parallel to biased representations, credibility of providers and facilitators is not always adequately supported. Reference to official accreditation of both providers and facilitators is scarce. Several websites promote services of highly skilled medical doctors which do not rely on details about training and experience but on 'superficial' messages. Similarly, to a great extent patient testimonials are displayed as credentials of high standards' services (Mason and Wright, 2011), and training and quality is most commonly emphasised through simple statements (Penney, 2011).

Patient: Misinformed, Disempowered

In light of the presented evidence, the commercial character of websites, coupled with lack of regulation, may be of concern. As with other types of online health

information (Bates *et al.*, 2006), it may be misleading, incorrect, or distracting attention from potential risks (Lunt *et al.*, 2009). The fact that websites rely on advertising fees from medical providers and serve business interests gives incentives to provide unreliable health information (Alleman *et al.*, 2010). Penney *et al.* (2011: 7) highlight that this approach may be understandable, nevertheless, it remains unethical and potentially misleading. They add that informed consent on the side of facilitators and providers would require more balanced information on risks and benefits. Privacy concerns may also be raised. Handling and circulation of medical history records, information on illness and treatment by these companies or portals may not respect the privacy of the patient (Lunt *et al.*, 2009). Furthermore, some websites support patient feedback on providers and doctors as a quality assurance mechanism, downplaying other forms of quality evaluation (Lunt *et al.*, 2009). Despite some positive aspects of giving voice to patients, clinical results or treatment risks are not always appropriately evaluated by patients.

It can be argued that information asymmetry perpetuated by commercial agents seriously limits patients' ability to decide upon their health care. What is of concern is that when it comes to medical travel, information asymmetry is reinforced by other information sources. Mainil *et al.* (2011) suggest that after the 2000s newspaper articles about medical travel in English are biased towards the positive aspects of the practice. The market discourse is promoted over the medical, the patient and the ethical. Objects such as business, trade, global services and their relation to medicine and medical care are prioritised. This occurs at the expense of ethics and medicine or tourism, medical travel and global as well as public health, the new

roles of the patient as joint decision maker, medical technology, and quality and standards. (Mainil *et al.,* 2011: 33). It is hard to see how the argument of an empowered patient can be supported when people deciding on a provider have to overcome the problem of interest-led information**.** In addition, Ormond and Sothern's (2012) work on available 'medical travellers' guides' in English, suggests that these guides maintain a positive approach to the development. Their authors instruct readers to see the failures of domestic health care systems; encourage them to see themselves as 'savvy' patients who successfully adjust to the new conditions of health care provision; and present the advantages of receiving health care abroad (Ormond and Sothern, 2012: 940). They legitimise their instruction by claiming their aim is not to sell but to inform. Except for the guides, promotional efforts of destinations also overemphasise positive aspects. For example, research findings on India's promotional efforts in Canada suggest that risks are de-emphasised (Crooks *et al.*, 2011). Distributed material in a trade show based promotional efforts on factors such as quality of care, accreditation of facilities, state-of-the-art equipment and well-trained medical doctors with no mention of risks.

The argument raised here is that patients are exposed to biased information coming from multiple sources. Except for agents, newspapers, specialised guides, and providers, often supported by governments have financial incentives to embellish the practice, its impact on people, populations and health care systems. Even though it is acknowledged that studies are relatively few, they all provide evidence of biased information promoted. Against this backdrop, it is questionable whether informed decision making by patients is possible. The image of an

empowered patient in a position to actively engage in decision making is put in question. In fact, lack of regulation over the practice entails considerable dangers for patients, systems, providers and populations.

State Initiatives: Country Studies

In several countries the state plays a pivotal role in the establishment of inbound patient flows. Initiatives are taken within a national developmental framework, where international patient movement is perceived as an industry, commonly discussed as the medical tourism industry. Examples of such policies and perceptions include special bodies facilitating collaboration among involved stakeholders (Helmy, 2011: 303), and the official stance of the Indian government that there lies an opportunity to improve the balance of payments (Sengupta, 2011: 317). Often state initiatives come in support of private sector efforts to attract patients from foreign countries (Chee, 2010: 338); in fact many policies are related to subsidies and tax allowances to private hospitals. Chee (2010) traces the idea of developing medical tourism in South East Asian countries, nowadays leading international destinations, in the aftermath of the financial crisis of 1997. Authorities were then desperately in search of sectors which would take the economy out of recession and medical travel appealed as a particularly lucrative option. As time goes by, more countries consider the option of promoting their health services internationally. The argumentation remains by and large focused on economic benefits; exports, growth, and development. This section reviews the existing literature on state policies implemented in Thailand, India, Malaysia, South Korea, Singapore and South Africa

and comments on the increased commercialisation that comes along with those policies.

Thailand

State intervention has boosted the sector of medical travel in Thailand (Kim *et al.*, 2009). Originally traced in the '80s, developmental policies were increasingly implemented after the financial crises of the 1990s. Thereafter, Thailand has been a destination for thousands visiting every year for wellness tourism and medical procedures. Bumrungrad hospital is perhaps the most famous international medical provider operating in Thailand; it attracts annually thousands of foreigners. In 2003 foreign patients accounted for 41% of its revenues and in 2006 Bumrungrad was the largest hospital in Southeast Asia (Chee, 2007: 19). The authorities concentrate efforts under a specially planned programme with the title 'Thailand: Centre of Excellent Health' (Lautier, 2008: 103), which in 2009 aimed at doubling current earnings by 2014 (Nicolaides, 2011: 11). Policy measures implemented refer both to foreign patients and local providers. For example, in order to ease access to the country, entrance without visa for long-term senior patients has been established (Kim *et al.*, 2012). In addition, in an effort to encourage foreign investment, for the start-up period, new providers enjoy reduced hospital taxes and import tariffs (Kim *et al.*, 2012).

Singapore

Chee traces the first efforts of the Singaporean state to attract foreigners for medical purposes in the beginning of the 1980's (2010). By that time, several

medical doctors were consulting foreign patients who in some cases comprised up to half of their clientele (Chee, 2010: 341). In 1986 the state set as a goal to transform Singapore to a leading international medical centre for the wider region (Chee, 2010: 342). By 1997 as many as 15 thousand patients were admitted in hospitals mainly from Indonesia and Malaysia, an inflow that the 1997 crisis slowed down. At this historical conjuncture, diversification was perceived as pivotal for stability and promotional efforts targeting different foreign countries (Chee, 2010: 342). The growth of neighbouring countries with lower prices as medical tourism destinations also hindered inbound flows. More recently, the tourism board, trade development association and economic development board have joined forces to boost development of the sector (Kim *et al.*, 2009). A special programme under the name 'Singapore Medicine' has been initiated to promote private hospitals' health care services abroad (Chee, 2009; Lee, 2010). Governmental resources have been allocated for the development of special services; the creation of medical packages; for the support of travel agencies and promotion to foreign nationals. Other state initiatives include an online network of hospitals, consultation, and multi-language information services (Kim *et al.*, 2009). In addition, tax allowances for the hospitals that attract foreigners, and discounts for foreign patients are provided, while foreign patient centres are created (Kim *et al.*, 2012). As far as health professionals are concerned, highly skilled medical doctors are promoted as a competitive advantage (Crush *et al.*, 2012: 7) while the rest of health professionals are encouraged to obtain tourism guide certificates (Kim *et al.*, 2012). According to Jones and McCullough (2007), a second medical school was established proactively to cater

for increasing inflows of foreign patients. The government targeted an increase in inbound patients from 410 thousands in 2006 to over a million in 2010 (Crush *et al.*, 2012: 7).

Malaysia

Malaysian private hospitals faced difficulties after the 1997 financial crisis. Medical tourism was then recognised by the government as one of the most promising sectors to lead the country out of recession (Musa *et al.*, 2012:525). Soon a national board was established by the state to support the efforts (Chee, 2010: 343); named the National Committee for the Promotion of Medical and Health Tourism (Chee, 2007), to be eventually renamed Malaysia Healthcare Travel Council. The Malaysian state took specific measures in support of the industry, such as relaxing the advertising restrictions in the medical sector and establishing an accreditation body to substitute the expensive Joint Commission International. It also provides tax incentives for the construction of medical facilities and the purchase of medical equipment; and tax allowances for revenues generated from foreign patients. In addition, price standardisation is promoted (Musa *et al.*, 2012: 528); hospitals are encouraged to put online success and mortality rates (Nicolaides, 2011: 11); while services are promoted abroad (Chee, 2010; Musa *et al.*, 2012). Nowadays, the majority of foreign patients seeking health care in Malaysia are from Indonesia but there are also patients visiting from Singapore, Japan and West Asia.

India

India has also seen growth in inbound patient flows. It is estimated that more than 310 million dollars were generated in 2005-2006 by foreign patients and that by 2012 the amount could reach 2 billion (Sengupta, 2011: 312). Private sector investments account for the growth, while the government works together with the private sector to encourage medical travel. Support of the sector gained momentum in 2002, after a report on the potential of the country, prepared by the Confederation of Indian Industry and McKinsey and Company was published (Chinai and Goswani, 2007). In India, hospitals enjoy low taxation, may rent state property at low rates (Kim *et al.*, 2012) and benefit from tax allowances to import medical equipment (Sengupta, 2011: 317). The government issues a special visa which is valid for one year for foreign patients and their companion (Chinai and Goswani, 2007) since 2006. It also funds promotional activities of hospitals accredited by the Joint Commission International and the corresponding domestic accreditation body since 2009 (Sengupta, 2011: 313; Nicolaides, 2011: 9).

South Korea

The state of Republic of Korea (Korea), taking as a starting point the success of other Asian countries, has taken initiatives, during the last few years, to establish the country as a destination for health care services. The authorities' plan is to link medical services to tourism and utilise specific regions as destinations. In light of this, academic research on the chosen provinces has been supported by the state; Korea has put an emphasis on research and planning so as avoid resource

allocation in a wasteful manner. For example, the Jeju province has been considered an appropriate area to host health tourism facilities and state and international funds are jointly invested in the creation of a large health resort. Korea has also initiated official data collection. Among other data, the Ministry of Health and Welfare collects data on foreign patients' nationality, medical procedures, spending, type of medical facility and stay (inpatient, outpatient). In addition, a recent study assesses the performance of the medical tourism industry and the progress succeeded (Kim *et al.*, 2012). Korea and Taiwan, that will be next examined, appear to have a preference over an evidence-based approach where planning is preceded by research.

Taiwan

Taiwan has also emerged as a country promoting medical tourism. The government, alongside health care providers, consider there is an opportunity in the sector and try to coordinate their efforts in developing medical tourism (Liu, 2012). A number of health, developmental, tourism, and trade committees and boards make up a network. Tourism Bureau is responsible for international promotion, Trade Office for contacts with overseas providers and Economic Research coordinates research in the field and collection of statistics to support marketing strategies (Liu, 2012). As a result, the government presented in 2007 a medical tourism programme and a task force committee. In addition, a considerable budget was allocated for promotional purposes (Liu, 2012). Even though the number of foreigners visiting for treatment has not been particularly high, the number of people undergoing plastic

surgery and medical examinations increased by 300% and 75% respectively in 2010 (Kim *et al.*, 2012). Taiwan attracts Chinese patients due to ease of communication in Mandarin, proximity for those living in the borders and cultural similarities (Kim *et al.*, 2012). Authorities strategically target Chinese from China in as much as Chinese people from US (Wang, 2012) and to support this end entrance procedures were relaxed in 2009 (Kim *et al.*, 2012). The Taiwanese government in collaboration with medical providers in 2007 took an initiative to promote specific treatments, including liver transplants, craniofacial surgery, cardiovascular surgery, and arthroplasty (Liu, 2012). At the same time, a medical complex is being built next to an international airport (Kim *et al.*, 2012).

Discussion

There are other countries with state actively supporting inbound patient flows, though less evidence is available. Tunisia, for example, held a conference at the beginning of December 2004 to attract health care purchasers from abroad. The concept was that both public and private foreign purchasers could be attracted by the potential to achieve as much as 50–80% savings (Lautier, 2008), since on average, Tunisian private clinics export 24% of their services (22 million $) (Lautier, 2008: 106). In addition, the government of South Africa has signed bilateral agreements with eighteen neighbouring countries whose citizens may be treated by public hospitals (Crush *et al.*, 2012: 2), while the private sector will be supported by a national programme (to be) planned in 2012 (Crush *et al.*, 2012: 7). Cuba, of course, has been one of the first countries to promote medical services to foreign

nationals for political (collaboration with overseas institutes increases the sphere of influence) and economic (balance of trade) reasons (de Arellano, 2011: 295). Already since 1990s, the Cuban state aimed at attracting patients from neighbouring countries that would normally visit the US (Goodrich, 1993).

Common denominator of state policies across countries is the reconceptualization of health care provision as a strategic sector for economic growth. The policies implemented include a mix of marketing efforts similar to tourism promotion abroad, and an infant-industry support scheme (including subsidies and tax allowances). These policies unavoidably entail the reconstruction of health care to a tradable service and the overall reinforcement of commercialisation. The extent to which the market rules penetrate health care provision, however, varies. Chee (2010), for example, explains that 'medical tourism' accentuates commercialisation in Malaysia, especially since the government abolished advertising restrictions in the medical field; in contrast, Lam (2011) informs us that the Taiwanese state refused to relax relevant restrictions despite exerted pressures from the private sector. Similarly, the Cuban state has been careful in controlling resources in a way that are not diverted away from locals (de Arellano, 2011), whereas in other Caribbean countries inbound foreign patients have negative consequences on primary care resources for their own citizens (de Arellano, 2011). Despite obvious differences, reframing health care as a commodity is not unproblematic. Though Cuba comprises a distinct case, perhaps an exception to the rule, support of private providers in their endeavour to attract foreign patients in most countries coincides with subsidies that inevitably absorb funds from a sector

which is already resource limited. There is no country that can proudly state its national health care provision does not suffer from considerable limitations in personnel or facilities. In light of these limitations, the internationalisation of health care has a crowding out effect on provision for the local population, and, just like privatisation, it reinforces a two-tier system domestically. Subsequently, concerns over health equity issues arise. A health policy analyst claims that foreign investments in health care in middle-income countries deteriorates equity in funding and worsens access for the lowest incomes (Lipson, 2001: 1139). In addition, prices in private facilities in Malaysia and Singapore have risen due to foreign patients with negative consequences for locals (Snyder *et al.*, 2012), while an internal brain drain comprises another cause for concern. Bagheri notes that a number of governmental plans on 'medical tourism' justify their initiatives on the claim of redistributing at least part of the profits to enhance the local health care resources (2010: 296).

The argument, however, that trade will bring in revenues and the state will take measures to mitigate the negative consequences of inbound patient flows (Cortez, 2008) is not particularly strong. The question is how and when reallocation is going to take place since most countries exempt profits generated from treating foreigners from taxation, and, instead, provide direct subsidies. Commenting on the case of India, Garud (2005) suggests that it is highly unrealistic to suggest that redistribution of part of the earnings will take place so as to benefit the wider public, and Sengupta (2011) characterises the subsidies to support medical tourism as 'subsidy for the elite'. As noted already, there will be significant differences among countries; and though inbound patients will worsen problems faced by 'fragile' national health care

systems (Garud, 2005), other states will mitigate negative effects to a considerable level. The irreversibility, however, of the action of opening up trade in health care is arguably a negative milestone for every health care system, in that increased commercialisation negatively affects health equity and leaves more people marginalised.

Physicians

Health professionals, and more specifically medical doctors, are key actors in health care provision; domestic or internationalised; commercialised or public. Nevertheless, their position within the system of provision is context-depended and, therefore, their role in the internationalised context is worthy of close examination. The literature on internationalisation of health care does not, as yet, include a contribution of research focused on MDs. Nevertheless, ethnographic studies and some country reports refer to MDs' experiences and perspectives in that context. This section will attempt to bring literature referring to medical doctors together and identify the remaining gaps.

Entrepreneurial approach and key role in the establishment of the sector

Medical doctors' role and perspective on the internationalisation of health care vary to a great extent. Some MDs tend to highlight their concerns with patient movement, while others have an active role in the expansion of the phenomenon. For example, medical doctors in South Africa have developed international clientele

(Crush *et al.*, 2012: 23); and despite restrictions on advertisements, professional websites, medical travel facilitators, referrals and personal connections have helped them attract foreign clientele. Similarly, Chee (2010: 341) notes that the first efforts of the Singaporean state to attract foreigners in the beginning of the 1980's, lagged behind the initiatives of some medical doctors who were already extensively consulting foreign patients. Another example of entrepreneurial initiatives by MDs is that of a Portuguese medical doctor who, jointly with an entrepreneur, dentist in profession, established a clinic with spa facilities in Macao to attract Chinese visitors from the mainland of China (Lam *et al.*, 2011: 71). In addition, in South Africa one of the medical travel facilitators is owned and run by medical doctors born in Nigeria (Crush *et al.*, 2012: 27), while online research shows a number of similar cases across the continents[4]. The ethnographic study of Ackerman (2010) on American citizens undertaking plastic surgery in Costa Rica is also insightful. Ackerman suggests that plastic surgeons, attracted by high financial rewards and increased work autonomy in the private sector, flee out the public system (2010: 403). More importantly for this research, it is noted that before large investors and states pay attention to cosmetic surgery 'tourism', Costa Rican surgeons had started accepting N. Americans for plastic surgery in collaboration with hotel owners (Ackerman, 2010: 406). The above cases illustrate examples of medics who take an entrepreneurial

[4] The Philippinese company PMTI (http://www.philmedtourism.com) focusing on medical tourism offers complete medical travel programmes. Medical doctors and/or members of their families are partners of the company (last retrieved 7/7/2011). Two out of five members of the directors' committee of the German Med2Heal are medical doctors and three out of four of the New Zealand's MEDTRAL (http://www.medtral.com) directors are MDs (last retrieved 7/7/2011). Further, the president and CEO of the French facilitator 'My Treatment Abroad' (http://www.mymedicaltreatmentabroad.com/) is an MD himself (last retrieved 7/7/2011). CEO of the UK based medical travel portal The Medical Tourist Company (http://themedicaltouristcompany.com) is a medical doctor as well (last retrieved 7/7/2011).

approach and try to seize the perceived business opportunities of patients seeking health care far from home. As such, it draws attention to the key role of medical doctors in the establishment of channels facilitating patient flows.

MDs' Publicised Scepticism over the practice

Despite the positive attitude of several Costa Rican surgeons, not all their peers embrace the practice. Some voice a critique over colleagues leaving the public sector to service foreigners for higher rewards and speak of the negative impact of patient inflows on the ethos of medics and the national provision of health care (Ackerman, 2010: 407). In India, Maheshwari *et al.* (2012), who work as medical doctors in a cardiac care unit, perceive inbound patient flows as a sign of failure of developing countries to offer treatment to their people. In response, the authors suggest, the state in origin countries should take action to meet local needs and interrupt outbound patient flows. Scepticism towards the phenomenon is also expressed by medical doctors in 'origin' countries, based on medical, economic, and moral grounds. Negative sentiments over the practice have become obvious in a number of publications authored by medical doctors, in medical and academic journals. The most commonly cited reason refers to increased health risks, and malpractice cases, and is often supported by the authors' own experience with patient complications after treatment abroad. For example, in the UK 37% of 203 certified plastic surgeons who responded to a survey in 2007, had seen patients with post-operative complications after surgery overseas. In light of these findings Jeevan and Armstrong (2008) publicise their concerns over British patients travelling

abroad. Similarly, an academic paper published by Canadian MDs urges for the health care risks involved in treatment abroad.

> 'We present a series of patients who have experienced complications because of medical tourism for bariatric surgery and required urgent surgical management at a tertiary care centre within Canada [...], we propose that a medical tourism approach to the surgical management of obesity—a chronic disease—is inappropriate and raises clear ethical and moral issues' (Birch *et al.*, 2010).

Barrowman *et al.* (2010) position themselves against 'dental tourism' outbound flows from Australia. They examine after treatment complication cases at the Royal Melbourne Hospital and Royal Dental Hospital of Melbourne and argue that in the case of malpractice no accountability can be held for medical practitioners in foreign jurisdictions. The premium in price paid domestically reflects, then, at least partially, the opportunity for continuity in care; the regulation in practitioners' training standards; the quality of the materials used and the hygiene rules followed (Barrowman *et al.*, 2010). In other papers, MDs call readers to consider the financial burden on the (British) National Health care System caused by malpractice cases overseas which require emergency care upon return home (Jeevan and Armstrong, 2008). Emergency treatments also affect waiting lists and delay care for other urgent cases; as such, state resources are misallocated (Jeevan and Armstrong, 2008). Malpractice cases may turn out as a substantial financial burden for patients themselves, when they seek care from local private providers; the cost of care back home may be significant (Miyagi *et al.*, 2011), out-setting the initial savings of the

travel (Freire, 2012). Parallel to this, health risks may also arise for larger populations as hospital-generated diseases are more possible to be transmitted across countries (Freire, 2012). In other instances warnings directly target the public and may contain a tone of panic, as in the case of a Dental Care Provider in UK.

> 'With diseases like HIV and increasing rates now of Hepatitis A,B,C,F & G abroad, as well as the further East you go the more resistant infections are to any medical treatments back here in the UK (eg: TB, Bird Flu, Conjunctivitis), such risks can infect family members and others too!' Smile Specialist.[5]

Other medical doctors explore ethical dimensions and try to advise peers on the 'right' attitude towards patients who travel abroad for treatment (Jones and McCullough, 2007). Jones and McCullough (2007) suggest that denying help to a patient with complications after treatment abroad may be unethical and at the same time unprofessional.

Papers authored by MDs and referring to medical malpractice cases overseas and complications upon return are numerous and originate from a number of countries such as UK, Canada, the US, Australia, and Germany (Borrowman *et al.,* 2010; Birch *et al.,* 2010; Cheung and Wilson, 2007; Foss, 2012; Garud, 2005; Green 2008; Jeevan & Armstrong, 2008; Jones & McCullough, 2007; McKelvey *et al.,* 2009; Miyagi *et al.,* 2011; Pimlott, 2012; Terzi *et al.,* 2008; Caulfield & Zarzeczny, 2012; Mattoras, 2005; Wachter, 2006). These papers are most often published in medical journals but in light of increased risks, collective agency has also been

[5] (http://www.smilespecialist.co.uk/dental-dangers-abroad-cheap-dentistry-tourism-warnings-safeguards.html, last retrieved on 03/11/2012).

initiated. For example, ISAPS (after the initiative of the president at the time) made available guidelines for patients who consider travelling abroad on ISAPS' website in 2006 (Foss, 2012) and other medical associations have followed. In Northern America, the Canadian medical community of fertility and andrology has initiated data collection on foreign patient admissions from all clinics, with the aim to restrain patient movement for fertility treatment (Inhorn and Patrizio, 2009: 905). Other initiatives may be also taken elsewhere, but as knowledge at this point remains limited further investigation is considered essential to shed more light on the role and initiatives on MDs at an individual and collective level.

International Patient Movement: Opportunity or Threat?

What becomes clear is that the positioning of medical doctors may play a role in their perspective over the phenomenon. Ideally, one would expect that MDs advise according to the best interest of patients. Nevertheless, it appears that personal interest may be an influential factor too. This section has illustrated how Costa Rican plastic surgeons' perspective and agency (Ackerman, 2010), for instance, comes in sharp contrast to that of the Canadian bariatric surgery medical team (Birch *et al.*, 2010) or even to their peers within the country who remain critical of international patient movement. Evidence is limited but indicates potential conflict across borders and interests. The stance that national and international medical associations (will) hold will be decisive. International plastic surgery associations (British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), the International Society of Aesthetic Plastic Surgery (ISAPS), and the American Society of Aesthetic Plastic

Surgeons (ASAPS)), for example, though not always categorically opposed to the practice, have moved fast to prepare guidelines and advice for patients (Miyagi *et al.*, 2011). ISAPS, however, opposes the practice;

> 'As a Chair of the MPA subcommittee I (JF) can emphasize that ISAPS does not, and will not, endorse medical tourism. ISAPS accepts that patients will travel overseas for surgery and surgeons will travel to other countries to perform surgery for financial gain, albeit with great reluctance and sadness' (Niechajev and Frame, 2012: 205).

Further research is essential to give a better picture of medical professionals' stance, given that current evidence, as has been presented in this section, leans towards predicting contradictions and discontinuities among MDs. MDs employ either the rhetoric of medical concern about quality and safety or even equity in resource allocation, or maintain a business approach related to private profit. Even though the first attitude is anticipated, the latter, if not surprising, merits closer examination. It is expected from medical professionals to warn of health risks since it is their role to do so, nevertheless, an entrepreneurial approach raises questions about motives, narratives, and activities. We are not used to seeing our medical doctor act and think as business people, therefore, the evidence on internationalisation of health care reveals the need to explore their behaviour and rationale. It is this gap that the current thesis will seek to fill, through empirical research on medical professionals actively seeking to expand their foreign clientele in Greece. The thesis draws on the sociology of the professions to understand the

role and position of medical doctors within society, and it is through this framework that an analysis of their experience and activity takes place. The next chapter presents the literature on professions and synthesises a conceptual framework in order to understand behaviour and initiatives within an internationalised and highly commercialised context. Within that framework, medical doctors are not perceived as passive receivers of an externally imposed order but are depicted as active agents within a dynamic environment which they are in a position to co-shape alongside other institutional forces.

Internationalisation, Commercialisation and Health Equity

The practice of cross-border care constitutes a rare case of marketised health care provision, which in the backdrop of current debates on introducing competition in health care, makes it an especially intriguing case for examination. Despite its relatively small size, the sub-market epitomises the advent of market rules in health care with advertising; brokers' involvement; consumerist behaviours; entrepreneurship and competition among providers dominating, in a setting characterised by lack of regulation. Relevant empirical work reveals significant shortcomings arising from the internationalisation of health care. For one thing, the supply side maintains a biased stance often supported by the mass media. As such, medical providers and intermediary companies downplay risks misinforming their audience; while governments, supporting the growth of the sector in their country, often maintain a monolithic stance towards the development; trade and economic benefits are overemphasised at the expense of issues such as equity and equality.

For the individual, the patient, travelling abroad for health care involves a challenging endeavour both rationally and emotionally as it involves an international trip, provider and physician choice, considerable economic concerns, days off work, and family life disruptions. The difficulty is escalated as, on the one hand, there is information asymmetry, and, on the other, neither national bodies nor international ones (that often promote the practice as a form of trade) have taken action to regulate the new market. It is difficult to see how in that context patients can be depicted as 'savvy' and 'empowered'.

One could argue that lack of regulation is one thing and the commercialisation of health care another; nevertheless, here they appear intertwined. Commercialisation poses serious concerns related to the vices of profiteering introduced to health care provision as an incentive for human activity. State (or international) regulation is then deemed necessary so as to restrain these vices. But commercialisation has its virtues too, as its proponents would argue, and it is these virtues that give reason (or at least justification) to states and transnational regulatory bodies to universally promote the ruling of the market. Privatisation gives more choice to patients; trade advances diffusion of knowledge and technology across countries; it increases wealth of all involved parts; while private providers compete to satisfy consumer preferences (Mohan, 1988). In other words, competition creates alliance between providers and consumers. This conceptualisation of competition as a means to create strong social ties between the seller and the consumer is not new. It goes at least back to George Simmel (Hirschman, 1982: 1472) and can be related to the

older *doux-commerce* thesis which stresses the positive effects of market dominance over society (Hirschman, 1982).

Critics of the commercialisation of health care, however, have strong objections. Lethbridge (1995: 212) suggests that neo-liberal policies encouraging privatisation, commercialisation and trade (by 'setting up the markets' and introducing quasi-markets), are in conflict with welfare-led developmental goals which are preoccupied with 'social protection for the population'. In fact, calls for cost reduction in Australia have in some cases led to a premature exit of patients from the hospital and shift of responsibility for patient care to community (Germov, 1995: 62). Cost reduction is also responsible for the abandonment of specific areas of care, together with detrimental effects on disadvantaged groups (Germov,1995: 62). In South East Asian countries two-tier systems caused by commercialisation and marketisation of health provision weaken the principle of universality and increase inequality (Baru, 2003: 4437). In light of this, Collyer and White (1997) object to the very core of neo-liberal argumentation; they reject the idea that competition is introduced with market principles. Competition, amongst MDs existed previously and hospitals [in Australia], the scholars argue, but it was centred on qualitative criteria instead of financial. Similarly, the state's support on equity was a normative decision; it is only recently that states begin to recede away from equity as a principle. By prioritising economic goals states promote efficiency as a value superior to equity (Yeatman,1990 cited in Collyer and White, 1997); emphasis on an economic rationale entails thus a political viewpoint, an ideology, which emphasises the 'means' and downplays the 'ends' of

health care provision. Neo-liberalism after all is an ideology (Germov, 1995; Zizek, 2009), taking flesh and bones under the auspices of powerful voices.

Health policy, however, is complicated even when it prioritises equity; commercial practices cannot be avoided since health care suppliers are large commercial enterprises; pharmaceuticals and medical equipment producers are multi-million dollar businesses with international presence and, therefore, considerable economic but also political influence. These industries have exerted pressure through international regulatory bodies on national policies to increase commercialisation. Specifically, Baru (2003: 4433) suggests that supra-national regulatory bodies such as the WHO (World Health Organisation), the WTO and the World Bank have promoted market rules in national health care provision, under the guidance of the pharmaceutical and medical technology industry. Similarly, Pollock and Price (2000) claim that the WTO force governments to reduce trade-restrictive measures in the sphere of public services, and health care in particular. Lethbridge (1995: 212) gives the example of information and communication technology (ICT); she suggests that encouragement of ICT investments prepare the ground for privatisation in health care and function as a necessary intermediate step to 'convert healthcare into a commodity that can be bought and sold.' While managerialism and competition are introduced as a solution to a problem presumably generated by demographic pressures of an ageing population, Collyer and White (1997) argue that commercialisation of public utilities is partly caused by increased global competition which slowed down profitability of the industrial sectors; services now appeal as lucrative sectors promising increasing returns.

> ‘The private sector conducts state business only where a profit can be made, and it conducts that business without burdening itself with the wider social responsibilities of the state’ (Collyer and White, 1997: 359).

Lethbridge (2005: 222) adds that private providers have an interest in taking over parts of public provision, due to increased stability provided by states as clients; in contrast, private insurance schemes are subject to market fluctuations and uncertainty.

The warnings of critical voices over commercialisation of health care find support in the publicised research findings on patients, states, agents, and medical providers within the context of transnational health care, as practiced so far. Within a commercialised environment actors’ roles are changing; and incentives and practices too. The motive of profit generation brings in advertising, consumerism, and entrepreneurship and replaces the motive of health equity which was promoted by restricting marketing, competition, and private provision. In light of a deterioration of health equity connected to commercialisation, the concern of Karl Polanyi (1944) over the extent to which the market rule may serve our society appears most relevant. And as marketisation advances in more and more spheres of human activity, his concern, nearly 70 years after it was first expressed, continues to be of relevance.

The current thesis will take up the challenge to examine where medical doctors treating foreign patients fit in these developments. The following chapter presents the conceptual framework which draws on the politics of health care and places

medical professionals at the centre of discussion. The theory on professions depicts medics as ‘the lords of the dance’ (Scott, 2008), namely, as active agents in a position to shape the institutions within health care. Through both a macro and micro approach the literature offers examples of professional collective agency but also individual or small group initiatives, in response to contextual changes. In this particular piece of work the framework will shed light on the entrepreneurial initiatives of medics. The framework depicts entrepreneurship as a nuance in medical agency, inevitably linked to increased commercialisation inherent in trade in health services, and will seek to understand the place is has within professionalism and the medical ethos.

CHAPTER 4

THE SOCIOLOGY OF THE PROFESSIONS

The Sociology of Professions comprises a distinct body of literature within Work and Occupations. As a branch of sociology it closely examines the way specific occupations have organized themselves and acquired a distinct position within Western industrialised societies. It is of increased importance here since it serves as a conceptual framework for the current study. As such, this chapter presents basic concepts in the literature including professions, professionalism, and professionalisation. In addition, contingencies and circumstances which support the establishment of professionalism but also various processes contributing both to continuation and change in professionalism are explicated.

The chapter is divided in two parts. The first one presents briefly the history of the theory of professions and outlines the role that elements such as knowledge, support by the state, education, credentialisation, licencing, and the code of professional ethics have historically played in support of professional power. It provides a rather static depiction of professions and stresses that these elements have played a crucial role in creating a market shelter for professions that allows a distinct position within society and the division of labour, alongside power, autonomy, and respectability for its members. The second part of the chapter

revisits this static depiction of professions. It draws on most recent contributions to the literature, which came as a necessary next step in the evolution of the theory, in order to examine the implications of contemporary economic and societal change on professionalism after the 1980s (e.g. neo-liberalism and corporatisation). Change in these accounts is often framed as external to professionals and envisaged as triggering various forms of professional agency. In light of this, strategies and tactics deployed by professionals at a micro and macro level are explored by numerous empirical studies. Research findings contribute to an understanding of professionalism as both changing and maintaining elements with regards to work organisation and society privileges. Most importantly, however, recent contributions emphasise the agentic capacity of professionals which play a double role in co-shaping -instead of simply responding to- societal change (e.g. by developing a new market) and in transforming the substance and essence of professionalism itself (e.g. by achieving/legitimising power based on expertise and entrepreneurship instead of disinterestedness). In other words, change is now understood as occurring in multiple levels and directions.

The current research benefits from such an analytical approach to professionalism. It offers a rich framework, first, for the conceptualisation of international patient movement from the position of medical professionals; second, the analysis of the response of medics to its emergence; and, last but not least, for a deeper understanding of the implications on professionalism. Concepts and processes that prove most useful in the analysis include professional power and dominance, professional ethics, collegiality and intra-professional competition,

commercialism, professional entrepreneurship, dynamic change, continuity in change, and adaptability. A rich framework is thus developed prior to empirical work to facilitate the analysis of collected data and allow a deeper understanding of real life processes which may in turn inform the literature with novel theoretical insights.

Part I: Dominance Paradigm

General Introduction and a Short History of the Literature on the Sociology of the Professions

The study of expert power and professions has been based primarily on the Anglo-American case (Henriksson, 2006), and the European (Continental and Nordic) to a lesser extent. In fact, the Anglo-American academic interest in professions preceded, and as such, influenced the theorising of professions elsewhere significantly. Theoretically, the sociology of the professions traces its roots in the traits' approach, where American scholars (i.e. Carr-Saunders and Wilson, 1933; Goode, 1957; Marshall, 1939) anchor their analysis on attributes such as knowledge and expertise, altruism, collegiality, a code of ethics and rationality, to depict professionalism (Saks, 2012). The sociology of professions is initially developed within a structural functionalist framework (MacDonald, 1995). Functionalists focus on a number of professional characteristics but also advance a 'structural relation between professions and society' (Saks, 2012). Their analysis maintains a rather positive approach and is inspired by the work of sociologists such as Durkheim or even Tawney (MacDonald, 1995: 2). Functional understandings of society are increasingly rejected by sociologists after the 1950s, and the

functionalist approach on professions follows the same fate (Burrage *et al.*, 1990). In addition, critics argue that these accounts were inspired by professionals' self-representations and as a result largely reproduce their ideology (Burrage *et al.*, 1990). Interactionists have contributed significantly to the theory of the professions, in the eve of the functionalist approach. Their work is substantially influenced by an ethnographic background (Dingwall, 1983) and examines the work of occupational groups and professions without making a clear distinction between the two. Prominent scholars of this approach are Hughes and his followers. Even though interactionists are criticised for not stressing the disguised self-interestedness of professionals (Crompton, 1990), they contribute to an understanding of professionals as autonomous actors and advance the study of their agency within the workplace (Stevens *et al.*, 2000).

At this point, change in the study of the professions (at least in the Anglo-American context) comes at two levels. First, the movement to a pluralist view on sociology shifted the central question from 'what part do the professions play in the established order of society' to 'how do such occupations manage to persuade society to grant them a privileged position' (MacDonald, 1995: xii). According to Gleeson and Knights (2006),

> 'Traditional assumptions about the municipal professional as a trusted civic authority have come into question. The recent growth of interest in the professional as a knowledge worker, a team player and facilitator of effective social and organizational relations, rather than as an administrator or guardian of

public values, mirrors a paradigm shift from professionalism (structure) to professionality (agency)' (Gleeson and Knights, 2006: 279).

Second, the political aspect is emphasised. The notion that professions serve society is replaced by a critical examination of professional efforts to fortify their position within the market, society and division of labour (Freidson, 1984: 3). In the name of public interest professionals advance their own. These Neo-Weberian approaches maintain a critical stance towards professions, and have been largely influential in late 1960s, '70s and early '80s. For example, 'professional project' is a highly influential term coined by Larson (1977) to refer to a constant effort of the members of a profession to maintain economic and social rewards, often irrespective of the outcomes for the whole of society. The *dominance* or *conflict* paradigm comprises the source of the basic theoretical pillars of the theory of professions. It is important to note that it draws on a particular historic period, the zenith of professionalism. According to Freidson (1985) and Starr (1982) the sociology of the professions (Anglo-American literature) implicitly employs as a benchmark to analyse the changes in the professions the period that starts in the early twentieth century and coincides with the peak of professional power in the mid twentieth century. This paradigm alongside its basic assumptions, which will now be described, commonly serves as the reference point of analysis.

Professional Power

Considering the role and place of the professions within society, it can be argued that status and power is a distinctive feature of professional groups. Fusing myth

with reality and societal values of another era with public policy decisions, some occupational groups obtained, through a complex historical process, a special position within society. Occasionally favoured by historical circumstances and, occasionally, by an explicit and successful attempt to manipulate public policy, these occupational groups experienced the realization of a 'professional project', which started with industrialization, urbanization and the emergence of a strong middle class (Larson, 1977: 6-7). Abbott (1988), Freidson (1994), and Johnson (1993) recognise the liberal professions as the first and foremost occupational groups in organising and institutionalising their expertise and services within capitalist societies (Reed, 1996: 583). Professional groups have enjoyed, to a larger or smaller extent, social and economic benefits, improved working conditions and freedom of choice. All these benefits, acquired through specific circumstances and actions, distinguish a profession from other occupational groups.

Marx's analysis of the non-alienable character of the professional product can prove insightful in understanding the powerful position of professions. According to Marx's analysis, the product of professionals differentiates itself from typical modes of production in the capitalist system as it tends to be consumed immediately after production (Larson, 1977: 213). The product is exchanged directly with revenue, the free professional keeps the whole of the payment and as such no surplus is extracted (Larson, 1977: 214). Under these conditions, liberal professional labour has remained outside the process of capitalist production and accumulation, or at least it did not participate directly (Larson, 1977: 213). The non-alienable nature of the product (Larson, 1977: 14), as a non-exploitable output, is enabled by the fact

that it is 'attached' to the producer. The product cannot be separated by the person who generates it; the members of the profession constitute the product themselves. This association is closely connected to the way that the service is delivered, based on the personal relationship between the provider and the producer (doctor-patient, lawyer-client) (Larson, 1977: 236). Each case is so special that the consultation is discretionary and cannot be replaced by mass production, as is the case for most other goods and services.

Interpersonal Relation between the Doctor and the Patient

Beyond Marxist considerations and the organisation of production, professions have been portrayed as having special social value due to the object of their work, knowledge and skills (Freidson, 1984: 2). The fact that professions anachronistically provide highly individualised services (Dingwall, 1983; Freidson, 2006 (1970)) and preoccupy themselves with personal/individual problems, sets them in a position of control over interpersonal situations (Larson, 1977: 236). Dingwall (1983) makes a special mention to the fact that professions deal with our health (medics), our social standing (lawyers), even with our souls (clerics). In medicine for example, the patient, being in a vulnerable situation and worrisome about her life, makes an ‘emotional investment’ in her doctor, a fact which provides the latter with increased power (Larson, 1977: 23). Putting aside the emotional effect, the patient accepts the physician as an expert and agrees to trust her. In other words, the superior knowledge of medical doctors is recognised and respected. The relationship between professional and client is unavoidably an unequal and undemocratic one

due to this knowledge asymmetry, as Parsons explains in his discussion of the 'professional complex' (Parsons, 1969). Trust in professional knowledge and competence is an important aspect of the relationship and a basic pillar of professional power. Nevertheless, amidst broader societal changes largely attributed to economic instability, trust is constantly open to dispute. This also holds at an aggregate level. While Larson argues (1977: 23) that consumers have shown no ability historically to organize themselves and counter balance the relative power of the professionals, such as physicians, during the last thirty years, patient movements have openly disputed medical power and knowledge and have mounted fierce critics of the abuse of professional power.

Autonomy

Autonomy is linked to many aspects of professionalism and accounts for professions' special position to a significant extent. It is granted to professionals based on the special knowledge they are exclusively assumed to possess and whose product, therefore, non-members are not qualified to evaluate. The application of this knowledge at work is assumed to require constant judgment and discretion which eliminates the possibility of routinisation. Some scholars attrıbute to professional knowledge a special weight as it relates to transcendent values like justice, spiritual and physical health, or the growth of reason' (Hamilton, 2008: 102). Autonomy is therefore ideologically justified by knowledge applied in discretion and assumed to be used not for self-interest but for patients/community's good (Netting and Williams, 1996). Practically, states depend on professions to organise and deliver public goods to the country. This has been the case in many western

societies a cause of professional autonomy; as Harrison explains (1999: 51) professions enjoy autonomy both in a macro as well as in a micro level.

Micro-Level

Freidson notes (1993: 55; 2001) that control over work by professionals instead of consumers or bureaucracy is the key distinguishing feature of professions. According to the scholar, even in the most 'adverse' external conditions, control over content of work secures a privileged position for professionals. Micro level autonomy refers to the right of professions to control the output of production at a given time and additionally the standards and quality of their services (Larson, 1977: 235). Moreover, it refers to the right to define their fees and own conditions of labour (Flynn, 1999:22). For example, physicians define disease, diagnose illness, and decide on the type of treatment and medication for the patient. Their 'ability' to do so is exclusive and the application of knowledge situation-specific; in light of this, professionals resist routinisation of their daily work (Doolin, 2002: 374). Furthermore, non-members are excluded from evaluation over the quality of professional work, since only a colleague is perceived knowledgeable enough to express opinion about the solution offered to a client. This functions as a protection mechanism for the members of a profession. For example, 'conspiracy of silence' is a term used to describe the observed unwillingness of medical practitioners to testify one against the other in court (Freidson, 1985: 25). While in the US the practice has largely ceased after the 1960s (Freidson, 1985), protection of colleagues has been a special aspect of medical autonomy across countries. Therefore, the perceived

inability of others to judge medical work and the subsequent self-regulation plays an instrumental role in claiming and maintaining autonomy over the content of daily work (Hamilton, 2008: 102).

Furthermore, very often professionals define the behaviour they will adopt towards clients and members of other occupations in the division of labour. Murphy (1984: 548) refers to subordination of other groups that are defined as inferior and ineligible as 'exclusionary closure'; literally a form of power imposition. In professions more specifically, quite a few examples may be given to illustrate subjugation of other occupational groups. Medical doctors, for instance, pass on tasks perceived as 'dirty' to nurses (Freidson, 1988). Simultaneously, it is interesting how nurses often show a form of deference towards doctors, and accept the power that they exercise over them (Porter, 1993). Alongside self-regulation, autonomy at a macro-level relates to authority over health policy, education and market power allowed by the state.

Macro-Level

Schlesinger (2002) refers to the influence over health policy by medical doctors as 'authority'. It involves participation in public resources' allocation (Schlesinger, 2002: 191-2) and allows control of the context within which professions work (Wilsford, 1993: 128). Given 'a monopoly over its skills', a profession is often 'consulted by the containing community' (Goode, 1957: 195). Relations with the state are crucial as willingness of the state to accept professional intervention is a prerequisite for an ability to shape collective decisions. In the Anglo-American

context, this has largely been the case. In fact, a distinctive feature of the professional project has been the long term relations with the state. In the words of Johnson (1982)

> 'the professions are emergent as an aspect of the state formation and state formation is a major condition of professional autonomy' (Johnson, 1982: 189; emphasis in original is omitted).

The interrelation between the state and the professions has been, however, 'messy' (MacDonald, 1995: 100). Professions have been used by the state to realize its intended policies and specific functions. Good examples are the accountants or the way that medics and lawyers (among others) have been used by the military, especially during wars (MacDonald, 1995: 114). Professions have been part of the welfare state and the administration of citizen rights (Bertilsson, 1994) while mutual benefit has been the cornerstone of the long term collaboration. As noted above, when the time came for the state to establish a universal healthcare system, both in the US and UK, public health was entrusted in the hands of the practitioners that appeared (or were) most convincing as far as their ability to take on such responsibility was concerned (Larson, 1977: 23). As a result, and in return, some occupational groups gained access to a 'guaranteed 'clientele' (Johnson, 1972: 78). In UK, for example, even the period prior to the National Health care System (NHS) formation in 1939 was characterised by increasing collaboration between medics and the state; on the one hand the state aimed at improving public health and reducing inequality and on the other hand, medical professionals joined the

expanding network of publicly supported hospitals to encounter their overpopulation (Larkin, 1993: 85).

At the same time, this access excluded other health occupations and created a 'market shelter'. It is interesting to note here that the monopoly of professions, even though related to mercantilism, was, nevertheless, realized at a period that the ideology of liberalism was prominent (MacDonald, 1985: 543). That can be justified by the growth of the state and its function in modern societies (MacDonald, 1995: 69) which had been for a long time in support of the professions. The result has been the achievement of social closure for a number of professional groups.

Furthermore, social closure plays a prominent role in the process of monopolizing a market. According to a neo-Weberian definition,

> 'closure refers to the process of mobilizing power in order to enhance or defend a group's share of rewards or resources" (Murphy, 1984: 548).

Occupational closure is a type of social closure which results in the creation of (legal) limits with the purpose of benefiting the group within at the expense of customers and excluded practitioners (Weeden, 2002). Exclusion is seen as a means to achieve monopoly in expertise and service, as well as a way to assure social and economic benefits (Evetts, 2003: 404). Goode (1957: 195) also notes that social closure has allowed relatively high incomes for professionals in comparison to other occupations. In addition, registration and licensing recognized by the state legalise exclusive rights and support social closure; these benefits have unsurprisingly inspired many occupational groups to make similar claims.

‘to attain the top of the scale by securing the passing of Act which registers the membership and specifies that the occupation’s services may only be provided to the public by persons on the register: in short, a legal monopoly’ (MacDonald, 1985: 543).

Abbott (1988) examines closure and exclusion from a different angle, focusing on the struggle among professions to define the tasks for which they are responsible in society and thus, the struggle to define their ‘jurisdiction’ (Abbott, 1988). The author gives examples of tasks that passed from the jurisdiction of one profession to the other, e.g. response to some forms of deviant behaviour have passed from law to the jurisdiction of medicine. Hence, except for a relation with institutions such as the state, Abbott (1988) stresses the competition among professions as a different way to look at how they have developed and organised.

Education, Credentialisation and Licencing

Of great importance for the self-regulation of a professional group is the control over their training, education and socialization, as mentioned above. In most advanced economies, at least until recently, the state finances education. Professions have, therefore, secured sponsorship when at the same time they have maintained control over the educational institutions. For example, medical doctors arrange recruitment and train practitioners without interference of the state or another occupation. In the US, the state's role has been crucial in sponsoring the monopolistic educational system (Larson, 1977: 18) and in trusting healthcare to the medical doctors. In addition, the firm relation between the medical association and

the medical schools has contributed towards a successful coordination between "the production and the transaction of services for a market" (Larson, 1977: 74 & 133). MacDonald (1995: 163), drawing on Weber, suggests that professional expertise needs to be certified and credentialized so that professionals distinguish themselves from other practitioners within the same but also other occupations. Alongside occupational exclusion, professions have achieved state recognition of credentialisation, which is also organised from within. Through the complete control over education, for example medical doctors manipulate the socialization process of the new practitioners. In effect,

> 'medical schools, like other professional schools, are supposed to have a profound socializing function. They are supposed to provide the student with the attitudes he needs to play the professional role properly and well… doctors are not wholly born but are in some way made by medical school' (Freidson, 2006: 16-17).

For example, Becker's *et al.* (1962) ethnographic work illustrates how medical students' attitudes are shaped through their studies. Students change their attitudes through semesters to comply with the line of the faculty in an effort to successfully fulfil the requirements of the highly demanding courses. The socialisation process has the potential to shape collegiality, identity and collective unity of professionals.

State & Country Variation

It is questionable how much professional power is delegated by the state (Larkin, 1993: 82). It is not accidental that interventions of the state account to a large extent

for the variation in professional power across countries and time. Freidson (1993: 59) notes that in countries with a highly interventionist state (i.e. the Bolshevik state in the Soviet Union or the Nazi regime in Germany) professions tend to have little power over their work content, selection of members and relations with clients. For example, in France the state has been planning health care policy independently from the medical profession, while the latter appears fragmented and disengaged from political action (Wilsford, 1993: 124). Krause (1996: 139) notes that increased numbers of graduates, relatively low wages and salaried work for the majority imposed steadily by the (strong) French state, suggest limited professional power by the end of the 1980s. Support of the state is therefore crucial, however, not the only influencing factor in power formation. According to Evetts (2003: 398) professional power in France, to use the same example, is evident but expressed in different terms. It is gained through bureaucracy and public sector organizations instead of collaboration with the state.

Knowledge

Professions are 'knowledge-based occupations' so, as with training, knowledge is of special importance to their function and status (MacDonald, 1995). As 'experts' they master and apply knowledge in a field which is perceived as 'scientific', i.e. incorporating complicated and extensive knowledge, systematically organised. The role of academic institutions is notable here as it includes the production of *academic* knowledge. Freidson suggests that the development of relationships with the university distinguishes professions from guilds and crafts (1994: 16). Academic

knowledge has a profound impact on the professional project and society as it 'accomplishes three tasks – legitimation, research, and instruction (Abbott, 1988: 56). Abstract knowledge is important for its capacity to invent and generate new diagnoses and treatments (Abbott, 1988: 55). As such, invention reinforces the scientific character of the professions and supports them in redefining or expanding their jurisdiction. In addition, (abstract) knowledge helps professionals maintain an air of mystery in dealing with problems which is used as a political tool providing for legitimacy and power.

Numerous scholars writing on professional power take a critical stance towards the way professional groups promote their knowledge in society. According to Bolton *et al.* (2008: 283), professional groups seek 'collective mobility' and 'social advancement' based on the technical and cultural resources they possess. It is suggested that the medical profession has deliberately sought to maintain its knowledge as controllable, indeterminable, storable (Reed, 1996: 575) and scarce so that it cannot be stolen or imitated (Larson, 1977). Professionals attempt to situate their knowledge between abstraction and extreme concreteness, so as to maintain the discretionary character of their intervention and at the same time differentiate themselves from mere craftsmen (Abbott, 1988: 102). Flynn suggests that they

> 'assert the authority of expertise and claim disinterested integrity. Their ability to sustain these claims rests on the indeterminacy of the knowledge and skills that

they posses, and the necessarily discretionary content of their work' (Flynn, 1999: 34).

This maintenance of knowledge and skill as esoteric has contributed to the image of prestige that surrounds medical doctors in the eyes of the public. Institutionalised training, official credentials and a formalised body of knowledge became distinguishing features of the professions (Bolton *et al.*, 2011).

'uncontroversial statements such as 'you wouldn't want Joe Bloggs performing brain surgery' [are] testament to the widely accepted legitimacy of professions, their functions and rewards' (Bolton *et al.*, 2011: 687).

The social status and the financial rewards are, thus, legitimized in the eyes of the people due to the 'intellectual superiority' that is assumed for the medical professionals (Larson, 1977: 225). In addition to expertise, Abbott explains that 'culturally, professions legitimate their control by attaching their expertise to values with general cultural legitimacy, increasing the values of rationality, efficiency, and science' (Abbott, 1988: 16).

Flynn (1999: 25) adds that trust that the public and the state show to professionals functions as a mode of control, while, trust is typically shown to those who behave and appear according to the 'socially accepted standards of repute and respectability' (MacDonald, 1995: 31). For example, practitioners gain social status through their collectivity and symbolism; impressive buildings and architecture at expensive sites (MacDonald, 1989: 57) aim specifically at signalling status.

Therefore, the obscure character of knowledge, credentials, and cultivated respectability, function as means of legitimation of professions' power.

Value Judgments and Moral responsibility

Based on expert knowledge, professionals are called to mitigate uncertainty experienced by their clients and offer services on issues of high risk (Evetts, 2003). 'Mystification' based on non-cognitive originated uncertainty assists practitioners maintain a social distance (Johnson, 1972: 42-43). Except for its scientific side, this moral aspect of the service of professions deters rationalization of their knowledge by the public (Halliday, 1980). Medical doctors, for example, maintain authority over lay people given their charisma to fight disease (Horobin, 1983: 93). Mystification is reinforced by an undisputed higher mission against natural common enemies (or at least it was for long time). It is expected from professionals, however, to use their special knowledge and positioning to serve the public interest, to fight the disease or injustice. According to Horobin (1983: 103) this is 'built in to the 'contract' between profession and public'. Larson expresses a similar view. She discusses that professional services include pre-capitalistic understandings of work (connected to value in work) and as such professionals often consider they have duties towards people (to protect the public) which justify their benefits within society (status, autonomy). Professional's 'duties' comprise the essence of professional ethics and are related to disinterestedness and a service orientation.

Professional Ethics

The professional code of ethics and claim of disinterestedness remain at the centre of sociological discussions over the role and position of professions within society. The ethic of service has been characterised as the 'soul' (Freidson, 2001: 216), or 'core', of professionalism (Timmermans and Oh, 2010). As noted above, relevant to a professional work ethic is the perception that high rank in society (through the profession in this case) is accompanied by both duties towards the community and privileges (Larson, 1977: 220). Duties are internalised as professional ethics and are displayed as serving the community (macro-level) and clients (micro-level).

Various schools of thought perceive the professional claim of disinterestedness in different terms. As it has become obvious from above, professions have been initially praised for their 'traits' and service to society (Saks, 2012), even when appraisal has been accompanied with scepticism (Crompton 1990). Professions have been criticised by neo-Marxists for using the rhetoric of disinterestedness in order to advance their own position within society regarding status, influence and financial rewards (Hafferty and White, 1995). For example, Bolton *et al.* (2008: 285) suggest that the medical profession calls upon arguments of 'ethical standards and public interest' in its attempt to further self-interested goals. It is argued elsewhere that promotion of self-interest and public interest (Saks, 1995) or clients' interest (Horobin, 1983) are not, per se, mutually exclusive. 'Healthy scepticism' (Horobin, 1983: 103) suggests that while mystification along with social closure, licensing and

restricted entry may guarantee a special market position, it cannot in itself dispute dedication of the professional to her client. A dualism is thus created between the macro level vice which cannot exclude a micro level virtue. A similar view of potential absence of conflict between self-interestedness and client service is shared by Saks (1995). Saks (2012) suggests that 'sometimes excessive and unjustifiably critical stance on professional groups' has been maintained. In mainstream economics professions are portrayed as a cause of major structural inefficiencies in the markets, which increase costs and reduce availability for consumers (Feldstein, 1983: 393). Nevertheless, professionalism has been recognised as a preferred way for organising specific functions of society, such as health care. Freidson (2001) suggests professionalism, based on morality and collegiality, as a superior logic over the logic of the market and bureaucracy. In a positive tone, Durkheim attributes importance to the functions that professions should perform for society and the contrast 'between professional solidarity and anomie' (Burrage, 1990: 2). Many economists also consider the market mechanism unsuitable to regulate health care provision (Paul Krugman; Joseph Stiglitz, (INET, 2012); Arrow, 1963).

It is important to consider at this point the significance of ethics. Irrespective of the debate on the nature of disinterestedness (is it real or merely professed?), it is generally accepted that the inability of professions to convince others of their altruistic incentives would weaken their (dominant) position. Professional dominance is based on autonomy, whereas autonomy is granted to professionals on the premise they are servicing community (Wolinsky, 1988: 44). Alongside expert

knowledge, disinterestedness becomes, thus, a means to elevate political power, and MDs attempt to demonstrate that what is in their interest is in the interest of society as a whole (Light, 1995: 27). Once other social partners become unconvinced of professional altruism, political power is rendered illegitimate and, therefore, open to dispute.

Professional Identity & Collegiality

Freidson suggests that professions cannot be conceptualised without the professional identity of their members (Freidson, 1994). Knowledge, expectations and commitments shape a strong sense of self (Halford and Leonard, 1999) and the sense of status contributes to identifying themselves with their occupation especially since they enter the profession by choice (Larson, 1977: 227). Knowledge and credentials linked to self-perceptions of status is not the only dimension of professional identity. There is a social dimension too which relates to norms, values and professional ethics (Hotho, 2008) as has been analysed above. Netting and Willson (1996) suggest that 'a call links the person to a larger community'; while professions have a call to use their expertise to serve society and at the same time act at the best interest of their clients. Even though the sociology of the professions suggests that an implicitly assumed disinterestedness required for servicing community is often a façade, professionals tend to behave as if it is enacted, and therefore, identify themselves with such a mission. Still, in contrast to capitalism where work is seen only as a means to reach a goal, satisfaction derived from professional work on a daily basis seems to survive and constitute one of the cornerstones of professional identity; professionalism incorporates a sense–making

of work that revives a pre-capitalist attachment of value to work (Larson, 1977: 228). In fact, the object of work in itself bonds the professional to his profession (Larson, 1977: 228). Moreover, 'professional fraternity' is an aspect which fosters the sense of community among professionals (Hotho, 2008). Recognition as an equal and participation in a group alongside shared orientation and common interests increase the feeling of belonging and reinforce identification with the profession. Simultaneously, professional identity functions as a mechanism which differentiates the profession from other groups.

A reflection of the dominance paradigm on the case of the Greek Medical Profession drawing on these concepts is provided just before the data analysis part. In this way the reader is introduced to the position of medics within the Greek health care system in recent years. This background information is deemed necessary to facilitate a better understanding of the contextual environment and prepare the reader for the analysis of the fieldwork findings on medics practicing in Greece.

Professionalism as a Distinct Logic

Freidson is renowned for his contribution to the sociology of the professions over several decades. This short section focuses on his seminal work 'Professionalism: The Third Logic' where a definition and description of an ideal model of professionalism is offered. It is presented here as conceptually akin to the dominance paradigm, the elements of which have been just described. More importantly professionalism as a third logic masterfully elevates these key characteristics of professionalism to an ideal; justifies professional dominance; and

provides an ideological support to its continuation. It is suggested that the ideal model functions as a heuristic device and that its usefulness lies to the opportunity to be compared and contrasted to research findings of empirical work.

Freidson defines professionalism as a distinct mode of work organisation for the production of services and attributes specific properties to clarify the concept. To identify the particular characteristics and circumstances under which occupations are considered as professions Freidson draws on the existing literature. He clarifies and organises these elements and circumstances in five categories. First, it is suggested that professional work is based on abstract and theoretical knowledge and corresponds to problem solving requiring discretion. Second, it is assumed that the occupation itself controls the division of labour in the production of professional services. Third, the occupation also controls the labour market through specific training credentials regulating the entry into the market and the career thereafter. Fourth, training programmes that produce credentials, highly evaluated knowledge, but also new knowledge, typically offered in universities, are again occupationally controlled. Last but not least, devotion to higher values such as disinterestedness instead of self-interest and materialism create an ideology of servicing others and a strong code of ethics to guide practice. These five elements form an ideal type of work organisation and production characteristic of professionalism. As an example of this model, Freidson (2001) offers the American medical profession in the mid-20th century; the scholar suggests that it makes perhaps the closest fit to this ideal type an occupation has ever achieved.

The most important contribution of Freidson is perhaps the emphasis on professionalism as a different logic than bureaucracy and commercialism and one that is worth of support. Freidson recognises the abuse of power and privilege by members of the professions but contends that the provision of knowledge-intensive services is beneficial for all to be provided under occupational control and ethics that emphasise dedication to continuous improvement in the quality of work. Monopoly or social closure may be a necessary prerequisite for this to take place and independence of workers from those who provide them with their living plays out as crucial in high end services. Ideally, moral obligation of the professional is to 'balance the public good against the needs and demands of the immediate clients or employers' (Freidson, 2001: 222).

This is where Freidson's argument becomes weak at least with respect to commercialism. Professionalism is assumed to be attached to a higher mission that emphasises the public interest. Therefore, it is assumed to be attached to the ethics and principles of social justice and the welfare state; the dominant ideology of much of the 20th century in Western societies. Nevertheless, professionalism may be inspired by ethics that emphasise high quality results for clients and leave it up to the markets to rule who the clients will be. By assuming that social justice (not a concern of the market mechanism) is not a basic principle of professionalism, the neat boundaries between commercialism and professionalism start to blur. Maximizing gain (commercialism) does not necessarily take place at the expense of the quality of work (especially when a poor quality result may not convince the client as a high quality one) but it does take place without concern over equality in the

distribution of benefits. According to marketing theory, when a firm positions itself in the market it may compete on the basis of high quality, speed, low cost, innovation or a combination of those. Commitment to highest quality is not incompatible to profit maximisation; in the contrary it may function as a competitive advantage. If the assumption that professionalism serves social justice is dropped, its clear distinction from commercialism erodes.

Another issue that may be worth of discussion with regards to Freidson's ideal model is that change is depicted as an external pressure on professionalism. Since managerialism and commercialism constitute two distinctively different logics their expansion to professional fields of work forms an 'assault' on professionalism. The next part is committed to presenting instances where the ascendance of managerialism and entrepreneurship is taking place at the expense of professionalism, confirming Freidson's assumption. There are also examples of cases showing how professionals struggle for the maintenance of 'old' professionalism. More importantly, however, it offers examples of hybridisation and cases of coexistence of different logics. Empirical work showcases professionals that cross the hypothetical borders and adopt practices and a mindset close to managerialism or entrepreneurship (Hoff, 2003; Kurunmäki, 2004, etc; Kirkpatrick *et al.*, 2009). These findings imply that new understandings of professionalism are deemed necessary in order to advance theorisation that goes beyond specific countries and eras.

Continuity and Change in Professionalism – After the Dominance Paradigm

In the early '80s, amidst large organisational re-arrangements in the English speaking world and Europe, the theory of professions faces something of a dead-end and empirical research is deemed essential so as to move forward (Hall, 1988). The reference point seems to be in need of refreshment. By the end of the 1980s, the literature employs more complex theories to analyse the transient status of professional authority and power (Abbott, 1993: 203). For instance, professionalisation is a concept primarily employed by Abbott (1991) to represent a dynamic and complex social process, which cannot be regarded as 'a simple collective action by a cohesive group' (Abbott, 1991: 380). Instead, Abbott (1991), inspired by Wilensky's (1964) work, suggests a model of historical process of professionalization, highlighting the importance of history and institutions. The examination of professions includes the study of dynamic changes and their impact on professions and the organisation of their work, identity, and position. Abbott calls scholars to conceptualise professions as systems and processes, while Burrage and Torstendahl (1990) to consider the role of other actors' projects in constraining and facilitating the professional one (Muzio *et al.*, 2013). Scholars start exploring professional agency in various work settings, countries, and eras, and focus on how changing contextual circumstances affect professionals. Empirical research offers examples of continuity and change in professionals and therefore, through abstraction and theorisation, continuity and change in professionalism. As such, most recent work contributes to a theorising of professionalism that transcends

geographical and historical boundaries. In addition, the interest of scholars from other fields (e.g. organisational studies or neo-institutional theory) in the theory of professions pushes further towards an enhanced and pluralistic theorisation of professions.

The second part of the chapter presents broad contextual changes as external to professions and examines micro and macro strategies and tactics employed by professionals to respond. As mentioned above, it shows cases of resistance and adaptation, but also instances of hybridisation of practices and mind-sets, which unavoidably imply co-penetration of the commercial, bureaucratic and professional logics.

Part II: Hierarchy, Commercialism & the Impact on Professions – The Erosion of Clear Distinctions between the Three Logics

It has been already demonstrated how the state and the professions collaborated to deliver social goods during times that belief in a social welfare and Keynesian-inspired public policies prevailed. After the economic instability of the 1970s, the victorious advent of neo-liberalism coincides with a new ideology over public policy. A significant number of countries follow the prescriptions of Milton Friedman and the Chicago School of Economics which dictate shrinking of state functions, privatisation, and strengthening of the private sector at the expense of the public. Even sectors such as the British NHS, which had for a long time escaped marketisation, are influenced by a neo-liberal ideology. As a result, policies such as

New Public Management (NPM) (Exworthy and Halford, 1999) and the introduction of quasi-markets (Flynn, 1999) are implemented. These policies entail cost containment, accountability, performance and output evaluation but also tax funding based on user demand instead of central bureaucratic allocation (Flynn, 1999). Such structural changes hold significant impact for professional work and, potentially, power. In the UK, the introduction of 'soft-bureaucracy' is translated into indirect control measures for professionals in the form of output targets (Dent, 2007: 105). Work autonomy as far as resource allocation is concerned is also taken away from the hands of professionals. To a significant extent self-regulation is replaced by external control (Evetts, 2002: 346). Introduction of managerialist logic to professional work is experienced throughout the world after the 1980s. Neogy and Kirkpatrick (2009) present the case of six European countries in which the state introduced managerialism in the health care sector and examine the variation in response and engagement of the medical profession. In the US, where the health care sector is private, medical professionals experience similar pressures. Quantifiable targets and performance measures have been gaining prominence, cost efficiency is a primary goal, while the necessity of the recommended-by-physicians medical procedures is scrutinised (Domagalski, 2007: 125-126). The neo-liberal ideology is often further advanced in countries with minimum social state, with the US being an exemplary case. Domagalski (2007: 124) confirms the strong ideological orientation towards the function of the markets in the US. Ironically, despite the promotion of free markets and competition, the expectations of 'market clearance' were never fulfilled in the US. In health care in particular, prices

continuously increase leading a significant number of citizens to impoverishment (health care expenses rank first in the causes of private bankruptcy in US, Himmelstein *et al.*, 2009) and making health care inaccessible to significant parts of society (for instance US is an important source of outbound patient flows motivated by monetary concerns).

What preceded neo-liberalism is the ascendance of corporatism in the private sector and the concentration of professionals in large organisational units. In the US health care sector the process started after the Second World War (Starr, 1982). Caronna and Scott (1999) masterfully show how the 'deviant' organisational model of a large hospital system, which exceptionally at the time employed MDs, prevailed after the 1960s. Gradually the 'organisational' professional (Hanlon, 1998) as a salaried employee replaces the solo-practitioner rewarded on a fee-for-service basis. Other occupational groups undergo similar structural changes as they concentrate in larger organisations. Social workers in the UK started to work for larger, unified agencies during the 1970s' and, within that context, a significant number saw themselves first as employees and secondarily as professional workers (Jones, 1997: 43-45). Concentration of professionals in large organisations does not lead to a deterioration of their position per se. In contrast, various scholars consider the power of professions within the sites of large organisations (Noordegraaf, 2011; Muzio and Kiripatrick, 2011; Faulconbridge and Muzio, 2008; Evetts, 2011) both in the public and private sector. Nevertheless, large organisations are the sites where professionals face increased bureaucracy and control imposed by managerialism.

At the same time, changes occur at an industrial organisation level. Especially in the US, the restructuring of the health care sector has strengthened the position of financial and industrial owners of healthcare establishments (Domagalski, 2007: 124). This occurred at the expense of the medical profession (Light, 1993: 77-78). In particular, insurance companies as third party payers put pressure on medics to reduce health expenses via financial incentives. Private insurance companies connect (inversely) MDs' salary to the health expenses of their patients in an effort to minimise costs (Stone, 1997: 449). Another example of sector re-organisation is the emergence of large professional firms as a new actor, especially in law and accounting. Flood (2011) argues that large law professional corporations have the ability to lobby transnational regulatory bodies such as the WTO and EU, but also state agents, and as a result shape professional regulation taking the reins of professional associations. Their interests, however, are not necessarily aligned with those of the majority of professionals working within the limits of a country. In fact, they are recognised as organisations supporting the deregulation agenda of transnational regulatory bodies for professional services both at a national and international level (Flood, 2011).

Other aspects of the impact on professional work organisation include the formal institutionalisation of market rulings in professional services. By the end of the 1970s' state preference over trade development led to a removal of professional restrictions on price competition (Freidson, 1984: 7), advertising and marketing in both law and medical services in the US (Schlesinger, 2002: 194). The lift of the ban came on the fertile ground of growing competition among rising numbers of

professionals and accentuated commercialisation, as advertising soon became commonplace (Schlesinger, 2002). The symbolic power of such a change is at least substantial, as it weakens the long-term narrative over professional disinterestedness. As it has been argued in the previous section, disinterestedness has been utilised by professions as a means to elevate political power and legitimise privilege. Schlesinger connects the expansion of advertising practices to the deterioration of the image of professionals in the eyes of the public. The medical profession, specifically, confronts the loss of 'consumer' confidence and sees the popularity of its profile as protector of the public health diminishing (Domagalski, 2007: 119). In the US deterioration of public trust in medics was reinforced by managed care scandals, the enforcement of informed consent and other events which gave rise to suspicion about medical professionals (Timmermans and Oh, 2010: S97). Moreover, an opening to complementary and alternative medicines by patients, women and patient movements in the 1960s, and the rise of consumerism changed perceptions over health care and empowered patients in relation to their physician (Timmermans and Oh, 2010). Self-regulation as a mode of organization is no longer considered credible by the state or by the public (Dent, 2007: 103). Most characteristic is the perception of the professions as 'lesser governments' or trade unions expressed by Mrs Thatcher (Muzio and Ackroyd, 2005; Abel, 2003).

Change in clients' structure and needs is an additional factor affecting professional work. Faulconbridge and Muzio's (2012) work shows how internationalisation of client corporations which require consistent professional services across countries, has led to the internationalisation of professional firms

such as law and accounting. In addition, professional associations internationalise. Transnational regulatory bodies such as the WTO and the EU, reregulate aspects of professional work (often disregarding nation states' regulations) in order to encourage trade; professionals then develop international professional associations (Evetts, 2002; Faulconbridge and Muzio, 2012) to negotiate top-down transnational reregulation. Except for bureaucratic structures, larger organisations entail an increase in functional divisions of labour and therefore the emergence of new occupations (Scott, 2008). The latter triggers a process where tasks among old and new occupations are renegotiated potentially leading to a struggle over jurisdictions.

Dominance of the rule of markets translates to a need for expertise in new-technologies which puts additional pressure on professional competence and/or competition (Adler and Kwon, 2007: 153). For example, Mclaughlin and Webster (1998) examine the introduction of a software tool in a micrology lab and illustrate the challenge it posed for both medics and scientific personnel in terms of professional competence and power. Furthermore, Scott (2008: 229-230) links technological innovation and knowledge creation to the proliferation of professional specialisations. Specialisation in medicine, for example, leads to professional fragmentation (Scott, 2008) but at the same time it fosters collaboration (Domagalski, 2007) due to inter-dependence (Muzio *et al.*, 2007: 15). It becomes obvious that a large spectrum of changes affect professional work, some directly and some indirectly. While the full function of mechanisms which shape contextual conditions and, thereafter, the evolution of institutions and events is not clearly discernible, an analysis of the nature of implications for professionals and

professionalism will be attempted in the remainder of this section. To serve this purpose, insights are offered through existing empirical work conducted in different settings and countries. Before that, however, the next section examines international patient movement as a contextual change for the medical profession.

Medical Travel as a contextual change

Increased flows of patients are perceived as a contemporary development with significant impact upon the medical profession, directly related to the spirit of neo-liberalism and the advent of marketisation in the health care sector. A notable effect is the division (or fragmentation) of medics according to location, as international competition gives a divisional meaning to national borders for the profession. The very moment that patients permeate jurisdictions, medical professionals become divided to those who are in 'origin' and those in 'destination' countries. The first lose individuals from the pool of patients who the latter gain. Their interests appear to be in conflict. This development is arguably unprecedented for medics; traditionally patients seek health care abroad when it is not available at home, a movement that creates no competitive tensions. Currently, it is to a large extent cost concerns that drive patients abroad, opening up medical services into international commercial competition.

Internationalisation of health care conceptualised as a top down process (like managerialism and corporatism) has two dimensions. First, as revealed in the literature review, the WTO plays a prominent role in advancing international trade in health care provision through the Trade Agreement in Health Services (within the

broader framework of the General Agreement on Trade in Services). The EU also promotes trade regulation. In the process, the special character of health care and its attachment to locality are disregarded. Trade is prioritised without a sensitive analysis of structures and needs of existing systems, and it is regulated with a characteristic ignorance over human vulnerability. The lack of mechanisms to protect any party is notable and the voices of a number of law scholars about the problems arising out of a lack of regulation grow louder (see the relevant section in the literature review). In addition, internationalisation of health care has an impact on groups of countries at once, reinforcing positive spill overs for trade. As such, it accentuates marketisation of health care from the back door of health care systems. Second, the neo-liberal trend has led, in many instances, to public disinvestment from health care, which practically translates to less coverage and therefore to higher private expenses. This in itself is recognised by the literature as an important push factor for patients and thus as a basic driver of medical travel. To sum up, trade in health care is formally encouraged by international regulatory bodies while, at the same time, constitutes a by-product of state policies. At the same time, medics cannot be perceived as neutral receivers of a new order; in spite of market pressures, MDs' initiatives to attract foreign clientele have actually preceded large private hospitals or state initiatives to support the sector. As it has been demonstrated in the literature review, there is scattered evidence in the literature that MDs have been pioneers in establishing this form of trade. It is perhaps important to note, that technological advancement and corporatism, as external forces, are also facilitating the internationalisation of health care. Broader mobility of

people for business and tourism is enabled through advances in transportation, while transfer of medical knowledge and medical technology from the core to the periphery countries has enabled common practices and standards in treatment. Large private hospitals play a vital role in the transfer of technology by importing expensive equipment, while the international movement of health professionals accelerates diffusion of medical knowledge across countries. All these secondary factors have an indirect positive external effect on international patient travel.

This line of thought implies that the internationalisation of health care can be conceptualised both as an external condition to the medical profession (mostly in origin countries), and, to a lesser extent, as a development reinforced by medics (in destination countries). The current thesis, then, focuses on medical professionals in 'destination' countries. In order to do this, it turns to a group of medics who try to increase this form of trade by attracting foreign patients in their private practices in Greece. Drawing on insights about medical agency from the sociology of the professions literature, this thesis aspires to explore the type and extent of professional involvement in the creation of the new sub-sector.

Forces shaping the landscape: Professionals Strategies and Tactics at a macro and micro level

The sociology of the professions as an analytical framework recognises that professionals respond actively to challenges triggered by contextual changes, irrespective of whether their mobilisation gives the intended outcome or not. A number of empirical studies investigate professional agency in a range of work

settings, historical periods and countries. Some studies highlight the collective and dynamic manner of professionals to respond to threats and opportunities, which is particularly relevant to the conflict paradigm discussed in the previous section. Within that framework, strategies deployed by organised professions (either they involve conflict or diplomacy) are perceived as part of the mechanism shaping the landscape of service provision. Other empirical studies focus on individual stance, motivation, and perspectives, and aspire to understand changes in professional values and identities, given contextual changes. In this way, they contribute to an understanding of the micro-behavioural mechanisms at work, which are also situation specific, as one would expect. Here both approaches are embraced in order to synthesise a conceptual framework that will offer analytical insights to the collective and individual agency of medics in Greece as a destination country for foreign patients.

Organised Professionalism: Tales of Conflict and Diplomacy

In the aftermath of the golden era for professionalism, largely attributed to the state-professions' collaboration, some scholars highlight the collective efforts of professionals to influence state agents and tackle increasing challenges. Referring to Armstrong (1984, 1985, 1986), Reed suggests that expert groups, 'often find themselves in an intense political struggle to secure' the privileges that stem from the monopoly of knowledge (Reed, 1996: 576). Agency is not necessarily uniform, conscious or always well-targeted. For example, Dent (2007: 107) suggests that the medical profession has embraced evidence-based medicine to counterbalance the

loss of public trust, a process which may have been only slow and gradual. Similarly, Brint (1994) explains how professional groups have turned, during the last decades, to arguments over expertise backed by scientific knowledge to revive their legitimacy in the eyes of the public. In other cases, professions' deliberate development of strategies to tackle challenges is documented. Actually, a large part of the literature on professions examines organised professional response to contextual changes with potentially adverse implications for professions. For example, in the US unionization of medical doctors has increased in light of salaried employment (Domagalski, 2007: 133), while the house of delegates of the American Medical Association and the American Bar Association pushed unionisation for their members in response to external pressures (Adler and Kwon, 2007: 153-154). As is the case with the legal and other professions, the medical profession has resisted reforms initiated by governments numerous times and in a number of countries. A relatively recent case of collective mobility against state reform is the reaction to the introduction of the Modernising Medical Careers' programme (MMC) by the UK government, which effectively intervened in the undergraduate and postgraduate curriculum of medical training (Bolton *et al.*, 2011). Bolton *et al.* identify a publicized opposition to the programme by the medical association, coloured by arguments over disinterestedness and doctors' struggle against 'a dubious commercial logic' (Bolton *et al.*, 2011: 690). Similarly, Nikolentzos and Mays (2008) show how the Greek medical profession has effectively blocked most attempts to reform the national health care system for almost two decades. Focusing on a different setting and challenge, Mclaughlin and Webster (1998) show how medics' legal rights over

diagnosis, the dis-attachment of professional knowledge and skill from the hospital as an organisation, and their membership of the profession were key discursive devices in preserving their power and control after the introduction of a new technology in a micrology lab. In contrast, the scientific personnel in the same work place, proved unable to inhibit deskilling and the downgrading of their position in face of the same challenge. The implicit struggle on the side of professions to maintain power depicted by such an analysis makes the concept of countervailing powers particularly relevant. This approach assumes that there are various competing actors in the field who interact and struggle for power. The struggle entails the acceptance that professionalism is a dynamic process (Dent, 2007: 102) and professional dominance is 'contextual' in nature (Light, 1995: 26), therefore renegotiated as changes occur in the socio-economic environment (Light, 1995; Dent, 2007). To illustrate his approach, Light (1993: 77-78) gives the example of the health care sector in the US; during the last four decades institutional buyers have gained power at the expense of medical professionals leading to the reorganisation of health care provision and the concentration of practitioners in larger health units. Light suggests that practitioners then started investing in these units to achieve economies of scale and practically resist the buyers' countervailing power. According to Flynn, this approach illustrates the political struggle between professionals and other actors as a continuous one:

> 'experts will constantly seek markets for their skills and endeavour to maximize their independence; but at the same time employers (and representatives of

clients) will continue to attempt to regulate and control expert labour' (Flynn, 1999: 22).

This is a 'classic' thesis in the sociology of the professions, which traces its roots to the work of Freidson (2006, 1988), Larson (1977), Johnson (1972) and other prominent scholars, as it has been presented in the first part of this chapter. The ever relevant question in the Sociology of the Professions over whether professionals are losing power then remains. On the one hand, Hafferty and Light conclude that according to most commentators, medical professionals' dominance in the US and abroad is maintained (1995: 135). On the other hand, Light (1993: 79) suggests that a significant change has already taken place as 'the game they are winning (at least so far) has ceased to be their game'. Even though opinions have been dramatically different, ranging from de-professionalisation and proletarianisation (Haug, 1988; McKinlay and Arches, 1985; McKinlay and Stoeckle, 1988) to maintenance of dominance (Freidson, 1984; 1985) it appears that mutation and continuity in change might be a better approximation to a potential answer (Larkin, 1993: 89). It is notable, in fact, that in many instances professionals show remarkable flexibility. Often they exhibit partial adaptation to changing environments, a phenomenon described as 'hybridisation'. Kurunmäki defines hybrid professionals as practitioners with an 'amalgam' of skills gained through a 'process of transfer and adoption' (2004: 329). She suggests that MDs in Finland, when confronted with the introduction of managerialism, adopted 'willingly' accounting techniques though not the relevant abstract knowledge, leading to a 'hybridisation of medical expertise' (Kurunmäki, 2004: 343). This analysis implies a form of conciliation from the side of

medical professionals. In the words of Noordegraaf members of hybrid professions 'are reflective practitioners' whose 'links with outside worlds are part of professionalism' and who 'know how to operate in organized, interdisciplinary settings that cannot be organized easily' (2007: 771 & 775). Similarly, Kirkpatrick *et al.* (2009) note that medical associations in Denmark, instead of exhibiting a negative stance per se, have engaged in the implementation of managerialism introduced by the state. In this way, medics actually were able to influence policy making. As a result their attempt to 'colonise management' may ultimately be conceived as a mechanism to maintain power. Another study shows how lawyers in managing positions in large law firms have acquired managerial attitudes and tasks (Muzio and Ackroyd, 2005). The authors carefully note that even though managerialism and entrepreneurship have 'infiltrated' these professionals, the process has actually enabled the profession to maintain control over its work. Openness to change, therefore, may be conceptualised as a type of diplomacy; a strategy deemed more effective than direct conflict.

Another strand of research is preoccupied with occupational change as an endogenous process generating significant spill-overs for other actors (Suddaby and Viale, 2011; Hanlon, 2004; Scott, 2008). Professionals are perceived not just as responding to external pressures but as agents that deliberate change in their environment. For example, the contention that professionals often employ reputational or social capital to seize arising opportunities and develop new markets is particularly relevant to the current research study (Hanlon, 2004). It is elsewhere illustrated how professionals utilise their legitimacy and expertise to recreate

institutions; employ their social capital to populate new areas; and define field boundaries by establishing new rules and standards (Suddaby and Viale, 2011). In essence, this neo-institutional perspective examines how change in professional organisation causes social change. Professionalisation is conceptualised as an institutionalisation process (Suddaby and Viale, 2011; Muzio *et al.*, 2013) and professionals as institutional entrepreneurs (Scott, 2008).

Reflecting on the internationalisation of Health Care

Considering internationalisation of health care as an externally imposed condition, the thesis of countervailing powers alongside the conflict paradigm would imply some form of collective agency from the side of medics, at least in the case where they perceive it harmful for their position or interests. It would be anticipated that MDs in 'origin' countries would prefer to slow down the outflows of patients, and therefore, would seek ways to influence both the public opinion and the state into taking measures against the practice. On the other hand, MDs in destination countries would discuss the potential of the international markets within their associations and would have an interest in promoting the sector. In their endeavour to do so, we would expect that MDs perhaps put pressure on the state to support the development of an international market (alongside private hospitals' investors). It would not be surprising to employ a narrative over economic growth (which would preach the benefits for the whole of society/economy) to support their claims. Timing is also 'good'; the emergence of financial capitalism coincides with an ever more unstable global economy which generates crises and increases unemployment.

Greece in particular is facing a dramatic shock of dis-investment and privatisations, which has crippled the domestic economy pushing it to a vicious cycle of recession. 'Growth' is more important than ever.

At the same time, it is interesting to examine the perspective of international professional organisations. Given the conflicting interests of their members, it would not be anticipated to hold a strong stance against or for the development of international patient movement. The sociology of the professions is therefore called to offer insight to a change which for the first time, perhaps, looks at medics divided according to national borders. In the wake of international competition, medics may find themselves in the embarrassing situation of being challenged by colleagues across the border. As commercialisation expands to an unprecedented scale, the perceived universal mission of medicine to fight human disease is put largely in doubt. It is perhaps more plausible to expect that medics would not like to expose their profession to an international feud triggered by trade. In order to draw some conclusions, it remains to listen to the voice of professionals and study their collective agency. In this light, the current thesis explores perceptions and incentives of medics actively involved in international patient movement, through the example of Greece.

Collegiality, Values, and Identity: Mutation and Adaptation and Continuity in Change in the work place

A micro-analysis of professional behaviour offers the opportunity for a closer exploration of mechanisms at play given external challenges. This micro-approach

which focuses on the individual reveals tension in identities and roles, modicums of fragmentation within professions, but also it reveals once again a flexibility which allows adaptation to new situations. It is recognised, that these mechanisms are heavily dependent upon institutions, therefore exhibit significant variation across countries, challenges, and occupational groups.

Research on clinical doctors' first managerial appointments within the market-inspired British NHS shows that on a personal level, MDs appeared overwhelmed by how differently they had to think of their work; they appeared unprepared for management roles and negatively orientated towards change (Dawson *et al.,* 1995). Research on Norwegian medical professionals assuming managerial positions also reveals that they have been significantly challenged and unprepared for the role (Spehar *et al.*, 2012). Nevertheless, in the UK some clinical managers – young in age – seemed to embrace the new type of power stemming from the emerging organisational setting. Dawson *et al.* recognise that this opportunistic behaviour could downplay collegiality. Findings of another study reveal that some MDs were motivated to assume managerial positions in the UK, by a promising career opportunity; whereas a few intended to protect their specialties from external influence and incompetent candidates (Forbes and Hallier, 2006). The scholars comment that when first exposed to managerialism most MDs found themselves in conflict with their dual role and the hospital managers (Forbes and Hallier, 2006: 37). Freidson (1985) suggests that conflict with managerial roles is the result of a differentiated orientation that distinguishes professionals from administrators. In particular, administrators serve the interests of the organisation and look at patients

from a macro-perspective, whereas practitioners are assumed to serve patients directly and therefore look at patients as individuals (Freidson, 1985). In light of this, it has been argued by Johnson (1972) that "'professional' sources of authority and the 'community' aspect of the occupation are undermined" (Johnson, 1972: 84) when practitioners respond to bureaucratization by taking over managerial and advisory positions. According to Domagalski (2007: 123), medical doctors that make a career in management serve the interests of their employers instead of their profession escaping, thus, the 'professional project'. It is noteworthy that Hoff's (1998) study of US physicians already holding executive positions reflects, in general, positive attitudes towards managerialism. His findings indicate commitment both to the profession and the employer, while younger individuals are found to exhibit a weaker belief in professional values. Other insightful work from Hoff, on solidarity among physicians in clinical practice versus physician-managers, reveals 'distrust, conflict and 'game playing behaviours'. In other words, it highlights fragmentation and competition rather than collegiality (Hoff, 1999: 326). Similarly, empirical work on primary schools in the UK after the introduction of managerialism and market elements in 1988, shows development of hierarchy in the work place, exposure of teachers to conflicts of interests and deterioration of collective values (Menter *et al.*, 1997). All this evidence offers empirical support to the argument that managerialism introduces hierarchy and structures which downgrade collegiality (Johnson, 1972: 84; Dawson *et al.*, 1995).

Except for a loss of collegiality, the above empirical findings suggest adaptation to new situations and new roles which are often relevant to adoption of new

identities and values. Hanlon (1996) uses the term ‘commercialised professionalism’ to depict the situation in which ethics of servicing community are downplayed as new roles gain importance. Research on accountants suggests that professionalism is perceived as completing tasks skilfully or ‘expertly’ (Hanlon, 1996) centred on client satisfaction (Anderson-Gough *et al.*, 2000). This understanding of professionalism does not include a moral aspect of servicing. Light and Levine (1988: 19) refer to Derber’s ‘ideological proletarianization’ to describe disassociation from professional ends and a ‘narrower conception of service’ (Scott, 2008: 233). Indeed, research findings illustrate that under marketisation, the social purpose of professionals does not lie within the sphere of ‘human service’ but within the sphere of ‘business service’ (Brint, 1994: 47-54). In accounting or law this occurred through a change in the organisational model from professionalism and partnership (P2) to ‘managed professional business’ (MPB) characterised by commercialism and managerialism (Mueller *et al.,* 2011; Faulconbridge and Muzio, 2008). Nevertheless, Anderson-Gough *et al.* note for accountants, that the commercial character of services does not mean it is overall void of ‘service ethic’ (2000: 1152). In this case, a call for high quality of service provision dominates the professional ethic; professionals might not aspire to serve society as a whole but do aspire to offer the highest quality of service to their clientele. As Brint has discovered through interviews with professionals in the US, professionalism is centred on good results, whilst only a few professionals ‘remark on the social importance of their work’ (Brint, 1994: 10).

Commitment of professionals to professional ethics may be also influenced by the work setting or the historical context. Wallace's (1995) comparison of lawyers working as employees in law firms as opposed to public or private corporations reveals differentiation in commitment to professionalism. Lawyers working in a nonprofessional environment appear to be relatively less committed to professional norms, which might be explained by better opportunities for promotion and perceived legitimacy of the reward system in law firms. This line of analysis implies that professional groups exhibit a tendency to adapt to their environment, even though, path dependency seems also to be shaping adaptation (Kirkpatrick *et al.*, 2009). For example, it is suggested that medical doctors in Denmark appear more willing to engage with management roles in comparison to MDs in UK (Kirkpatrick *et al.*, 2009). The authors explain that both historical institutions and conjunctions of events account for the differences between medics' approach in the two countries. The contribution of Muzio and Flood (2012) in placing such changes in the broader picture is notable. The scholars draw on path dependency and the importance of the historical context, to show that at least within law firms, collegiality was developed in the relatively stable economic environment of the twentieth century. Collegiality was crucial in branding firm's reputation and effectiveness in a society that placed importance on such values. In sharp contrast, however, they show that professionals working in big firms during the 19th century are better described as individualists and entrepreneurial. Nowadays, once again, professionalism seems to turn towards individualism and entrepreneurship. Similar observations on such cyclicality are expressed by Stone (1997) in her work on MDs in the US. The scholar

suggests that in the 20th century doctors evolved from craftsmen and businessmen to professionals, to transform once again into entrepreneurs, who explicitly incorporate financial concerns in their decision making during service delivery. Professional identity, therefore, cannot be perceived as constant but as renegotiated to adapt to changing conditions of work or even societal value systems; new roles encompass new self-understandings.

We see that the context within which professions operate along with the choices, strategies and actions of the specific actors of each era shapes their evolution. The theoretical pillars of professionalism as presented in the first part of this chapter are elements that are not stable but renegotiated and transformed as illustrated in the second part. Terms such as path dependency (Kirkpatrick *et al.*, 2009; Muzio and Flood; 2012), mutation and adaptation (Larkin, 1993: 89; Adler and Kwon, 2007), continuity and change (Evetts, 2011) are employed in the literature to express new meanings and understandings of professionalism. The clear distinctions between managerialism, commercialism and professionalism (Freidson, 2001) are often not supported empirically; the examples above comprise a rich pool of cases illustrating the co-penetration of logics.

The advantage of Freidson's ideal model is that it facilitates an understanding of what a profession strives to be, or perhaps, what image a profession wishes to cultivate. Dedication to a higher mission of offering good results, satisfaction from serving a mission, and priority to the benefit of the receivers of work instead of own material benefit or employer's interest portrays the logic of professionalism. Evetts

(2003) traces Freidson's ideal-type of professionalism to Parson's argument over professionals' collective orientation to a higher mission which is characteristically reflected to their identity. This emphasis on a normative aspect is practically and analytically valuable in the way professionalism comprises an aspiration for occupational groups (Evetts, 2003). The appeal of professionalism is omnipresent. For example, several professionalisation projects take place, while their success or failure of those attempts is not necessarily the most interesting issue (Fournier, 1999). Moreover, managers or employers in large organisations draw on professionalism as a discourse to claim legitimacy,

> 'to elicit commitment, maintain control and legitimize processes of organizational change. […] the label profession has an instrumental value […] which is deployed to secure specific outcomes (Muzio *et al.*, 2011).

Common denominator of the theory of professions is that expert knowledge is present to all societies, and consequently so is the interest in studying its organisation and regulation (Crompton, 1990: 157). Despite definitional challenges[6] professionals are knowledge workers primarily producing services, and their study becomes most interesting due to the relatively recent expansion of the services' sector (in the expense of manufacturing and agriculture) both in developed and developing economies (Sako, 2013). This economic development causes an expansion of service occupations which, perhaps unsurprisingly, coincides with an

[6] Several scholars observe that definitional problems arise with the concepts 'profession' and 'professionalism' within the Anglo-American context, especially when their historic and cultural boundaries are not recognised (Crompton, 1990: 156). Dingwall (1976) suggests that the usage of a 'lay' term both in everyday life and scholarly communities causes further confusion and suggests that it should be treated as a term broad enough to incorporate changes in its meaning. Sako (2013) abstains from providing a definition of professions all together recognising the differentiated meaning across countries.

increment in efforts for professionalisation (Sako, 2013). Professionalism's appeal to numerous occupational groups shows then how professionalism penetrates other spheres and logics. For example, key elements of professionalism, such as collegiality, are particularly suitable for knowledge intensive work, Adler *et al*. (2008) suggest. The exchange and diffusion of ideas is a salient mechanism to support knowledge creation. It becomes, therefore, obvious that professionalism is not just restrained or infiltrated by the logic of managerialism or commercialism. It plays out as a powerful and appealing discourse too. Viewed from that perspective, the sociology of the professions, despite its shortcomings and biases, continues to contribute substantially to the theorising of expert knowledge organisation and regulation.

In light of these considerations, the current thesis aspires to explore the perspective of medical doctors who are actively involved in medical travel. How they pursue this goal, under what conditions it was initiated and why it comprises an aspiration for medical doctors in Greece will be explored vis-à-vis the potential impact upon their work and organisation, the domestic health care sector, and the cohesion of the profession in a national and international level. Drawing on recent contributions to the theory of professions it will examine how professionals change and how they cause change to their environment.

Discussion

The movement of patients coincides with symbolic changes in the penetration of commercial practices in health care. Most importantly it epitomises the moral

acceptance of inequality in access to health care, since lack of access to health care is a basic driver of patients' travel. These considerations pose serious challenges to medics as professionals at multiple levels. First, at an organisational level medical professionals need to work in an environment that is friendly to foreign patients, to people with different religion, culture, and language and most importantly, to people whose home and social network stays overseas; most often patients are escorted by one family member or a friend. The needs of these patients can only be increased therefore a supportive mechanism is necessary alongside treatment. Medics need to collaborate with occupational groups out of the sphere of healthcare to deliver services, such as business consultants, tourism and hospitality experts, translators or even brokers. Second, at an industrial organisation level new actors emerge in the international scene which now functions under different incentives and structures. Medical professionals will perhaps need to re-negotiate their position in respect to the new organisational arrangements and actors. After all, they provide no doubt the most essential service, but just one part of an assembly of services. Assistance with travelling and accommodation, translation and transaction activities or facilitators and patient travel consultants are necessary. Third, medics have to consider their stance towards the practice at two levels; first, as to whether travelling for health care is medically advisable considering the travel risks, and second, as to whether it is ethical. As a result, the sociology of the professions, as an analytical framework is called to offer insight to the stance of medical professionals both at a micro-level of individual behaviour and at a macro-level which examines the collective response of professionals.

The choice of the specific framework is particularly relevant based on evidence in the literature of medical travel which confirms that medical professionals have been active both at an individual and collective level. The stance of individual medical doctors most characteristically depends on the country they work; i.e. whether it is an origin or destination country for travelling patients. In particular, medics in 'origin' countries have been fierce critics of the practice. Drawing on argumentation over health risks for patients or increased costs for local health care systems in case of emergency care after overseas malpractice, individual MDs from Canada, Australia, UK, US, and Germany have publicised their opposition to the practice in medical journals. Similarly, MDs have utilised their websites or the press to 'warn' patients of the involved risks, often in a dramatic tone. In contrast, as it has been noted above, MDs in destination countries have been pioneers in establishing this form of trade. This implies an enterprising profession using own initiative. Accordingly, entrepreneurialism may allow medical doctors to appropriate the benefits of the rising numbers of patient movement. At the same time, as it has been demonstrated from the literature review, the structure of the sub-market offering services to foreigners includes new actors and potentially entails a differentiated power balance. Specifically, large hospitals develop business strategies targeted to foreign patients and lobby governments to provide incentives for the development of the sector and a favourable legal framework. Competition may arise between medics and steering groups of large hospitals promoting exports or alternatively between medics and intermediary companies, a new key actor, responsible for the movement of patients. At an organised level further research is required; most possibly, however, medical

associations have remained relatively neutral. Though not openly critical, international medical associations appear reserved about the practice and provide guidelines which advise patients to be careful in their choices and to keep in mind potential risks. The Sociology of the Professions offers a rich framework for insightful analysis of these dynamics in the health care sector, taking into account the involved actors at a collective but also disaggregated level. It allows an analysis of politics in the new sub-market as much as an analysis of individual change in ethics and values for medical professionals in the current context.

Purpose of the Study

Overall, the purpose of this thesis is to investigate the attitudes and perceptions of medical doctors involved in the international movement of patients, and thereafter their role in the emergence and growth of the international health care market. In particular, through the lens of the sociology of the professions it will be explored whether medics in Greece perceive the practice as an opportunity or challenge with regards to themselves, the country, and patients. Given the fact that the group of MDs in focus seek to attract foreigners, a positive attitude towards the phenomenon is anticipated. Advertising efforts become apparent from MDs' websites, not only in Greece but in other destinations, and this thesis seeks to understand how MDs reconcile their role as medics with their personal involvement in a highly commercialised practice. The theory of professions would anticipate conflict in identities stemming from the tension between marketisation and professional values and ethics. In this light, the study attempts to reveal what constitutes the motivation

for MDs' involvement. In addition, the empirical work explores their relations with other stakeholders, but also the very experience of treating foreign patients. In addition to a micro-level approach, the thesis then aspires to throw some light on the strategies developed by organised medicine. This is deemed especially important since MDs as solo practitioners are almost exclusively promoting the sector in the country, or at least were at the beginning of the current research, back in 2010. Large private hospitals were surprisingly absent at that point in time, despite their capacity to invest in marketing and/or lobby the government to facilitate its development. In particular, it is interesting to find out whether there have been any efforts from the side of medical associations or unions to put pressure on state agents or collaborate with the business sector of tourism and hospitality. Questions that explore medics' opinion about the future of the sector in Greece, its importance for the country, the role of the state, but also the role and involvement of the medical associations prove a useful means in discovering more about MDs' collective mobility. Qualitative semi-structured interviews were conducted to give voice to medical professionals' views on these topics in Greece. The following chapter elaborates the method employed and explains the reasons it was chosen as the most suitable research technique.

CHAPTER 5

RESEARCH METHODS

Introduction

This chapter outlines the methodological approach adopted to answer the basic research questions of the study. It presents the methodology in a successive way; it starts by describing the background as a means of introducing the rationale of research, which justifies the qualitative nature of inquiry and the particular research questions. The way is then paved to explain why semi-structured interviewing comprises the most suitable qualitative technique but also to outline the ontological positioning of the study. The sampling and description of data collection follow, while the process of data analysis and ethical considerations lead to the conclusion of the chapter.

Background, Rationale and Research Question

It is argued that the internationalisation of healthcare emerges in a commercialised environment. Patients most often cover the medical expenses out-of-pocket, providers and agents receive a fee for patients, and trade is encouraged by international organisations and specific states. Advertising and marketing have also a role to play, though small and medium medical practices, steered by medical

professionals appear to attract significant percentage of the flows of patients. This leads to the question of what types of initiatives medical professionals take to attract foreign patients, and what is the rationale that lies behind. Analysing the situation through the framework of the Sociology of the Professions implies that a professional logic contradicts that of the market (Freidson, 2001). While medical doctors adapt to changes by acquiring managerial and business skills (when working in organisations that undergo a top-down process of change), change is widely recognised as externally imposed. In contrast, internationalisation of health care is a development taking place without necessarily affecting professionals. The willing engagement of solo practitioners, therefore, calls for further examination of their commercial practices and their perception over the internationalisation, the patients, and themselves. The reflections of actions and perceptions on their value system and professional identity comprise also an intriguing topic, as they can potentially capture the dynamics underway. In light of this, this study set out to understand the role of medical doctors in the emergence of transnational health care and their experiences from treating foreign patients visiting Greece for health care.

A qualitative research approach

The nature of the research questions does not leave much doubt that qualitative inquiry is the most suitable research approach. The focus on perceptions, motives, and the role of medical doctors underpins that the necessary rich, descriptive information sought, requires qualitative fieldwork. The latter is the type of inquiry suitable to generate sociological insights such as attitudes, roles, values, processes

and patterns (Miller, 2002). In particular, the development of internationalisation of health care is overall only recently put under academic scrutiny and as such it is characterised by considerable gaps in knowledge about how and why it occurred; or how it currently functions and evolves. The role of MDs in the evolution of the development is overlooked with most studies focusing on other issues or actors, such as patients, states, agents, or the supply side of the sector *in general*. The current study, drawing on existing evidence, raises the issue of how and why MDs take over entrepreneurial initiatives as a burning question. Answers to questions such as 'why?' and 'how?' preoccupy the current research (instead of what) can be better approximated through qualitative data (Hancock, 1998: 2; Marshall, 1996: 522). Furthermore, the exploratory nature of the research study underlines the need to uncover original insights which qualitative inquiry affords (Patton, 2002). Instead of deductive inquiry, which takes hypotheses as given based on theory, qualitative research draws on induction, which seeks to formulate hypotheses based on observations (Curry *et al.*, 2009; Hancock, 1998). As emphasised above, the opportunity for novel insights means that interviewing may uncover unanticipated forces forging attitudes and behaviours. This is a particularly desired strength for exploratory studies.

Qualitative inquiry allows researchers to study participants in their natural environment; where they 'live or work or play' (Rubin and Rubin, 1995: 2). It aims at shedding light on meanings participants give to phenomena (Denzin and Lincoln, 2005: 3). The researcher delves deeply into their world, listens to their voice, observes their environment and contextual conditions, and has the opportunity to

discover aspects difficult to conceptualise otherwise. Qualitative research, thus, by studying phenomena in their natural context transforms the disadvantage of contextual complexity into advantage. The work of MDs, studied here, is bound to contextual developments. For example, the advancing commercialisation of health care at an international level; the priority that state policies put on privatisation and private-sector-inspired organisational arrangements; or historical conjunctions such as the global economic crisis of 2008, the Greek debt crisis, are all relevant to the increasing numbers of patients seeking care overseas. The way that MDs interpret these contextual changes vis-à-vis their daily work will highlight both their proactive and reactive agency. However, since observing such perspectives (Patton, 1987: 109) or even measuring them is not possible, the researcher has to directly ask participants about them. This leads to the conclusion that interviewing is the most suitable qualitative technique for this particular research.

Qualitative inquiry may refer to a number of research techniques such as ethnography, focus groups and in-depth interviews. Given that the current research seeks to understand beliefs, perceptions, and motives of individuals, leaving people to speak for themselves is a particularly appropriate method. In depth-interviews allow room for participants to express themselves in their own words (May, 2001:121), and helps the researcher elaborate on their 'own perspective on their lived world' (Kvale, 1996: 105), their layered motives and beliefs, within contextual complexity (Cavaya, 1996). In this particular case, why MDs engage in commercial practices and how this is reflected in their value system, is under exploration. Answers may be better elicited through discussion. Arksey and Knight suggest that

‘interviewing is a powerful way of helping people […] articulate their tacit perceptions, feelings and understandings’ (Arksey and Knight, 1999: 32). The current research encourages participants to share experiences and perceptions over international patient movement.

As Leidner describes, interviews allow ‘room to pursue topics of particular interest’ to the subjects (quoted by Bryman, 1994: 438) and it is this strength that the current study builds on. The open-ended questions of a semi-structured interview, in particular, give the initial delimitation of the topic but also give freedom. As such the interviewee may bring in unexpected information (Hanock, 2002: 9-10) and make clear which aspects, events or topics are perceived most important. At a more technical level, Patton stresses that the advantages of a discussion guide, especially in comparison to unstructured interviewing, lie in the combination of flexibility on topics to be discussed in detail, opportunity for good time management, and the collection of systematic information (Patton, 1987: 110-2). The researcher can probe and prompt answers to elicit responses on topics of interest, while phrasing and ordering of questions may be adjusted to each interview allowing further adaptability and flexibility in the process (Robson, 2002: 270). Another advantage of qualitative interviewing is that interviewees have the opportunity to react and co-shape the process of data collection (Rubin and Rubin, 1995). Instead of passive receivers of questions or passive subjects under investigation, they can immediately interact with the interviewer as an expert on the field, as a future contact or simply as a person.

Silverman suggests that the strength of qualitative analysis to achieve in-depth understanding and rich descriptions of social realities is at the same time its weakness (Silverman, 2005: 211). Drawing from the work of Mehan, he points out that representativeness, anecdotitalism and refutability of raw material interpretations undermine the validity of the method (Silverman, 2005: 211). Reliability of collected data is also of concern. People do not always behave as they claim they do and they do not act as they intend to, even if they are honest (Bryman, 2004: 465-66). Similarly, Arksey acknowledges that it "can be awkward for some people to say some things in face-to-face settings'' (1999: 34). Evidence, however, suggests that in quantitative approaches honesty of research participants can be problematic too. Laumann *et al.* (1995) suggest that all information one seeks to have from people is unreliable, to different degrees, due to the 'self-report' problem. The latter refers to the observed untrustworthiness of people's answers during surveys and interviews.

Moreover, qualitative interviewing is criticised for intervening in the scene of data collection. Research participants are influenced by the personality and the verbal behaviour of the interviewer. The latter becomes the 'measurement tool' (Patton, 2002) and, given her embeddedness in a historical and contextual frame, and her conscious and unconscious biases, beliefs and incentives (Scheurich, 1995), the data collection process cannot be considered neutral (Denzin and Lincoln, 2005: 696). The influence that the interviewee exercises on the process affects the collected data (May, 2001: 127). Simultaneously, interviewing creates power relations between the two parts. While Rubin and Rubin (1995) stress that

interviewees have the opportunity to react and co-shape the process, most often it is the interviewer who has the first move and upper hand (DiCicco-Bloom and Crabtree, 2006). Reflexivity is required on the side of the researcher and the ethics of research have a significant role to play. It is also notable, however, that qualitative fieldwork involves great challenges for the researcher herself, who now comes into direct contact with the participants (De Laine, 2000: 16); ethical dilemmas may arise while at instances, qualitative research can prove particularly stressful and emotionally demanding. An additional difficulty lies in the fact that rapport with the interviewee has to be established to allow sharing of information. The interpersonal relationship may not always be easy while rapport has to be built within a short period of time (DiCicco-Bloom and Crabtree, 2006). In comparison to quantitative approaches, qualitative interviewing is time consuming (Robson, 2002: 273); contacting potential interviewees, arranging and conducting interviews and transcribing the outcome require months' work, while data analysis is no less time demanding (Robson, 2002: 273). Qualitative research is sometimes criticised for its inherent inability to generalise outcomes. Nevertheless, generalisability does not comprise the aim of qualitative inquiry (Hancock, 1998: 3). The latter has a different role to play than establish general 'laws' on social relations or summarise and provide definitions. In fact, very often the group under research is a subgroup of a community with significant variation from the 'general population' (Hancock, 1998: 3). This variation becomes then of interest in itself.

Despite its weaknesses, semi-structured interviewing remains the best option among alternative quantitative and qualitative research approaches for the current

study. Qualitative research methods such as ethnography and ethnographic interviews, despite their rich informative data, are particularly demanding in recourses. Semi-structured interviewing remains the qualitative method with lowest demands in time, with ethnography involving additional difficulties in obtaining permission to access organisations. Further than this, observation during ethnographic work or focus groups would not serve the research objectives of this study. Personal matters are better asked on a one-to-one basis. Group interactions could discourage the interviewee to develop her deeper thoughts and narrate personal experiences. Simultaneously, observational data (e.g. implicit assumptions of the interviewee which cannot easily be understood during an interview) are always welcome, but given the research questions and the financial constraints are here deemed as relatively unimportant.

Considering the suitability of a quantitative approach which would utilise questionnaires or structured interviews, conclusions are similar. Quantitative inquiry would give technical and dry data particularly unsuitable to serve the research objectives.

> 'The conventional positivist view of interviewing vastly underestimates the complexity, uniqueness, and indeterminateness of each one-to-one human interaction…' (Fontana and Frey, 2005: 696).

In contrast, discussion is a basic form of human communication (Kvale, 1996) which allows the collection of rich, contextually informed data. Quantitative inquiry largely misses contextual information. Specifically, it misses all information that is

not predefined or cannot be quantified. And even though monetary flows and numerical representations of people moving abroad for treatment, or information from a large sample of doctors would be useful, it would answer different types of research questions. Other than that, quantification of basic aspects of this complex and multi-faceted phenomenon is not only impossible but also of limited value. That is partly due to analytical techniques as deductive methods seem here of limited scope. In the contemporary, rapidly changing society, theory-laden hypothesis-testing fails to capture the dynamics of developments. For example, the internationalisation of health care is distinguished for its multi-disciplinary character as it is a real life development that transcends cultures, borders, and spaces. Inductive approaches, then, are appraised for coping better with the dynamics of social change (Flick, 2002 cited in Denzin and Lincoln, 2005: 11).

Critical Realism and its Philosophical Underpinnings in the current research

Fayerabend and like-minded philosophers argue that there is no 'scientific' method which categorically leads researchers to knowledge (Hughes and Sharrock, 1990). Instead, each method carries inherent presumptions and therefore encounters limitations. The aim is to expand knowledge, nevertheless, the question of whether the employed method can actually serve as a means to answer the inquiry is always of relevance. It depends on the assumptions carried by the research questions concerning the nature of being (ontology) and ways to reach knowledge (epistemology). The previous section elaborated on epistemology and

why qualitative interviewing is offered as the most suitable method to serve the particular research questions. This section will attempt to elaborate the ontological assumptions of the research questions.

The recognition of the role of structures and agents and of their interaction in co-shaping developments in this piece of research does not leave much doubt that a critical realist approach is embraced. Realists accept that the world exists independently of our knowledge (Bhaskar, 1989). Critical realists understand events as the result of structural powers constraining or facilitating agents who, in their turn, utilise their power to strategically reflect on constraints and deliberately act in a beneficial way for themselves (Archer, 1998). As such, Archer (1998) highlights that structure and agency cannot be reduced to one another. This is fundamental for the current research that depicts the internationalisation of health care as a development related to structural powers external to the medical profession, while at the same time, it recognises medical professionals as individual and collective agents who strive to maintain power amidst arising opportunities and constraints, and who are, consequently, in the position to co-shape social reality. The central research question on the role of medical professionals in the internationalisation of health care clearly puts an emphasis on the interaction of structure and agency and the interplay of their causal powers (Archer, 1998; Bhaskar, 1989). It justifies the choice of the sociology of the professions as a suitable conceptual framework because it also puts a dual emphasis on structure (e.g. state legislation, the system of capitalism, market dynamics) constraining or facilitating professional dominance and the agency (individual and collective) of empowered professions. The neo-

Marxist analysis in the sociology of the professions (Larson, 1977; Johnson, 1972; MacDonald, 1995 etc.) is focused on the struggle amongst actors (e.g. the 'countervailing powers' in Light, 1995 or turf battles over jurisdiction in Abbott, 1988) and the analysis of contextual changes as highly influential in the evolution of the system with the creation of events. In particular, the two-directional causality of macro-events and micro-level agency of individual(s) is congruous with critical realism philosophy. The common Marxist grounds account potentially for this consistency.

Despite its ontological positioning, critical realism distances itself from positivism and the logic of deduction. Even though it accepts that research is informed by theory, it essentially leaves room for processes not foreseen and anticipates that 'as the research proceeds, special interest in particular kinds of data may develop' (Ackroyd, 2008). A realist ontology implies that mechanisms that are not empirically observed are still present and potentially influential (Benton and Craib, 2001). As such, a deductivist approach may be a method of reasoning suitable to experimental set-ups but weak when investigating open systems (Lawson, 1999: 4). It may indicate the emergence but does not explain the forces and the actors' role behind events (Patomäki and Wight, 2000). In contrast, abduction (Ackroyd, 2008) starts research with theory-laden assumptions, while at the same time is compatible with the potential of novel insights so characteristic of qualitative inquiry. Realist ontology accepts the richness and advantage of qualitative inquiry and does not restrict researchers to explore 'only what can be quantified … [and] leave out all the things that cannot be measured' (Sayer, 1992: 177). In particular, Bashkar (1989)

recognises that ontology is distinct from epistemology so a realist approach does not precondition the way a researcher seeks knowledge. Pluralism in epistemology and methods is achieved though the stratification of ontology. Critical realists advocate that the ontology is layered into the real, the actual and the empirical.

> 'The 'empirical ' and 'actual' level are where perceptions and events occur. They have their origin in a deeper level, where structures, mechanisms and powers operate.' (Kennedy and Kennedy, 2004: 304).

Reflections of causal mechanisms (taking place in the real) are observed as patterns into the layer of the actual (Bhaskar, 1997, Sayer, 2000: 11). If we consider the effects and their causal mechanisms in the same aggregation level, we miss the chance to acknowledge that causal mechanisms, depending on the context, do not always manifest themselves (Mingers, 2006). We need also to acknowledge that the context in which the mechanisms operate influences not only their actualisation but also our empirical experience of them (Ackroyd, 2010). This distinction between empirical experience and actualisation leaves room for interpretivist research approaches. Accepting the subjectivity in the interpretation of the researcher (Klein, 2004) critical realism has an interpretive / hermeneutic dimension and 'acknowledges that social phenomena are intrinsically meaningful'' and ''concept-depended' (Sayer, 2000: 17). Going back to manifestation of causal forces, Kennedy and Kennedy (2004: 206) note that latent powers may not actualise at every instance depending on the particular historical context.

‘the tendential power relations and mechanisms which are generated by particular structures (and which lead to empirical events and actions) will vary in their importance for reproducing or transforming the historically specific transitive domain of society (for example, patriarchal relations)’ (Kennedy and Kennedy, 2004: 206).

As such, the stratification of ontology is a concise way to illustrate social complexity and a satisfactory explanation to the reason why we face difficulties in understanding social worlds. This leads us back to the observation that the emergence of new events cannot be explored disconnected from the broader context.

‘Contexts and causal groups are rarely just background; exploration of how the context is structured and how the key agents under study fit into it – interact with it and constitute it – is vital for exploration’ (Sayer, 1992: 248).

The context is responsible for the manifestation of causal powers.

Research Design and Data Collection

The empirical findings of this report are based on fieldwork conducted in Greece during the spring and summer of 2012. Data were collected through interviews with health professionals, mainly MDs, in Athens and Crete. Two pilot interviews took place with a thoracic surgeon and a general doctor, geriatrist trainee, before data collection started. They were both approached through personal contacts and one was interviewed in his office and the other in a public space, while both discussions

were not recorded. Robson (2002: 4) suggests that pilot work is useful in determining what is feasible. It might also give the researcher a first impression of the variability of responses and therefore refine the interview format (Teijlingen and Hundley, 2001). Indeed, the first interviewee appeared largely unaware of the growth of international patient movement, while the second one was well-informed and enthusiastic about the discussion topic, reinforcing the belief that purposeful sampling targeting MDs already involved in the market would yield rich findings. The majority of professionals in most specialisations remain uniformed about the current trend and the expressed interest by the international supply side, which renders interviews obsolete. Discussion on common grounds cannot be reached. The second interview gave confidence that the questions' guide elicits intriguing views about the phenomenon and the local medical community. It seemed successful in keeping up the rhythm and flow of discussion by bringing in new topics and stimulating discussion. Given the overt interest of the second interviewee in profit generation, a question about the identity of the medical doctors was included in the guide. This was meant to explore potential tensions between the medical and business self.

Sampling

After the guide was complemented, fieldwork started. A number of medical doctors were chosen through purposeful sampling and were directly contacted for interviewing. It was deemed necessary that MDs would be, at least, well informed about the international development in patient movement (popularly known as

medical tourism), and, at best, actively involved. Patton (1990) suggests that purposeful sampling enables the selection of information rich cases, particularly useful for effective qualitative inquiry

> 'Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research' (Patton, 1990: 169).

It was, thus, anticipated that MDs with an interest or involvement in servicing foreign patients would share important information (Morse, 1991). Even though sampling was purposeful, a small number of participants proved to have little involvement or knowledge over patient movement, resulting in a sample with a broader variety in responses (Coyne, 1997). These participants, as in the case of the first pilot interview, appeared most often neutral or indifferent and at some times surprised at the research topic. Their attitude indicates that there might be strong polarisation between a minority of medical professionals who are actively involved and the majority that remain to a great extent uninformed of the international and local development of the market.

Identification of participants

An online search was conducted through the Google search engine to identify professionals that would be approached. Using key words such as 'surgery', 'treatment', 'dental care', 'aesthetic surgery' etc. in combination to location names such as 'Greece', 'Athens', 'Crete', 'Rhodes' etc., a number of practices were identified. The choice of key words was guided by the literature on patient movement and internet sources that indicate which treatments account for the

majority of outbound flows from Western countries. By the end of summer 2011 a list with names and contact details was prepared for the fieldwork of the following spring. The criterion used to include professionals in the list was whether their professional website had a version in English and/or other foreign languages. Webpages translated in foreign language(s) were perceived by the researcher as a sign of interest in attracting foreign patients or a necessary prerequisite for practitioners already treating international patients from abroad. Moreover, some of the pages had a special tab dedicated to international patients and/or testimonials from foreign patients. It was shown that in two cases there was no real interest in the subject area. In one case in particular, a webpage in English was deemed necessary to demonstrate their work and profile to colleagues practicing in other countries. In the other case, the English website enabled communication with foreign patients living in Greece, either expatriates or home owners that annually spend the summer period in the country. Other potential interviewees were identified through specialised medical tourism portals that included their practices in their lists. Finally, identification of representatives of two large hospitals was pursued by visiting the establishments directly. Since there was no online information, communication with a range of working staff allowed identification of managers who were involved in international patients' issues.

The choice of geographical areas was based on the observation that practices with (advertising activity and) English/multilingual website versions are basically concentrated in the two largest cities of Greece, Athens and Thessaloniki, and to a lesser extent the islands of Crete and Rhodes. Thereafter, Athens and Crete were

preferred for personal convenience (freely available accommodation and familiarity with both locations), and for representing an urban and a rural area, respectively. In particular, Athens is a large metropolitan area which concentrates the bulk of private health care provision in Greece, and Crete is an area in the periphery with relatively good health care facilities and high international tourism demand. Most often contact was pursued by visiting practices in opening times; meeting very briefly the practitioner in between consultation appointments and, after a brief introduction to the topic, asking him or her to participate in the research. When the medical professional was absent an envelope with relevant information was left with the secretary (presentation of research and researchers, alongside the consent form) and the professional was later contacted via phone. In fewer cases medical doctors were approached through mail or telephone directly. The physical presence was preferred as a way to increase recruitment chances given the particularly tight time frames of private practitioners. In addition, the cultural endowment of Greece favours face-to-face contact as it reduces the feeling of uncertainty. Professionals were, after all, asked to share sensitive information about professional initiatives, perceptions, and experiences through a research method that is still quite uncommon in Greece. Structured questionnaires alongside a positivist understanding of research inquiry remain the most widespread approaches to data collection, especially within the medical communities. In addition, the pool of potential interviewees was not greater than 100 to 150 individuals aggregated for both Athens and Crete, which meant that a low response rate would significantly limit the success of the research study. After participation agreement was given,

most participants favoured telephone calls to arrange an appointment. Calls allowed flexibility and in many instances meetings were rescheduled to prioritise treatment and/or surgery of patients.

Study Participants

The medical specialisations included in the research are aesthetic and reconstructive plastic surgery, ophthalmology, fertility treatment, hair transplantation, dental care, and cardiac surgery. Interviews were also held with a psychologist and a midwife working in medium sized practices, who are in contact with patients from abroad, and two hospital managers. All medical doctors who were actively involved had specialisation or training in other Western countries, with the exception of three. The vast majority gained their specialisation and working experience in the UK and the USA or both, while two of the practitioners were trained in Germany, one in France, and one in Belgium. Specialisation and subsequent training periods abroad are not uncommon for local practitioners[7]. To a large extent it is due to long waiting lists for access to specialisation after graduation. Waiting times may reach a decade, depending on the specialisation, which pushes young doctors to specialise abroad. Similarly, three out of four health professionals and managers have had either a Master of Science or a PhD degree awarded in the UK. The vast majority of interviewees were men, with most women concentrated in dental practice and other non-medical occupations.

[7] For example, the members of the Hellenic American Medical society (http://hams.gr/), an association of MDs of all specialisations trained in US but working in Greece, amount to 273 (last retrieved 26th of August 2012). Considering additionally the number of MDs trained in UK and in continental European countries or even in the non-members of the HAMS trained in US, over the Greek population might give a high ratio of MDs with foreign credentials.

Table 4 Study Participants

Specialisation	No	Athens	Crete	Male	Female	Experience aborad
Cardiac surgeon	2	1	1	2		none, France
Plastic Surgeon	8	7	1	8		UK, US, Germany, S. Africa, Israel, none
Eye specialist	2	1	1	2		US, UK
Hair Transpl. surgeon	1	1		1		none
Dental Specialists	8	6	2	6	2	UK, US, Germany, none
IVF specialist	6	6		6		UK, US, Belgium
General Practitioner	1	1		1		none
Hospital Manager	2	2		1	1	none, UK
Midwife	1	1			1	UK
Psychologist	1	1			1	UK
Total	32	27	5	27	5	

The Interview Process

Considerable effort was put in preparing the interviews. Since prior experience with qualitative methods was limited there were concerns about problems that could be realised only in late stages of the analysis (Kvale, 2007). In the beginning of each interview the purpose of the interview and style of communication within semi-structured interviewing were briefly discussed. Participants were also informed about the usefulness of the recorder and permission for its usage was sought. Questions were mainly of three types: opinion questions, behavioural and a few knowledge questions (Patton, 1987). Opinion or belief questions play a central role in the specific research that seeks to understand how medical doctors in Greece perceive the development of international patient movement. In this case, opinion questions were closely related to knowledge queries. That is because the aim was

to grasp how much information medical doctors have about the extent and nature of the phenomenon within the country and abroad, before understanding what is their opinion about it. Behavioural questions were useful in exploring the service provision to foreign patients and the perceived relationship between doctor and patient. Simulation questions were actually useful in eliciting descriptive behavioural answers, i.e. the person was asked to assume that an invisible observer was present while treating a foreign patient and then comment on what would seem worth mentioning or perhaps striking to this observer (Patton, 1987: 130). In addition, questions that proved useful in eliciting informative insights about the emergence of the sub-market in Greece concerned the personal story behind doctors' involvement in the sector. Overall, follow-up questions on interviewees' answers, probing and prompting encouraged participants to clarify and extend their statements (Kvale, 2007: 4, King and Horrocks, 2010: 40-1). Questions had to communicate neutrality therefore examples of opinions or behaviours of others generally included both positive and negative responses (Patton, 1987: 128). At the end of the discussion, interviewees were asked whether there was anything more they would like to say (Kvale, 2007: 56). It is worth noting that contact is maintained with some of the study participants and follow-up meetings did take place in an informal and relaxed style to discuss developments in the field.

Interviews lasted from 20 minutes to two hours with an average discussion time of 40 minutes. The vast majority took place in the office of the professional. The intention was to make the interviewee feel comfortable so as to better express thoughts, beliefs, motives and emotions (Ackroyd and Hughes, 1992: 103). Two

interviews took place in public spaces at the request of the participant. Overall, attitudes towards the interviews varied. Some interviewees were relaxed and open to share information and thoughts, while others were obviously under time pressure. Disruptions from patients, administrative staff or their peers were also not uncommon. In two cases, hand notes instead of voice recording were preferred by the interviewee. All the rest of interviews were voice recorded and transcribed by the researcher during August 2013, giving almost 180,000 words of text.

Data Analysis

After fieldwork was completed and interviews transcribed, the researcher became immersed in the data for a period of few weeks. Reading and re-reading the material contributed to recognising consistently recurring themes. The subsequent coding of these themes did not take the form of copying and pasting parts under headings. This technique feels like disconnecting the pieces of text from their natural context. Instead, repeated themes were highlighted with colours and had a number assigned; this made easier the navigation of the theme through different transcripts. Themes were then organised into several logical thematic parts distinguished into context-related; perception-related and processes or events that affect the evolution of developments (Wiersma, 1995: 217). These were in accordance to the interview guide and resulted in an ensemble of minor and more important themes. After interrelating them with insights from the sociology of the professions, three major themes were developed and comprised the backbone of data analysis. Before

presenting the latter, a brief presentation of the spontaneously arising themes will help the reader comprehend the successive steps at data analysis.

First, themes of contextual data refer to professional arrangements in Greece, the organisation of the private health care sector, the particular conjunction of the debt crisis with its multi-faceted impact on economy and society, the profile of professionals and their special skills (multi-lingual with extended training or working periods abroad), and the profile of foreign patients. The second thematic unit relates to the perceptions of interviewees about a number of developments and the actors involved. These include self-reflections, the growth of internationalisation of health care in a global scale, the state in Greece and its role in attracting patients from abroad. In addition, interviewees elaborate on perceptions of the patients and their interaction; their peers and their associations; the intermediating companies, and the future of Greece in that area. Finally, themes related to processes and events include motives to develop foreign clientele, the origins of the idea of developing one in itself, the actual way they do so, and the way MDs negotiate with agents. It is clear that the themes are infiltrated by theoretical insights from the sociology of the professions in multiple ways. For example, the micro-politics between professionals and the new actor are largely conceived within the framework of professional dominance, according to which professionals tend to impose their control over the work of other actors in health care supply (Freidson, 1985). In addition, incentives of medics to develop foreign clientele are understood within the framework of a new type of professionalism, more akin to a commercial logic. Following the logic of abduction, it is recognised that ‘facts do not speak for themselves; they must be

interpreted' (Denzin, 1978 cited in Patton, 2002). Deep consideration of the meaning of these diverse thematic units and their interrelation to the theory of professions, through a 'view from the top' synthetic process, leads to their organisation in few central parts. As a result, three major themes prevail, with minor ones playing a pivotal connective role. In the next section, it will become clear how these minor themes support the coherence and, simultaneously, guarantee the smooth flow of argumentation throughout the ' presentation of research findings.

Synthesis

Patton (2002) would place the process of data analysis deployed above within the framework of a theory-based analytic approach. In particular, the last phase of data analysis falls under the 'creative synthesis' phase where all pieces are brought together into a 'total experience' (Patton, 2002: 487). Similarly, this piece of work discerned three major themes, which were analysed through the sociology of the professions, to be finally synthesised for presentation purposes in three chapters.

The first major theme examines the role of professionals in the emergence of the market, captured as an unfolding entrepreneurial albeit disaggregated agency. This first major theme relies largely on two minor ones for coherence and insightful comments. Namely, how professionals conceptualise international patient movement with respect to their profession and Greece (i.e. an opportunity for profit and economic growth, respectively), alongside their perception over state and their associations (low trust) offer valuable insights on the basic theme which presents the role of medics in the emergence of the sub-market. To a great extent it explains

the entrepreneurial but disaggregated style of agency. In the second chapter, the positive experiences with patients but problematic interaction with travel agents leads to a consideration of politics within the new internationalised landscape. The theory over deliberate actions that fortify dominance finds a new application here. Medical professionals feel challenged and thus restrain collaboration with the new actor. In contrast, satisfaction is derived from the doctor - (foreign) patient relation suggesting that professionals do not feel challenged by the perceived well-informed and empowered patients. The second major theme emerging from the data narrates thus the negotiation of power relations in the new market. This differentiated attitude towards other agents, alongside their entrepreneurial initiatives, calls for a closer examination of the professional value system and identity. It is the latter two entities that the third theme develops; the penetration of entrepreneurship in the professional value system and the generated ambivalence in professional identity. These are explored through self-reported motives and concerns over the practice of servicing foreign nationals.

While, then, the first two thematic parts contribute to the bigger picture of the function of the submarket, the third one offers a much deeper qualitative analysis of the value system and identities of professionals. A well-thought organisation of contextual and major themes in two levels, a macro and a micro-perspective, does not only contribute to a rich understanding of the market dynamics and the role of medical professionals within. It is also well fitted with the sociology of the professions, as a theory that draws on and develops both levels of analysis; the

collective agency and individual behaviour; alongside the macro trends and micro work-environment within organisations.

Research Ethics

Research is a mode of human activity within society and, thus, moral judgments are embedded in it (Ravetz, 1971: x). In light of this, researchers are called, through all phases of research, from conceptualization, design and implementation to data analysis, to consider which of their choices are right or wrong. Davies and Dodd (2002: 281) argue that ethics are 'always in progress, never to be taken for granted, flexible, and responsive to change'. Researchers are called, in addition, to consider the impact on various actors; the participants, their peers and discipline, the readers of the study, the whole of the society but also knowledge itself. This study aspires to enrich scientific knowledge through the lengthy social process of research involving directly and indirectly a number of stakeholders.

Looking at the various steps of the research process, defining a research question incorporates, except for implicit assumptions, value judgments that predominate over others, (May, 2001: 51). This study in particular reflects Weberian and Marxist thought due to its reliance on the sociology of the professions, which has necessarily played a role on shaping the research question (i.e. to understand what the role of medical professionals is). Its ontological position over the existence of social reality and an ability of agents to shape it are also influential assumptions. Similarly, the choice of research method might depend on preference instead of suitability (May, 2001:53), albeit in this particular case, the qualitative nature of

inquiry and the kind of research questions highlight the clear advantages of qualitative interviewing. Interpretation of data and reaching conclusions is also not value free but rather a 'political, contested and unstable activity' (Maynard and Purvis, 1994: 7 in Sin, 2005: 281), while, the results and conclusions of the research study can be used in more than one ways for different purposes (Sin, 2005: 281).

Basic focus of the research ethics remains, however, the stance of the researcher towards the research participant. Six basic principles are widely recognised as a guide for the protection of people participating in a research, which Brinkmann and Kvale (2005: 167) call the microethics of research. These are the well-being of participants, informed consent, privacy, confidentiality, honesty and deception, integrity. It is recognised that research could potentially harm participants. De Laine argues that qualitative research in particular demands 'more maturity, greater sensitivity, authenticity and integrity' (De Laine, 2000: 16) and suggests that the researcher has 'to be with rather than look at' the others 'the with standing for a symmetrical relationship' (De Laine, 2000: 17 and 44). Often the research setting is the everyday environment of participants in which the researcher intrudes. In response to these considerations, the researcher in the current study did recognise the sensitivity of the working space of health professionals, their relationship with their peers and other staff. Participation might prove stressful or disturbing at instances and might also cause an unexpected self-awareness, which the person might not be in the right psychological situation to deal with (Sin, 2005: 279). In field work, things become more complicated when participants are in especially vulnerable groups of people, such as children, patients, elderly or

individuals with disabilities. Even though participants of the specific study did not belong to a sensitive group as such, they did discuss and disclose sensitive professional issues, which were and are treated carefully. Respect of privacy is a major ethical issue during research. Discussions were thus restrained to the public sphere, keeping aside the private life of participants.

Confidentiality should be also assured, as it is important both for the achievement of consent and the respectability of privacy. As Gregory (2003: 50) suggests, participants will not disclose their opinion, thoughts, and emotions about themselves, organizations and institutions, unless they are assured about confidentiality. Further than this, anonymity through publication is essential so as to protect participants from identification. Participants should not be able to recognize themselves in the writings as they might feel deceived and exploited (De Laine, 2000: 29). Sin (2005: 281) argues that researchers have to deal with the 'politics of disclosure'. The term is coined by Renzetti and Lee (1993) to refer to the issues concerning which data and what aspects of the data analysed should be revealed, who should have access to them, how the results will be published. For this reason, the cover letter provided to potential participants before the study included information about the researcher, the research questions, how data will be stored and who will have access to them. It was always suggested before the interview that they can have a copy, and in one case a copy was indeed requested and provided. The last two principles of research ethics refer to honesty and deception and integrity of the researcher. To respect these principles the researcher refrained from

any action that would manipulate, ignore or change the results of the conducted study.

In summary, research is not conducted in an ethics free zone. A researcher needs to reflect on her own assumptions and actions. Priority for the investigator is to conduct research without causing harm to any group or individual, but also with the will to serve society and enhance scientific knowledge. Gregory (2003: 52) suggests also, that if researchers were to harm in any way the participants, the trust in social scientists would be endangered and downgraded. He also suggests that violations of the trust in the research community have potentially detrimental effects to the research community (Gregory, 2003: 65).

Reflecting on the Research Process

Evaluating the impact of the researcher on the research process and the collected data is a significant part of qualitative research. The study design, fieldwork, analysis, and writing up are all influenced to a certain extent by the background, age, gender and approach of the researcher (Patton, 2002; Irvine and Gaffikin, 2006; Richards and Emslie, 2000). This part aims to briefly assess the impact of such influence on the research phases of the current study. In light of this, it seems important to start by introducing briefly the researcher: a female in her late twenties, who is trained as an economist, from a prestigious European University, conducts sociological research based in a university in the UK. She approaches medical and health professionals in Greece during a period of economic crisis for the country to ask them to participate in research examining their professional

perceptions and plans about a relatively new phenomenon for Greece: medical tourism. The methodology employed is largely unknown to participants. Thus, overall, the research is exploratory in the way the researcher is herself immersed in new ideas and methodological approaches, which she then introduces to participants who are unfamiliar with the qualitative paradigm and the researcher.

Study design

The research study was initially driven by an interest in the development of the internationalisation of health care. While several studies start from the theory, identify gaps and aim to offer insights, the empirical phenomenon was the centre of attention of the current work. Looking at the various actors and the under-developed literature on 'Medical Tourism', the most obvious gap was an outstanding lack of knowledge over patient decision making and experiences within the internationalised context. Exploring the perspectives of patients through qualitative inquiry was deemed, at first, a priority. Despite that, considering my background in Economics and quantitative methods, which coincided with lack of experience and skills in qualitative research, the research focus was reconsidered. Patients comprise a vulnerable group and since good intentions were not backed up by at least some research experience an ethical dilemma arose. At the same time, since the research would be geographically focused on Greece, another actor appeared as a particularly intriguing case for exploration. There was evidence that medical doctors play a significant role within the sector. As such, research on patients moving abroad for health care was postponed potentially for post-doctoral research and medical doctors as key actors became the focus of the study.

A qualitative approach has been something new, a significant change in conceptualising and analysing the research objectives. Coupled with a sociological approach instead of one based on economic theory it has proven to be a radical change; as much as an exciting challenge to accomplish. A determination to qualify research dexterity with qualitative skills, and a passion for the topic under investigation have been great sources of inspiration to carry out the project within relatively tight time-frames.

Fieldwork – An Equal but Outsider

Perhaps the most important consideration for a researcher is to reflect on the degree of participation and involvement in the fieldwork and the image participants shape for her (Patton, 2002: 331). In the case of the current research, the setting was formal, most of the times in the office or practice of the interviewee, an hour before, after or in between appointments with patients. In such a formal setting most of the times it was not clear how my age and gender affected the process. I assume in some instances it facilitated access. Nevertheless, comments on my (underestimated) age or my presence as a 'girl' doing an interesting piece of research were expressed only twice. The high status attached to PhD studies, graduate and post-graduate degrees attained at good universities within the country and abroad, and living in four different countries for work and studies, affected the process by making it 'formal' and 'professional'. On the one hand, most participants have had training at good universities, extensive work experience in foreign countries and personal experience of living abroad, so in some sense I was perceived as an equal. That became obvious in several cases when I was asked

whether I would prefer to stay in Greece or live abroad, a dilemma they faced themselves before returning to Greece. On the other hand, without reference from a friend or relative, or even without medical training, for some I was an outsider. In one case, it was initially assumed I was a medical school graduate, while in other cases there was some ambiguity about my role, expressed through questions about future professional plans. Several participants asked me, for example, whether I am intending to do business as a medical tourism intermediary upon completion of my degree. While some were interested to learn because they would be open for collaboration, others were actually 'suspicious'. The latter was illustrated by the comment of a dental surgeon who knew 'an economist trying to come into agreement with MDs and be the manager of the whole thing. Because when there is money everybody wants to get involved'. I would then take the opportunity to clarify that I have had working experience before in the private sector and that I was planning to pursue a solid academic career in the future. Reflecting on that, I came to wonder whether having presented myself as a sociologist or perhaps as coming from a department other than that of 'Management' within a 'Business School' would potentially affect their perceptions over my role and intentions. It is also interesting that several participants, though not all, would agree to give me an interview as they expected to discuss with an 'expert' in the field, get information about the developments, or simply share ideas and information about an interesting topic. For some, there was a potential that I would make their problems public and could potentially push the government to take action to support the sector.

With regards to the research technique employed, most participants are unfamiliar with qualitative interviews. Nevertheless, person-to-person interactions over an issue (most commonly health status) form their daily routine. In that sense the discussion was something they were comfortable with. Either with patients or medical representatives, even in some cases with journalists, MDs are not only experienced in face-to-face interactions but are normally the dominant participant in the relationship; their role is to advise or offer their opinion as an expert. Keeping that in mind, I would carefully phrase my questions, though the reversed 'ritual' proved unusual for some. This is illustrated by the case of the owner of a dental clinic who had met me several times before the interview and with whom there was already familiarity and rapport in place. Still, on the day of the interview he wondered why he had to comment on the topics I was interested in and thinking aloud wondered whether 'this was all about a quiz' he had to answer.

If it had not been for a short period of working experience as a door-to-door sales person in my undergraduate past, I consider that the learning curve from the fieldwork experience would have been much steeper. Irrespective of the research topic, interviewing a considerable number of people over the same issue is certainly informative about how differently people react in similar situations. As a result, the learning curve involved more knowledge over the movement of patients, the medics in Greece, their views over the development and their self-perceptions. I consider I have also learnt a lot about the politics within the country and how in particular the health care system works. More importantly, I feel privileged to have met a significant number of notable people before completing the fieldwork.

Analysis

As themes started to emerge in the data analysis phase, confusion arose with regards to literature on the Professions. The honest reference of participants to profit making was somewhat surprising, when a rhetoric of disinterestedness instead of self-interestedness was anticipated. Additionally, the lack of an internal cohesion within the profession, the low opinion of members over their associations, the perception of the state and politicians as an enemy, were also striking. Certainly professionalism in Greece does not take the form it does in the UK, partly because there is a strong private sector and this is where I was looking. Initial biases over what professionalism is, clearly spurred by the focus of the literature on 'professionalism of old' which 'is grounded in autonomy and dominance and houses an immense disdain for commercialism' (Castellani and Hafferty, 2006: 12) soon came to an end. Explanatory power was minimal, while most recent contributions from the US over MDs as businessmen or new interpretations of professionalism through examples of different country cases and work settings proved informative. This analytical strategy itself was something new for me. With regards to data analysis an Economics background implies a positivist epistemology; most commonly there is a theory that the researcher tests against the (collected) data. In contrast, qualitative data analysis means that the researcher searches through the literature to discover which analyses and pieces of work are most relevant to the emerging themes. Similarly, which theoretical insights are particularly useful in making sense of the data, and in the end what new elements does the data add to these accounts and retrospectively how theory is enriched. This is a slow and

painstaking procedure and one that emphasises synthesis as much as analysis. There was nothing that could have prepared me to deal with the ambiguity of qualitative data and the continuous interaction of collecting data, reflecting on theory and empirical context, reading new papers, re-reading the old ones, analysing, synthesising. The room for creativity and imagination in sociological qualitative analysis allows parallelisms to art making, indeed allowing its comparison to an artistic endeavour.

Conclusion

This chapter began by discussing the commercialised context within which the internationalisation of health care takes place. The argument put forward is that within a marketised setting, key players tend to act like market agents. While this might not appear as an argument of exceptional novelty, things are not so straightforward when the discussion comes to medical providers and specifically medical doctors. Essentially, it has been for long time the case that medical professionals distance themselves from commerce. Nevertheless, a careful observer of transnational health care soon realises that solo practices of medical doctors account for a significant part of the overall international patient movement in a range of countries. This presupposes entrepreneurial agency which then raises the question of what is the role of medical professionals, how this is realised and obviously how it is justified. These questions sought to uncover the agency of medics and reveal the mechanisms that account for it. They are essentially qualitative in nature and as such require the conduct of qualitative research.

Perceptions, beliefs, experiences and attitudes need to be explored if the research questions are to be answered and this can only be better served when someone asks directly the person of interest to talk about them. Semi-structured interviews were thus deemed most useful and the researcher embarked on the fieldwork with a guide to questions.

After two pilot interviewees, a series of interviews took place with health professionals in Athens and Crete. The collected data were read and re-read in order to discern patterns of themes. Indeed, themes were soon to be observed, often already considered during interviews. They were carefully coded and analysed according to whether they were related to the context, perceptions or whether they had to do with processes potentially causing generation or evolution of events. The next and final step was to make sense of these themes in a broader sense and synthesise a picture which successfully represents what the participants experience, think and do with respect to the internationalisation of health care in the current highly commercialised context. It is there that the data analysis chapters turn by demonstrating the research findings of this stimulating research journey. Before presenting the data analysis, a brief presentation of the health care system and professional power in Greece takes place. The aim is to introduce the reader to key characteristics of domestic provision and the medical profession, in order to set the scene within which the empirical research takes place.

CHAPTER 6

PRIVATE HEALTH CARE AND THE MEDICAL PROFESSION IN GREECE

This chapter offers some background to the health care provision in Greece and the position of the medical profession within it. Primary aim is to introduce the reader to the dynamics of the private sector, which is the focus of the empirical research. Nevertheless, private provision is inextricably linked to the public one with respect to health policy, and, as such, it is deemed necessary to present here both. Attention is drawn on particularities of the domestic health care as they comprise important contextual information. Characteristic examples are the oversupply of medical professionals, the corruption within the public sector, and the profitability of the private sector. In addition, in order to prepare the reader for the data analysis, the chapter examines the nature and sources of medical power in Greece. While in the public sector power stems from a clientelistic relationship with governing parties, which is interwoven with party politics, in the private sector, the uninterrupted relationship between the patient and the doctor allows medical professionals to maintain a dominant position.

The Public Health Care Sector in Greece

In most countries that a welfare state was established during the 20th century, the state assumed responsibility of public health. In order to secure protection of the general population it initiated collaboration with medical professionals which resulted in replacing 'clinician's traditional contract with the individual patient […] by one with the state' as Doolin notes in his work about New Zealand (2002: 374). In Greece, however, despite the establishment of a National Health Care System in 1983, a real NHS never existed (Cabiedes and Guillen, 2001) due to partial implementation of the corresponding laws. Specifically, despite the mass recruitment of MDs, the expansion of health care facilities all over the country and the restrictions on private provision during the 1980s, the plan to create an NHS largely failed. As far as medical professionals is concerned, the state never managed to control user fees to medical doctors, as for example, was the case in Canada (Coburn, 1993: 94), nor to replace the 'contract' between practitioner and patient. Banned user fees took the form of illegal payments which gave way to the emergence of a corrupt system, never to be resolved or controlled. Informal payments by patients to doctors within the Greek NHS confirm an uninterrupted (financial) relation. Unsurprisingly, a clear distinction between the public and private sphere was never achieved (Cabiedes and Guillen, 2001). In fact, MDs often use their tenure in the NHS to redirect patients to their private practices. In addition, a significant percentage of MDs in the public sector receive financial rewards to direct patients to private diagnosis centres and prescribe specific drugs by pharmaceutical companies.

The Private Health Care Sector in Greece

The private sector in Greece expanded rapidly during the 1950s and 1960s, mainly through the increase of solo-practitioners and small clinics (Economou, 2010). Their development depended to a large extent on contracts with (public) insurance funds for primary care (Economou, 2010: 20). With the establishment of the National Health System in 1980s, the expansion of the private sector continued through diagnosis centres mainly established by health professionals (Economou, 2010), as restrictions were imposed upon private for-profit hospitals and several non-profit institutions were nationalised (Cabiedes and Guillen, 2001: 1214). The impact on private establishments was substantial.

> 'While most of the small clinics were closed down, some of them, as well as private hospitals with luxury facilities, survived by signing contracts with private insurance companies and, more recently, also with the social insurance funds. These are mainly general and maternity hospitals' (Economou, 2010: 34).

Restrictions on for-profit hospitals were abolished in 1990s and were not re-introduced. Instead, at the time, non-profit private establishments were provided with subsidies and patients obtained the right to choose among both public and private providers (Cabiedes and Guillen, 2001: 1214). Economou suggests that today private hospitals are more than 200 and account for 25% of the total days of hospitalisation in Greece with public hospitals accounting for the rest. Most of the private hospitals and clinics are medium or small sized and offer moderate quality services. Few have large facilities with considerable capacity and maintain state-of-

the-art equipment which allows them to offer high quality of services. According to Boutsioli (2007), concentration in the sector is high, as four general and neuropsychiatric hospitals have half of the market share, and two of the maternity hospitals hold 81% of the market share. It is important to note here that most often hospitals' founders and shareholders have been groups of medical doctors. It is only recently that businessmen entered the health care sector (Economou, 2010: 71).

As far as patient recruitment is concerned, patients usually do not walk to private hospitals to seek health care. If they do not seek consultation in public facilities, they visit specialised medical doctors in their private practices. In fact, medical specialists have a central role in private health provision in Greece. Around 65% of specialists work in the private sector; while solo private practices have been estimated as more than 20 thousand back in 2005, with around 1000 MDs joining per year (Tountas *et al.*, 2005). MDs are most often paid on a fee for service basis and their fee usually ranges from 40 to 100 euro (Economou, 2010), with university professors earning considerably higher amounts per visit. Financing of health care in the private sector comes from private and public expenditure with the latter being considerably lower than the first. It is basically private expenditure that covers health care costs in the private sector, while the largest part of it is paid by patients out of pocket.

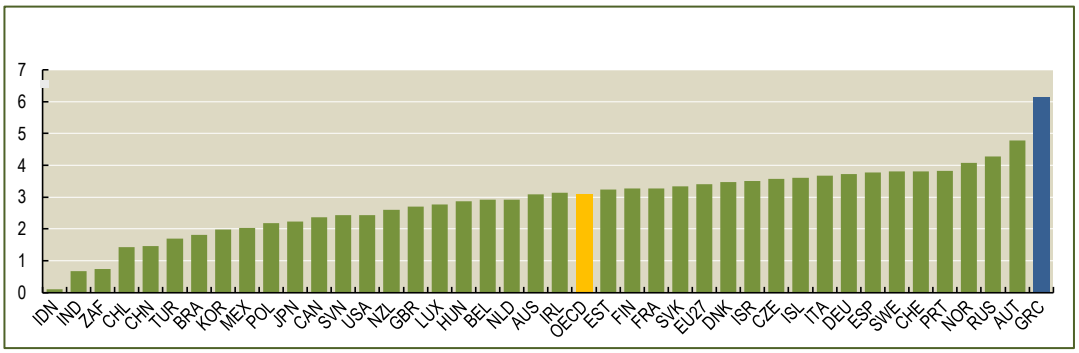
Professional Power

Power to influence public policy by Organised Medicine

Wilsford (1993: 128) frames the vigour of collective medicine within two dimensions; internal cohesion and ability to influence the context within which the medical profession works. Even though research on the internal cohesion of the Greek medical profession has been somewhat scarce, efforts of medics to manipulate health policy has been highlighted by a number of scholars as instrumental (Economou, 2008; Nikolentzos and Mays, 2008; Mossialos *et al.*, 2005). In contrast to this view, Colombotos and Fakiolas (1993) suggest that fragmentation and 'organizational weakness' (Wilsford, 1993: 128) lead to an inability of Greek MDs to effectively influence public policy. The latter view is based on a number of arguments. First, official medical associations in Greece are public institutions and act on behalf of the state. Specifically, their internal function is defined by state laws; as such they operate under governmental surveillance, while their advisory role to the ministries is effectively downplayed (Colombotos and Fakiolas, 1993). In addition, the scholars stress as a cause of weakness, the penetration of political parties in medical associations (Colombotos and Fakiolas, 1993). According to this argument, representatives of associations have been open supporters of one of the two largest parties succeeding one another in power during the last decades. As a result, medical associations support or struggle against health care plans (very often through strikes) depending on the leader's party affiliation instead of the benefit of professionals and the profession (Colombotos and

Fakiolas, 1993: 145). This fragmentation along party politics is considered detrimental for organised medicine in Greece (Colombotos and Fakiolas, 1993) as it has been argued also for Italy by Krause (cited in Hafferty, 1988). One could add in the line of argumentation about weakness, that the medical community in Greece does not control credentialing, licencing or the number of medical school graduates. Undergraduate and post-graduate training of medical professionals are under the surveillance of the Ministry of Education, while licensing is provided by the Ministry of Health Affairs (Economou, 2010: 30). As in France (Wilsford 1993: 129), in Greece the establishment of new medical schools by the state (during '80s) led to an oversupply of medical doctors which took place literary out of medical doctors' control. The increasing numbers were further accentuated by significant numbers of locals studying medicine abroad. As a result, Greece has the highest physician/citizen ratio among OECD countries (6.13 MDs per 1000 inhabitants, OECD Factbook 2013) a fact that creates conditions for fierce competition in the private sector. Tountas *et al.* (2005) suggest that this oversupply of practitioners leads to a supply-induced demand.

Figure 8. Practicing Physicians over 1000 inhabitants



Source: OECD Factbook 2013: Economic, Environmental and Social Statistics

A number of scholars, however, hold a different perspective on the power of organised medicine. The difference might lie in the fact that the latter examine the agency of non-official trade unions of MDs which often draw power from physicians in the public sector. Evidence of the ability of MDs to influence public health policies is provided by the work of Nikoletzos (2008), who emphasises the role of doctors in blocking healthcare reforms during the period 1983-2001. Specifically, MDs' professional associations have directly disputed, opposed or even blocked any reform that was perceived as negatively affecting their working rights and status. Even though fragmentation between the elite practitioners and the young graduates has been at times strongly evident (Nikoletzos, 2008), MDs have in general worked together in protecting their professional position. Since strong professional associations have not been recognised by the parliament as official consultation bodies, they have been influencing the parliament decisions mainly through (non-transparent) lobbying practices or strikes (Nikolentzos, 2008).

Some scholars suggest that a basic driver of medical professionals' agency against reforms was a desire to maintain the informal payments' system in place. For example, Mossialos *et al.* (2005: 161) advocate that hospital doctors' unions have successfully resisted recommendations of an international committee report back in 1994 claiming that the suggested changes hinder their permanent employment in the public sector and that they impose an unacceptable 'actuarial' logic upon medical care provision, whereas they feared also that informal payments and the clientelistic culture within the public hospitals was threatened. In another case that a 1992 law faced strong opposition, Nikolentzos and Mays (2008: 169)

suggest that according to a number of parliament members interviewed, opposition by the majority of medical associations was due to MDs' preference for informal payments while working in public hospitals rather than in a setting in which they would work part-time in the public sector and would be taxed for their private surgeries as provided by the law.

Similarly, Sotiropoulos (2004) focuses on resistance to health care reforms since 1983 to showcase medical power. He notes, however, that university professors along with public hospital employees and investors in the private sector have undermined the reform efforts. Other writers also recognise additional groups who contributed to the disruption of public policy, such as, the noble funds (Mossialos *et al.*, 2005: 149), and 'protected categories' which refers to relatively privileged funds (Guillen and Matsaganis, 2000: 124).

> 'the opposition of the powerful trade unions affiliated with the noble funds, the liberal professions, and the medical profession, hindered the formation of a universal health insurance system and resulted in the growth of 'both informal payments and private provision' (Mossialos *et al.*, 2005: 149).

Though the above observations may correspond to collective efforts of medics in Greece, it is important to note that it is not merely the health sector that has been characterised by a lack of planned policy implementation due to reactions from various groups. Most interest groups within the country exercise similar pressures. The effectiveness of pressure is interestingly enough similar in almost every sector;

particularly the public sector[8]. The state does not enforce most 'necessary' changes and reforms. Numerous plans concerning development and modernising of the economy (i.e. during '80s) remained as studies and pre-election announcements never to be implemented. Except for social policies, industrial policies during '80s which targeted at boosting exports and advancing technologically production units largely failed too. Lyberaki and Tsakalotos (2002) employ an institutional theory approach to give basically two explanations for this situation. First, this failure is often understood within the framework of a clientelistic political system that perpetuates itself in the country.

> 'This initiative, like so many in PASOK's first two terms (1981–89), suffered numerous delays and was never fully implemented. […] as in all other areas, PASOK's policies were crucially undermined by the role of clientelistic practices in the appointment of personnel, in the use of the new institutions as informal instruments of selective social policy in order to consolidate PASOK's social and electoral base, and by ad hoc political interventions at all levels […]Delays in getting the appropriate legislation together, spasmodic and incomplete implementation, and attempts at avoiding the political cost were just as evident in the 1990s as they were in the 1980s' (Lyberaki and Tsakalotos, 2002: 104).

[8] There seems to exist a strong division in the labour market between the public and private sphere with people working in the latter abstaining from strikes and demonstrations basically as the vast majority works in small companies. A short period of industrialisation in '50s and '60s was followed by de-industrialisation in Greece, during which manufacturing units shut down or moved abroad, while after 1980s the service's sector comprising mainly from small and medium companies has been inflated occupying the majority of the labour force.

Similarly, Guillen and Matsaganis (2000) in their analysis of the welfare policies in Mediterranean countries note for Greece:

> 'While the socialists fought, not convincingly, against allegations of corruption at the highest level, their social policies seemed to reinforce the clientelistic aspects of Greece's welfare state' (2000: 124).

The other argument provided by Lyberaki and Tsakalotos (2002) is the mistrust, omnipresent in Greek society, especially towards governments. This provokes constant reactions and each group is interested in fortifying its sole position and in protecting its own rights irrespective of the policies introduced and the 'general good'. It is not that only doctors or only professions do so. Most occupational or working unions do, many of them successfully. Actually, clientilism and populism exercised by the governments largely fed (and feeds) mistrust.

> '...mutual suspicions between the groups, and between such groups and the government—whose inclination, let alone ability, to enter into long-term credible commitments was, somewhat justifiably, always in doubt—made the focus on short-term gains the dominant strategy, fatally weakening the policy of socialisation even before it had got off the ground' (Lyberaki and Tsakalotos, 2002: 104).

That does not mean that medics in Greece do not hold a strong position within society. There is plenty of evidence that they control public and private resource allocation and are almost under no type of surveillance. Nevertheless, politics in Greece are complicated and cannot be easily understood in isolation from the whole

picture or the institutions in force. In fact, the success of MDs in influencing policy can be better understood as part of making politics in Greece by a state unwilling to enforce changes or the laws in most spheres of social and economic life.

Autonomy over Content of Work in the Public Sector

Freidson suggests that medical dominance is retained based on control over the content of work by medical professionals (Freidson, 1985) even when it is not possible to exercise control over the conditions and terms or work. Under this rationale, the autonomy of MDs in Greece is not a matter of debate; medical doctors both in the private and public sector avoid surveillance over the content of their daily work and the allocation of resources. Specifically, in the public sector managerialism affected medics and it remains to be seen to what extent the New Public Management, enforced by the Troika intervening in the Greek internal politics during the last three years, will be implemented. Absence of any type of control over doctors' work becomes evident by lack of work guidelines, position descriptions, or institutionalised productivity motives (Polyzos and Yfantopoulos, 2000). In addition, Rovithis (2006) reports substantial misallocation of resources in the public sector due to lack of cost-effectiveness in ordering supplies or vested interests by MDs who are responsible for these.

> ‘The above ideology impacts on public procurement policies (mainly in hospitals) for supplies and equipment, where there is no actual assessment of needs and procurement is usually based on doctors’ opinion. […] Doctors often have financial interests in promoting expensive medical technology or have the

perception that the latest or apparently more high-tech equipment is necessarily highly effective' (Rovithis, 2006: 391).

Autonomy of MDs in the public sphere actually crosses the limits and reaches corruption. Except for lack of control over their work, MDs are often accused of encouraging bribing. It is estimated that at least 80% of physicians in Greece receive bribing by their patients in the public sector (Nikoletzos and Mays, 2008). Empirical studies suggest that patients seek high quality of care and faster access to healthcare by bribing medical doctors (Liaropoulos *et al.,* 2008; Siskou *et al.*, 2009) while no less than 20% of the respondents of a questionnaire stated that MDs *demanded* an informal payment (Liaropoulos *et al.*, 2008). The situation seems worst when it comes to surgeries where the chances of an 'under-the-table' payment are 137% higher. Socio-economic characteristics of patients do not play a role in informal payments (Liaropoulos *et al.*, 2008). As far as their relationship with pharmaceutical companies is concerned, Rovithis suggests that MDs receive payments to promote specific or new drugs.

'Physicians are eager to prescribe expensive new drugs for reasons of profit due to relatively high margins between the reimbursement and market prices, and because of the secret deals between them and the pharmaceutical companies, which use financial incentives to promote the prescribing of their products. This problem seems to be particularly intense with IKA (Social Insurance Fund) doctors, the salaries of which are low and often seek alternative ways to supplement their income' (Rovithis, 2006: 391).

Economou (2010) also relates corrupt practices of MDs in the public sector to low salaries.

> 'Doctors and dentists contacted by social insurance funds are paid on a fee-for-service basis, which theoretically induces unnecessary demand for health care services. Some physicians charge for additional visits or prescribe more diagnostic tests and drugs than are medically required in order to boost their income. Also, as fees are usually set at a very low level, informal additional payments are regularly made by patients to doctors' (Economou, 2010: 66).

Over-prescription of drugs becomes evident by the high levels of consumption of drugs per capita in Greece (Tountas *et al.* 2005). Similarly, according to Cabiedes and Guillen, (2001: 1214) practices such as excessive prescription of diagnosis tests and redirection of patients from the public to the private practices are largely orchestrated by MDs in the public sector and in the long term have made impossible a clear distinction between the private and public provision (Cabiedes and Guillen, 2001: 1214). As it will be elaborated below, over-prescription of drugs and diagnosis tests occurs in the private sector for similar reasons.

Another aspect of medical autonomy is the extent to which MDs are held accountable for medical mistakes. In Greece, there are no formal review procedures for practitioners nor is there a patient complains system in place. 'Conspiracy of silence' is a term used to describe the observed unwillingness of practitioners to testify one against the other in court (Freidson, 1985: 25). While in US the practice has largely ceased after 1960s, in Greece medical doctors continue to cover up

mistakes of colleagues. ‘Doctors’ mistakes are buried’ is a common phrase within medical communities in Greece, which portrays both the seriousness of consequences for patients and the widespread impunity for medical mistakes. Polyzos and Yfantopoulos (2000) highlight that charges by the disciplinary bodies are extremely rare. In contrast, restrictions on advertising and marketing are enforced (even though not for all specialisations). This supports collegiality and mitigates market competition, leaving MDs relatively intact from common marketing practices.

Medical Authority in the Private Sector

Irrespective to power to shape macro-economic policies, i.e. their power vis-à-vis the state, the position of medical professionals in the actual provision of public and private health care appears privileged. Patient recruitment is central for medical dominance in the private sector, since patients most commonly contact an MD when they face a health issue. They choose their doctor most often based on word-of-mouth, therefore, practitioners do not depend on third parties for patient recruitment. The patient pays health expenses mostly out-of-pocket (Tountas *et al.*, 2005) according to MD’s advice. This sets medical professionals in the advantageous position of allocating private spending. Namely, on behalf of the patient, MDs order diagnosis tests, drugs’ consumption, hospitalisation and invasive/non-invasive treatment. Statistical data show that more than 37% of health expenses are private expenses (Economou, 2010: 47) placing Greece among the countries with highest private expenditure both within the EU and OECD countries (Avgerinos *et al.*, 2006).

Even though significant portion of that amount is absorbed by the black market of informal payments in the public sector (cite), a substantial portion is directed to the private sector.

At the same time, MDs develop client-provider relationship with private hospitals. They are affiliated with one or sometimes more hospitals and use their facilities and health staff for therapy of their patients. Since a contractual or an employee-employer relation is not established, conditions required for any type of control over MDs' work have not emerged as yet. In contrast, hospitals' profits depend basically on affiliated MDs' decisions over their patients' health needs. Similar relations are developed between MDs and diagnosis centres or pharmaceutical companies, which often give incentives to MDs to boost demand. Indeed, supply-induced demand is a well-documented phenomenon in Greece, with a number of scholars framing it as one of the main problems of domestic health care provision. The phenomenon is partly explained by lack of cost controls over privately practicing MDs.

> 'Apart from the large number of doctors, overconsumption is fed by the lack of any sort of control over the practice of private doctors who do not implement any gatekeeping role, neither for hospital care nor for referral to diagnostic or other specialized services. In most cases, doctors are paid a percentage for each referral. A similar situation occurs for drug prescription which pose a burden on the overall cost of medical care' (Tountas *et al.*, 2005: 176).

In addition, according to Economou (2010: 47) only 2.1% of health expenditure is covered by private insurance. In its absence there is limited auditing on private health care expenses. In other words, MDs hold the key of the whole private health care sector by maintaining an uninterrupted recruitment process and relationship with patients. The aim of this section was to highlight that medical professionals direct patients to hospitals, diagnosis centres and define medication consumption, no matter how the expenditure is covered (by insurance funds or out-of-pocket). This generates a client-provider relationship between MDs and the rest of health care suppliers who are eager to bribe or give portion of their profits to MDs so as to secure the greatest possible part of patients' expenditure.

Conclusion

Medical doctors have a special position within the health care sector in Greece, both in the public and private sphere. This becomes evident by the autonomy they enjoy in their daily work; their power to influence policy making; and the privileged position among other key actors in the health care provision, such as private investors and third party payers. At a state level, medical associations' agency is perceived by scholars as a significant driver of unsuccessful implementation of several health care reforms. This view, even though not universal among commentators, highlights a profession with the ability to shape or at least to disrupt public policy. As far as autonomy over content of work is concerned, managerialism has not affected MDs in the public sector; MDs have control over resources while no accountability mechanisms are put in place as yet. In addition, affiliation with more

than one hospitals, instead of employment or contractual arrangements, allow MDs working in the private sector to set their terms to a large extent. It is noteworthy, that hospitals' founders and shareholders are to a large extent doctors themselves, a fact that has only partially been changed recently. In addition, MDs take over decision making on behalf of their patients and as a result direct health expenditure (both out-of-pocket and amounts covered by insurance funds) to providers of their choice. This transforms MDs into clients of all health care suppliers: hospitals, diagnosis centres, pharmaceutical companies and in some cases medical equipment manufacturers. The ability of MDs to control patients' decision making process and private expenditure proves crucial as it gives an advantage over other actors in the health care provision. The above indicate that despite their overpopulation and lack of control over licensing and training, MDs dominate the health care sector in Greece; indeed one of the most profit-generating industries in the country, at least in the pre-crisis era.

CHAPTER 7

CONCEPTUALISATION OF INTERNATIONAL PATIENT MOVEMENT & THE ORGANISATION OF THE SUB-MARKET IN GREECE

This chapter demonstrates the central role of medical doctors in the emergence of international patient movement through the example of medical doctors practicing in Greece. The participants speak of their business initiatives to attract foreign clientele, their views over the phenomenon of international patient movement broadly, and explain the reasons why action is individualised instead of collective. It prepares the ground for the next topic which investigates the politics in the emerging internationalised health care market. In particular, the considerations and actions of professionals with regards to two arenas where professional dominance is usually displayed are presented. That is the patient-doctor relationship and the relation to other occupations in the division of labour within health care delivery. The findings are compared to existing empirical research while the data analysis proceeds with a deeper examination of professional agency. In particular, the last theme emerges from an analysis of the value-system of participants which reveals an entrepreneurial spirit and identity. The latter coincides with deep changes that underpin what can be described as an enterprising profession.

The Conceptualisation of International Patient Movement by Health Professionals

The 'Naturalists'

A widespread understanding of the phenomenon of medical travel is a demand-driven approach which emphasises the initiative of individuals and ease of travel. As elaborated in the literature review, according to this perspective, push factors drive patients abroad in conjunction with pull factors associated with specific destinations, and technological advancements that ease communication and transportation. Similarly, a number of interviewees conceptualise the phenomenon in terms of increased costs, long waiting lists, and unavailability of treatment at home. A cardiac surgeon explains,

> 'A basic [reason] is provision of care and cost. Namely, when you have no opportunity to have services where you live, or when prices are so high that do not allow [treatment], you may go to do this elsewhere, right? So it is basically financial reasons, second, it is the time it will take to have this service that is necessary for you, and third, if there is or not an opportunity to stay at home' (Medical Professional 25).

Medical travel is portrayed as a 'natural' consequence of health systems' shortcomings, in combination with a 'flat' world of easy transportation. A plastic surgeon suggests there is nothing exceptional about patients' decision to travel abroad.

‘well, it [patient movement] was expected, since there is a common market in Europe…this is basic. Second, in US the cost of services is very high and third, in some countries like Russia or Middle East perhaps the level of services is not good and since transportation is easy now, it is normal to have such movement’ (Medical Professional 02).

Another factor cited by participants is the advancement of communication through the internet. The role of the internet is often emphasised during interviews, as it bridges the geographical distance among patients, and patients and providers in the same way that English as a communication mode bridges the cultural distance. Patients find specialists through the internet, contact providers via email, and later recommend providers to other patients through patient forums. An IVF expert emphasises online communication,

‘it has to do with the internet. This is the whole point. It clearly has to do with internet […] how people come into contact with one another [patient forums]. I am sure about it; I have investigated a lot on that’ (Medical Professional 07).

On the one hand, the emphasis on the new era of communication and transportation echoes an uncritical reflection. Attributing the phenomenon to patient choice and technology advancements reflects a rather narrow focus which does not attempt to place the development in a broader picture. As such it remains de-conceptualised, failing to take under consideration political agendas over trade liberalisation, or shrinking of the state function and the concurrent marketisation of health care.

Win-Win situation

On the other hand, perhaps it should not come as a surprise that the phenomenon is depicted by and large as a 'win-win' situation. According to most practitioners, all parties involved actually benefit from the practice. Patients have access to health care at the time they need it and at affordable prices, whilst, they may also choose the medical doctor they prefer and receive services of high quality. An IVF expert suggests that medical travel increases choice; 'it is big thing for anybody to be able to find what she wants, how she wants it and at the price she wants' (Medical Professional 07). At the same time, the practice is beneficial for the health professional. Medical doctors may expand their clientele and enhance their daily routine by creating an international environment at work; as it is explored later, most participants state increased work satisfaction from interaction with foreign patients. At the same time, professionals highlight the multiple benefits for a wide range of parties in the destination country. Complementary activities to health care generate income for tourism, transportation and consumption. An IVF expert employs the rhetoric of economic development to stress the benefits for the whole of the country.

> 'It might sound like trade, but I believe it is something that can provide development for the country and jobs, and given that the rules that should be respected are indeed respected' (Medical Professional 06).

More so, in times of crises, like those Greece is undergoing, inbound flows of patients may boost the economy.

‘We will increase currency reserves. We are begging for money [at state level]... This is net money. It is not only the doctor who will work; the surgeon, his assistant will also work; the anaesthesiologist; a team will get to work; the hospitals that are not in good shape at the moment will also get income, some revenues, and these revenues will not be from here but from abroad’ (Medical Professional 03).

The Greek debt crisis has financially hit medical doctors in Greece and most importantly it has weakened the morale of health professionals. The domestic demand is shrinking and exports appear one of the few solutions to help out of the crisis.

‘This is how Greece is going to survive, from medical tourism. Without medical tourism Greece is dead. It is at least one of the important things. Why? Because it is not just the tourism ‘I come and eat’, it is the doctor, the hotels….[they] come determined not to have comfort…they do not come here, thinking ‘let’s save a bit in order to stay longer’…this is why everybody [can benefit]. The state through its taxes, the hotels, tourism, Athens…everybody!’ (Medical Professional 07).

Another surgeon stresses a long term benefit for Greece in the positive sentiments experienced by people being treated here. The positive externalities transcend time.

‘Medical tourism has a great charisma; it has an enormous added value. Someone that seeks therapy in Greece and gets it, gets what she wants, namely her health…you understand that her sentiment for Greece changes completely

[….] you may only speak positively about Greece, the country profile changes…' (Medical Professional 30).

As Light notes (1995), professionals often present benefits for themselves as benefits for the whole society. In light of the current crisis, arguments over economic growth obtain a special importance and give professionals the chance to depict medical travel as a form of rescue for the crippled economy and themselves as heroes in the rescue. Considering that medical professionals draw on social values to present themselves as guardians of the nation's health (Bolton *et al.*, 2011), it appears paradoxical that they draw on business related activities to support their arguments. Nevertheless, as it will be examined later, MDs have been explicit about self-interest as a motive to engage in medical travel too. In that sense, personal interests and broader benefits co-exist harmoniously.

Commercialisation of Health Care

Scepticism and deeper analysis over the development of international patient movement are also expressed. Sometimes loosely, sometimes directly, patient movement is connected to increased commercialisation of health care. Several participants offer an understanding of the context in which the phenomenon emerges drawing on marketization of health care, medical marketing and consumerism. The practitioner below observes that patient movement is associated with the detachment of health care provision from its public character.

‘It is a market – health is also a market – and everybody is in search of the best and most cost-efficient. As a result, it is no surprise that there are people visiting us’ (Medical Professional 14).

Another practitioner emphasises the triumph of the rule of the market in health care through the example of the US. He explains that during the 1950s prices increased and patients started to look for cheaper alternatives. First, they had to move to the countryside, away from large urban centres, and eventually, patients had to travel abroad, to reduce costs even further. Medical marketing was invented around the same era, to promote health care services, and it was applied in the efforts to attract patients to Florida. The practitioner successfully portrays how both patients and medical providers in the US undertook specific roles and initiatives when marketization radically expanded. He adds that medical marketing is a practice of utmost importance for today’s medical tourism. Consumerist attitudes of patients (also connected to commercialisation and medical travel) are another aspect of patient behaviour, especially in plastic aesthetic surgery. As private services are expensive in the UK and the US, many decide to reduce costs by ‘shopping’ for services from another country. Elective surgery, in particular, is characterised by high price elasticity. This plastic surgeon explains,

‘It is, lets say, like shopping for them (patients). They are interested in having it at the lowest possible cost. For many women, this is dominant. Possibly a woman that with high cost treatment could not do anything, is really interested in low

cost, because this places her within the group of women that can access this service' (Medical Professional 17).

Ackerman (2010) confirms through her ethnographic research the consumerist decision making faced by American citizens visiting Costa Rica for plastic surgery.

'recuperating patients spend a lot of time discussing and comparing prices for different procedures, as if bodies and body parts are objects to be acquired and displayed as commodities' (Ackerman, 2010: 410).

This link to commercialisation that several practitioners recognise is a particularly interesting finding since the critical voice in their accounts is not as vociferous as might be expected. Less often, MDs stress the negative aspects of the market element reinforced by medical tourism. Some consider that health care is not 'like any other product' and stress that trade has inherent vices:

'When economics are mixed up with the doctor, there is a thin red line between the end of ethics and engagement in those things [medical tourism] […] in my opinion, medicine and marketing are difficult to combine' (Medical Professional 13).

The implications for patients and their relationship with their doctor are also noted. Even though quite a few are confident that continuity is not an issue under certain conditions, others suggest that in its ideal form, medical travel would presuppose collaboration with a medical professional in the origin country. In this context, a small number of interviewees were careful to phrase the practice as

something clearly differentiated from 'tourism', (with reference to the popular term 'medical tourism'). Prompted by the hassle and stress of patients and their abstention from vacation during their stay, the complexity involved is emphasised.

> 'They come here and they are worried, they feel that they take a long trip and that they undergo great hassle, real trouble…they do not think of themselves like tourists, they do not even want to hear that' (Medical Professional 20).

Generally speaking, however, participants reflect on marketization as an irresistible force which is part of the inevitable order of things. Leicht *et al.* (1995) give a similar example of feeling among physicians participating in managed care plans; it is also experienced as an unavoidable trend. Correspondingly, *they* appear as disempowered individuals in a global world. In face of this order accompanied with disempowerment, they claim to be happy to see their client base from abroad expanding, feel compassion for patients' hardships associated with travelling, and are determined to work towards increasing inbound flows further.

Florida of Europe

Overall, participants express an ambitious vision for the future of the sector in Greece; which can be summarised successfully by the phrase '*Florida of Europe'* that a number of practitioners employ to describe the potential growth in Greece. Even though they recognise multiple shortcomings which hinder growth, practitioners claim that the Greek private health sector; Greece's membership in the EU; well-trained MDs; alongside local natural beauty and the historical culture, make

the country a unique destination for health care. In light of this, by and large medical professionals perceive the development as an opportunity, which is met with enthusiasm, ambition, and to a lesser extent concern. Notwithstanding the related increase in commercialisation that quite a few recognise, the interviewees express no remorse for the potential consequences over health systems or professionalism. Probing questions did not produce any artefact.

Marketisation brings an opportunity for new clientele, and, as we shall see further, for an enhanced daily routine. Therefore, its vices are put aside and remain at an abstract level. Arguably, this largely uncritical acceptance of the idea of medical travel, albeit understandable, is striking; for many it appears as something 'natural' and 'expected'. This is not to say that it is a ground breaking development per se, after all patients have been travelling for care far from home throughout history. Nevertheless, due to the health risks involved in patient travel, it would be anticipated that MDs emphasise the medical aspect of the initiative; more so, concurrently, that the practice is taking on more significance and could have significant impact over patients and systems.

Distrust towards the State and Medical Associations

In light of this positive perception of international patient movement and the narrative over nation-wide growth, several interviewees suggest that the state should actively support the sector. Even though other participants appear disappointed and do not expect any serious support by the state, arguments over facilitating the entrance of patients in the country are also voiced:

'[The state] can simply ease access [for patients]. And access, it is true, that for countries outside Europe is very difficult. Special visa is required…and this…they [patients] experience too many hardships. We have patients coming from Palestine, Syria, Iraq etc. and they are telling us that they struggle for a year to get a visa' (Medical Professional 14).

Other professionals stress that the state should take large scale promotional initiatives so as to have an international impact, as opposed to current individualised and disaggregated efforts of a few professionals.

'in essence they are going to promote it […]. An advertisement, an advertisement of the Ministry of Tourism would help this collaboration. Namely, this is the duty of the state, to facilitate some business sectors getting closer […] the individual will only face difficulties on her own' (Medical Professional 02)

'Here the state should take an initiative, to give special attention, weight, in something like this so that all these [isolated efforts] move forward…because each of us [MDs] tries…but alone, on his own? And another one, and another? Whereas if the Ministry of Health and I am not sure which other Ministries collaboratively try, we will definitely have other opportunities, another dynamic. […] To enlighten the world, that we, here, not only we are not second to anything, we may be better […] No, [the state] does not support us, it makes us feel disappointed' (Medical Professional 03).

General shortcomings of the country such as transportation, country reputation and local infrastructure are also mentioned by participants as problems that the

state should solve; improvements would then have positive externalities for medical travel. In light of these perceptions and drawing on insights from sociology of the professions literature, it would be anticipated that MDs put pressure on the state to actively support inbound flows of patients, potentially through their medical associations. Nevertheless, contrary to the Anglo-American example, interviewed professionals appear alienated from their associations and at the same time cynical or even hostile towards the state. The belief that nothing could be expected either from the associations or the state is almost unanimous. For one thing, the associations are corrupt, old-fashioned, and do not function to the best interests of the doctors.

> 'All these people are guilds, they are branches of the state, they always function under state control…they are people unproductive; they are not preoccupied [with medicine]' (Medical Professional 20).

Moreover, it became obvious that in face of (political) party-led associations, the representation bodies are illegitimate in the eyes of MDs.

> 'They [medical associations] do not have meaning, they do not have power. They do not have a role to play. It is just a club of old people…the dental association has in Athens around 5,000 registered dentists…you can look it up, it is impressive, it is an anecdote; in the Attica region. When elections take place check how many votes the president collects: 200, 250 or 260 votes. It is not a representative body' (Medical Professional 01).

Given the fact that trust in institutions is particularly low amongst Greek citizens (Oorschot and Arts 2005: 14; Akcomak and Weel, 2009) this finding should not come as a surprise, even when it is in sharp contrast to the example of other countries' organised medicine. Social capital, overall, is low in Greece with fragmentation being prominent even when civic activism is not; Lyberaki and Paraskevopoulos (2002) characteristically note that in many instances activism is 'mediated either by state agencies/funds or by (until recently) party machineries'. Research findings from the interviews confirm that medical associations in Greece are no exception to the rule. Political clientelism is an omnipresent source of fragmentation.

> 'They do not even have this mentality, namely, in the medical association there are people who are not important in their field. They are not the people they should be…they are people of political parties. I remember some of them at university…they would distribute things to us [political leaflets] and would never study…We were wondering, why are they losing their time with these staff? I could not even imagine that these people would easily find jobs, much earlier than I start making any money…they had their ways' (Medical Professional 12).

Neither is the lack of an effective representational body settled through another one. Despite the clarification questions, MDs state negligent relations with peers other than personal friends and former university colleagues. There appears to be no active medical community as an alternative, at least in the private sector. Therefore, the research findings show that there is little room for concerted action so

as to support the growth of the sector. In comparison to the classic understanding of professionals forming 'communities within community' (Goode, 1957), especially in the Anglo-American historical context, these findings reveal different patterns of professionalism in Greece. One could argue, that the difference partly lies in the contradictory character of the commercialised endeavour. It is not easy for medics, after all, to strive for trade or to lobby the government for trade purposes. Nevertheless, this does not seem to be the issue; MDs appear particularly affiliated with business. Besides that, there is evidence of coordinated efforts among medics in other countries. Most relevant is the case of Hungary and Hungarian dentists who exhibit a (strikingly different to the Greek case) collective mobility. An informal discussion with a consultant in the ministry of Health Affairs responsible for the Medical Tourism issue in Greece provides information about medics' organised initiatives there. The consultant participated in a workshop for knowledge exchange in Hungary, where the local experience with the foreign patients' market was presented. In contrast to the Greek case, Hungarian dentists collaborate to make aggregated medical material orders from suppliers and achieve low prices. The purpose is to decrease cost and offer competitive services to foreign patients. According to interviewees, something similar would be unthinkable for Greek medics or dentists. Party penetration of course is not a single explanation. Professions in general protect their profits and status from competition (Abel, 2003: 471). Nevertheless, demographic pressures within the Greek over-populated medical profession reinforce it. In this case, the impact of advanced competition on collective

mobility can only be negative. A number of interviewees describe the Greek sector as entailing fierce competition among professionals.

> 'In Greece you cannot refer easily a patient to another doctor…let's say you see that the case costs ten thousand euro…these things in Greece do not exist. In the US things are easy because the market is massive and the referring physician who loses a complicated case has ten patients waiting outside…' (Medical Professional 24).

> 'The profession is really competitive. You asked me before if there are any collective initiatives. This I why I told you this is not… this cannot happen, it does not exist!' (Medical Professional 20).

In addition to lack of trust in their associations, the state is perceived as inefficient and indifferent with state agents also depicted as corrupt and incapable of conceiving or implementing any successful policy.

> 'There are no people who know how to promote it [the sector]. All of our politicians, most of them are graduates of high school, how can they understand those things? He [a politician] will tell you and **/**, what do **/** personally benefit from all these?' (Medical Professional 29).

> 'I know all the ministers of tourism throughout, I have been in their offices, I have talked to them, and whatever. All of them are indifferent to those things. They are indifferent. They do not see themselves into this product; and if they do not see themselves into this product they do not give a damn about it. If they say *what,*

what is there for me [in the business]? Nothing? Then I do not give a damn! (Medical Professional 30).

The negative feelings against the state are especially accentuated due to the free fall Greece has been experiencing since 2009. To a large extent the blame for the crisis is put on poor political handling.

Apparently, disaggregated effort is the way forward with initiatives taken by solo practitioners or MDs in small groups dominating. The next section will briefly present research findings on the sub-market servicing foreign patients in Greece, including information on how the practice emerged, how it is organised, where are the patients from, and under what conditions it functions. It will establish that MDs are the key actor in the development of the sector and will set the basis for the next themes, which analyse their business agency, their identity as medics and entrepreneurs, but also their struggle to remain dominant in relation to the countervailing power of medical travel agents.

The Key Role of Medical Professionals in the Organisation of the Sub-Market in Greece

In the first phase of this study, preliminary research on the sub-sector of the private health care in Greece indicated that patients visiting for health care consult small and medium medical practices as opposed to large hospitals. Research of internet sources, in particular medical providers' websites, but also online newspaper articles, reinforces the argument that medical doctors are principal

agents in the development of this (still marginal) sector. As it has been articulated in the method's chapter, this observation was a decisive factor for the research focus of the study. The role of medical professionals was evaluated as meriting thorough examination. The subsequent exploratory study is a rich source of information not only for the conduct of medics, but also for the current state and function of the sub-sector in Greece. It is this information that this section takes the opportunity to present before it examines the experiences of MDs in the delivery of services to foreigners.

Medical Professionals' Active Involvement

Private Practices and Websites

Websites serve as basic means of public relations and commercial promotion for medical providers. In Greece a number of medical doctors maintain websites which target current and potential patients and less often peers from the local and the international medical community. They include information on services, professionals' experience and qualification, pictures of medical facilities, and contact details. Because of the Greek restrictive law on medical advertisement, prices are rarely online; a fact that partially conceals the advanced commodification of health care services and the strong competition among peers domestically. Websites are often in more than one language and some make special sections dedicated to foreign patients' needs (information about accommodation, flights, but also testimonials of foreign patients, a short introduction of Greece as a destination and the phenomenon of 'medical tourism'). In economic theory terms, entrance barriers

to the international market are small as they only include the creation of a website in foreign language(s). Promotion of the services, thereafter, comprises a distinct challenge, which relates to state advertising bans and the advertising choices of the MD. For example, a number of MDs in Greece agree to include their site (or contact details) on specialised medical tourism portals for a fee. Alternatively some promote it through search engines such as Google or even through mass media advertisements. In this way they give their practice a better chance to be advertised.

The Idea of expanding clientele beyond national borders

The sub-sector serving foreign patients in Greece is in its infancy. It is, therefore, worth exploring how the idea emerged and subsequently how it materialised. This endeavour, except for its historical importance, allows a deeper understanding of the market dynamics included.

Cosmopolitans

Research findings show that an influencing factor in the development of international patient movement is the working experience of a significant number of Greek MDs in foreign countries. This is particularly interesting finding for the examination of professions in the international level. For one thing, medical professionals move abroad in search for training and working experience (Allshop *et al.*, 2009). Factors accounting to a significant extent for this mobility include historical colonial relationships; demand-driven pull factors; origin country push factors; state regulation which encourages inward mobility; and most recently supra-national regulatory interventions that aim at qualification and training harmonisation

(Allshop *et al.*, 2009). The findings of this research support a strong link between international patient movement and professional mobility. International experience of Greek professionals allows a fair understanding of patient needs but also shortcomings of medical provision in multiple health care systems. Interviewees often refer to weaknesses and strengths of the British NHS and/or the American health care system during the interviews. They refer to high prices in US, the inability of patients to choose their MD in UK, the dissatisfaction with specific medical facilities in UK, and the legal obstacles in fertility treatment in Italy or Sweden. Another issue raised is the concentration of high quality private services in few a metropolitan areas. Occasionally patients need to travel long distances within their country to receive care in the private sector; some decide to travel abroad instead, where they might achieve significant savings for high quality care. A practitioner explains,

> 'Someone from Scotland that would like to overcome the NHS lists or is not eligible for IVF […] instead of going to London where private clinics exist, because there is no private unit in Scotland, […] prefers to fly to Athens, have the IVF for 2,500 euros and stay five, six days in a hotel in Athens. So everything inclusive it would cost three, three and a half thousand euro, if you compare to five, six thousand pounds, it is double cost there' (Medical Professional 20).

The knowledge over push factors are often translated into business opportunities. For example, one respondent returned to Greece after many years in the UK, planning to establish a clinic with specialised treatment serving foreigners. He

considered that there is an adequate international demand for such a venture; he witnessed dissatisfaction of patients with certain provisions of the British NHS; was aware of the non-availability of services in other countries due to a prohibitive legal framework; and is himself a prominent expert in his field. Another medical professional, a plastic surgeon, claims that while working in the UK, quite a few patients were asking whether they could undertake the operation in Greece. Similarly, a dental surgeon explains that when she was in US a number of patients did visit Greece to take advantage of lower prices.

> 'I was thinking about it when I was in US because I could see many Greeks that desired to come or even Americans, because things there are very expensive, they wanted to come here for their teeth' (Medical Professional 12).

Their training and practice remains far from business and management – but working abroad and at the same time as solo practitioners back home obviously helps some MDs evaluate new opportunities in business terms. It is interesting to note that economic studies show increased entrepreneurship among migrants upon return home, especially among educated individuals (McCormick and Wabha, 2003). MDs comprise an empowered expert labour force, therefore, economic theory could be expanded to account for the increased entrepreneurship observed in this particular case.

Media, Agents and Patient Initiatives

The research findings indicate that agencies might have introduced or reinforced the idea of attracting foreign patients for a number of practitioners. Several

interviewees speak of having been approached by representatives of the so called 'medical tourism' portals or by individual mediators living abroad. During the interview some participants shared contact details of representatives of facilitators, their email communication, and discussions with them. The conclusion to draw is that multiple intermediary companies contact medical doctors in Greece, present the opportunity in the growing numbers of 'medical tourists' and the 'promising' new regulations of the EU Directive on Patient Mobility. Their aim is to convince MDs that by participating in their portal (and by paying the corresponding fee), they gain access to an 'infinite' clientele from abroad. The description of a dental surgeon below summarises the strong presence of these companies, as experienced by other participants as well.

> 'they call you to international conferences for medical tourism, they inform you about exhibitions that you can join […] until 2008 the emails I would receive from such companies were almost more than emails I would get from patients' (Medical Professional 17).

Even though sometimes met by suspicion, this active involvement of facilitators has fostered the interest of many medical doctors. As revealed below, intermediaries account for a share of inbound patient flows. In other cases, it is the patient's initiative to make the contact through the internet and subsequently travel for consultation that has motivated MDs to consider the international market more seriously. Quite a few fertility treatment experts suggest they receive inquiries without advertising their services at all. Some claim they did not think of the option

until the first patients arrived. ‘Medical tourism found me, it was not me who found it’ (Medical Professional 20), narrates an IVF expert who increasingly consults couples from a number of European countries.

To a large extent, mass media introduce the phenomenon of “*medical tourism”* as an idea and practice. Media reports about flows of British and German citizens to Eastern European countries, of American citizens in South America and Asia, and TV documentaries have been important sources of information for a number of practitioners. A plastic surgeon recalls a documentary he watched while still in UK.

> ‘I had seen in UK, in some documentaries, Plastic Surgery from Hell was the title, and I watched, there was a house, no, it was a flat in Poland transformed into a clinic […] it was half price in comparison to UK and despite that [low quality of care] they were going there’ (Medical Professional 02).

Some are inspired by stories they read in the news and eagerly desire to develop their own international clientele. Walking into the office of the head of a dental practice in Crete, it does not take long to observe a newspaper article hanging on the wall. It is the success story of a clinic treating foreigners in Eastern Europe, the practitioner would later explain. Another dental surgeon in Athens appeared excited about the opportunities arising from the growth in medical travel. The practitioner had found information on the internet about other established destinations. ‘I was very impressed by Hungary; having such a large flow [of patients]’ (Medical Professional 24).

Overall, medical doctors take useful insights from articles, personal experience, professional advice from mediators and the experiences of their patients. Some combine the acquired knowledge with an entrepreneurial spirit and dedicate time and effort to plan a strategy, while others are not sure how to handle the information or wish to confine their time exclusively to the medical part of their work, as will be revealed in the following chapter. The way medics' interest is initiated, then, is related to the subsequent development of communication channels and networks with patients. It does not come as a surprise that internet advertising, promotion by mediators, personal networks of MDs and thereafter the word of mouth effect account for inbound patient flows in Greece.

Local Practices and Foreign Patients: Communication Channels

Mediators

As discussed above, agents communicate with medical practices in Greece and make bilateral commercial arrangements; typically, practices are included in an online list of advertised providers according to destination country or are referred by mediators who consult patients. In exchange the mediator receives a fee. In most interviews MDs refer to mediators based in the UK. These are usually companies with an international presence, but there are also small offices advertising locally to attract patients and refer them to collaborating providers. Indeed, foreign nationals contact medical providers in Greece through such portals, and as the plastic surgeon below explains, the collaboration may prove strategic for someone starting up a new practice.

‘I use a company […], I use it now for six years, seven years, perhaps even more…when they were starting, I was starting too. And it has helped me a lot…’ (Medical Professional 02).

Another surgeon narrates that for a long time British patients coming through a representative in UK had been the main pool of clientele for his practice. As a result, collaboration with agents may prove particularly beneficial.

‘I had collaboration with a British, as a manager, who was doing his own advertisement there with my name and my results…he started bringing in clients, from 2002 until around 2007 then we stopped collaborating’ (Medical Professional 18).

It is not always, however, agents’ initiative to contact medical professionals. Some practitioners engage actively in search of portals that may advertise their services abroad. The dental surgeon perceives these portals as a basic means to come into contact with patients.

‘Yes, there is one [medical tourism portal] … you might know it, from there strangely enough most patients find us… My partner has put the website in several other portals […] She has put it in ten- fifteen [German and English] portals’ (Medical Professional 13).

Agencies, therefore, emerge as key actors in the scene of transnational health care provision. The mediation between patient and provider offers the opportunity for financial gain but also a powerful presence in the health care sector. This

dynamic involvement challenges the power balances in health care provision, an event which does not leave medics indifferent. The collaboration is not always unproblematic as many MDs appear reluctant to advertise their services through facilitators' specialised websites, while others decide to interrupt their subscription after sometime. The tension between medics and agents will be examined in detail further on in the data analysis, as it emerges a separate theme.

Referrals by colleagues

Some practitioners provide consultation and treatment to patients referred by colleagues in foreign countries. For example, as the legal framework for fertility treatment is stricter in most European countries in comparison to Greece, some physicians provide their patients the option to consult a colleague abroad (in that case Greece) with whom they have close relations.

> '[Patients contact the clinic] via our website. Or via MDs [working in this clinic] that have a connection to Italy. We have some doctors there with whom we collaborate and who refer patients to us' (Medical Professional 14).

Relations with MDs in foreign countries might be established during international medical conferences or might rely on friendships created during the years of specialisation in a foreign country. The surgeon below highlights how a network as such might also support continuity of care:

> '…or they [foreign patients] come advised by colleagues who work abroad…and because I have worked and studied with various chaps that work in different

countries around the world, for example in London I have a very good friend that they can visit there, in Germany I know in many cities dentists that if something goes wrong … [the colleague] will take a photo and will send it to me, eee, so the back-up exists, and I do believe that medical tourism is dangerous if it is not properly practiced (Medical Professional 13).

Referring patients to a medical doctor occurs more often through former patients and family or friends. Word-of-mouth is perhaps the most important factor in developing clientele for a professional, but also one of the most decisive factors for the person in need of medical treatment.

Word of Mouth

Word-of-mouth has a strong impact in health care provision not only domestically but also beyond borders. As health care loses its 'territorial' character (Glinos *et al.*, 2010) and the internet usage expands, cyber communities become places of discussion, advice and information exchange. In health care, online discussion forums have gained popularity among patients (Eysenbach *et al.*, 2004; Kummervold *et al.*, 2002); indeed, interviewees explain that some patients first learn about them through virtual communities. A reconstructive plastic surgeon explains that satisfied clients comment positively in patient forums about his results and this is what brings in patients from abroad.

'Basically via the internet [our webpage], which we have set up properly, and then afterwards foreigners do the work, since they are satisfied, they communicate it [the satisfaction], and you see that this Briton, or this German or

this [patient] from UAE […]; they write in forums that I went there and I solved my problem. These [comments] are circulated, others read them, and they come' (Medical Professional 03).

Similarly, another participant highlights the impact of patient forums on patient decision making.

'This is what I count on [word of the mouth] to be honest with you. Namely the quality of my work. Satisfied clients. They come from Sweden and they tell me, do you know, you are very famous [in Sweden], people write on forums about you…' (Medical Professional 07).

Most often, however, word-of-mouth functions in the traditional way; 'patients' learn from their relatives and friends about a medical professional and despite the distance they decide to travel for consultation. 'I spent five years there [continental Europe], obtained some reputation and clientele and some [] patients visit me here' (Medical Professional 14), an IVF specialist explains.

A plastic surgeon gives two examples of personal networking as a reason for patient movement.

'I know of specific surgeons who take along specific patients. Like me. You know, I do not really advertise outside the country but I have my patient base outside the country. That's what I bring in. And there is for example a guy […] who is a Danish-Greek and he brings in bariatric patients from Denmark, which is relatively a well-established business. You know, he does not complain. […], in

my case these patients basically come because they are, somehow, old patients of mine; or friends of theirs, and so forth. It is a personal network I have established over the past ten years in Germany and in Britain' (Medical Professional 04).

Another surgeon worked in UK for 12 years and established his practice in Athens three years ago where he also operates surgeries on clients from the UK.

'I owe that [having foreign clientele] not to the fact that I took any special action but to the fact that I was in England. […] Because I am known among people. This is how.' (Medical Professional 09).

This type of movement highlights the significance patients place on the choice of medical professional. While medical travel is often depicted as a practice that interrupts the patient-doctor relation (Johnston *et al.*, 2012), one realises that medical professionals' movement between countries motivates patients to travel to maintain this relationship. Finally, patients are also referred to MDs by locals or foreign communities within the country. Patients from the Greek diaspora, Greek expatriates, or Greeks who live permanently abroad return home for medical care.

'Up to date I had [patients] from the US who are Greek Americans […], Europeans that are related in some way to Greece and choose to have it [treatment] here instead of their country, and I have had quite a few Cypriots […] Often one of them [the couple] is Greek and the other European who live abroad but visit Greece often' (Medical Professional 20).

Familiarity with the health care provision in combination to lower prices and a supportive social network often influence their decision to undertake treatment in Greece. Other medical doctors have clients who are relatives of house owners on Greek islands. Members of these foreign communities and friends also seem to take advantage of the lower prices and English speaking local professionals in Athens and other cities.

> 'All foreign patients that come, they come because of the internet and because of word of mouth… […] because there are so many foreigners here with their own houses. Pensioners. Who also inform their relatives abroad. Many of them who come here and stay for two- three months bring one another' (Medical Professional 29).

The majority of MDs who are orientated to international demand advertise themselves through portals and their own webpage. Only one of the interviewees stated he had advertised his clinic through television programmes abroad. He stated that he had given interviews promoting his services in the UK and Germany for a fee. Others, also desired to do so, but considered the financial burden high.

The multiple ways in which patients and doctors in different countries are connected highlight the complexity of the phenomenon of international patient movement (Glinos *et al.,* 2010). The Greek case shows that old and new elements co-exist. On the one hand, personal networking of MDs plays a prominent role. It is interesting how the international movement of professionals is causally linked to movement of patients. It is demonstrated that patients in some cases follow their

doctor when the latter moves overseas. Though the literature examining the patient decision-making process, demonstrates the importance of the medical doctor, it does not capture this particular incentive. In addition, to a significant extent medical travel does not involve commonplace commercial practices to attract clients, such as direct advertising. Instead, being introduced to doctors through other patients or colleagues is common, which is not surprising in light of advertising restrictions. On the other hand, the findings underline a nuance in the sub-market of health care for foreign patients. The presence of 'medical tourism' facilitators highlights the expansion of commercial advertising through commonplace marketing techniques, with the internet constituting the most prominent space of relevant activity.

Conclusion

This chapter outlines perceptions of Greek health professionals over the international patient movement; it describes their initiatives and sketches out the reasons that account for this particular line of action. In specific, participants perceive international patient movement as an inevitable development owing to increasing costs, long waiting lists, law restrictions and easiness in travel, while a few contextualise it within the framework of health care marketization, commercialism and consumerism. It is notable that the perception of patient travel as an inevitable global development depicts professionals as individuals who have no power or means to influence the evolution of events. Although conceptualised as an external condition, it is envisaged by and large as a unique opportunity. At the same time, international patient movement is discussed as a chance to achieve high

value-added growth and boost the economy. Amidst the dramatic debt crisis that Greece is undergoing, growth of such a business sector is indispensable. The role of medical professionals is then advanced as central in supporting the economy; a rhetoric deployed as a strategy of legitimacy (Suddaby and Greenwood, 2005). In this light, state support is essential not only because of trade balance benefits but also because disaggregated efforts could only slowly (if at all) fulfil the potential of Greece to become the 'Florida of Europe'.

Despite the perceived importance of the state, research findings show that efforts remain disaggregated with no intention for collective action. Participants express high levels of distrust towards the state but also towards medical associations. This reveals the special nature of professionalism in Greece and calls for further investigation of its impact on professional dominance. To a certain extent it accounts for the individualist approach that professionals have taken in their attempt to establish international networks. In particular, personal networks of MDs and agents' activity account for the bulk of international patient flows in the country, concurrent to relatively low involvement of the state and prolonged initiatives of large private hospitals. Research data indicate then the co-existence of two basic fashions of professional engagement. The first is closely related to work as usual, albeit expanding across borders; it includes referrals from colleagues and former patients to their relatives and friends (word of mouth). The characteristic albeit important difference lies to the fact that patients are referred to overseas doctors. The second way of retrieving clientele, entails elements of novelty; new methods (including advertising and marketing their product), novel means (the internet plays a

conspicuous role in the process), and new types of 'referees' (including brokers rewarded with fees, and word of mouth effect through online patient forums). Involvement to international patient movement is therefore opening–up new venues for communication and public relations, which appear strongly related to medical marketing (a formerly limited practice among Greek medical professionals). This 'new way of doing things and their exploitation' lies in the heart of innovation, a basic aspect of entrepreneurship in itself (DTI 2003). Simultaneously, marketing initiatives expose health care provision to advanced commercialisation; it is expected that these practices will be gradually spread and thus become more common within the domestic market with an eminent impact on the health care sector. Chee (2007) illustrates how medical travel accentuated the process of commercialisation in the Malaysian health care sector. With medics increasingly adopting commercial techniques and entrepreneurial attitudes, the research findings indicate that a similar process has been initiated in Greece.

The next chapter sheds light to the politics in the emerging market with regards to the relations of the doctors with patients and the 'medical tourism facilitators'. On the one hand, health professionals derive increased satisfaction from treating foreign patients. The reason is that despite cultural distance these patients exhibit high levels of cooperation during therapy, while their presence fills locals with honour and pride. The positive experience from the actual interaction has positive spill overs, and despite concerns, it feeds back to positive perceptions encouraging interviewees to increase involvement. On the other hand, the relation with agents is overshadowed by lack of trust and controversies over fees. As a result, while there

is some nuance with respect to empowered patients, the problematic relation with agents presents a case of continuity in perpetuating professional dominance.

CHAPTER 8

POLITICS IN THE EMERGING SUB-MARKET:

SAVVY PATIENTS AND MEDICAL TOURISM

AGENCIES

Key actors in an internationalised health care setting differ from the actors within a national one. Health care is an open system and most of the actors have international counterparts. Foreign providers are added to domestic ones; state regulation is complemented (or at times surpassed) by transnational bodies' regulatory framework; patients move abroad for care while foreign patients flow into the country, and a new key actor, the intermediary companies - often called 'Medical Tourism' facilitators, fulfil a new dual role. First, they assist patients to choose foreign provider and make travel arrangements, and second, they advertise medical providers to overseas patients. Quality accreditation organisations also gain momentum by increasing their international operations. Many overseas providers desire international quality accreditation so as to demonstrate their quality standards and attract foreign nationals. Pharmaceutical and medical devices' industries are already internationalised to a great extent. The resulting landscape is essentially more complex than the national one. This chapter focuses on the dynamics of the sector and attempts to analyse the renegotiation of power relations among actors in

the new environment. Sociological insights over health care politics suggest that the medical profession most often occupies a dominant position within provision. To a significant extent is autonomous, enjoys a market shelter supported by the state, and exercises control over other actors. It is the latter aspect that is closely examined here.

The Sociology of the Professions contends that deliberate mystification of work (Johnson, 1972; Horobin, 1983; Abbott, 1988) and subjugation of other health professionals through control of their daily tasks (Freidson 1985) comprise two aspects of medical dominance. The accounts of study participants are interrelated with these aspects and develop into an intriguing theme. They discuss their relation with two of the actors, the patients, and the agents. On the one hand, medical professionals appear fond of well-informed patients. Instead of perceiving them as a threat (Britten 2010), knowledgeable foreign patients increase work satisfaction. Consequently, this positive experience feeds back to the overall positive perceptions over international patient movement. In contrast, the agency of tourism facilitators is largely perceived as a challenge to medical dominance. The additional actor in the supply side is gaining control over the doctor-patient relationship and, often, negotiates medical doctors' fees. In that context, MDs' suspicion, often expressed by minimal or reluctant collaboration with agents, is not surprising. The chapter is divided in two parts where the perceptions over patients and tourism agents are examined, respectively. The experience of treating foreign patients introduce professional attitudes towards the foreign, savvy patients, while, an analysis of the problematic relation with tourism agents follows and concludes the chapter.

The Experience of treating Foreign Patients

Background: Profile and Decision Making of Foreign patients in Greece

Patient profile and decision making have been central in medical travel literature. The interviews provide some information about the patients' origin and socio-economic status, and some indirect information about their decision to visit Greece for health care. This section offers a brief outline of such data.

Country of origin, Language & Communication, Treatment and Socio-economic profile

Patients travel to Athens and Crete for health care from a wide range of countries. Countries mentioned most often are UK, Cyprus, Scandinavian countries, and the USA. In addition, MDs mention people visiting from Australia, Canada, Italy, France, Belgium, Germany, the Netherlands but also the Arabic countries of the Gulf, Middle East and North Africa[9].

> 'British [patients] are numerous, Swedish travel from what I know, Germans, Australians, Canadians […]' (Medical Professional 07).

The majority of patients appear to be English speaking or to have a fair command of the English language (e.g. Scandinavians). This may be reflecting the familiarisation

[9] During 2011 and 2012 an excessive number of patients flew from Libya to the private health care sector in Greece. Their number is estimated to more than four thousands and the amount spent on treatment to multiple hundred thousands of euros. Beneficiaries were mainly large hospitals in Athens and Thessaloniki. The participants, however, did not discuss the inflow of Libyan patients within the framework of 'medical tourism'. That was mainly because these patients were (mostly) injured during the war in Libya but also because the vast majority were treated in private hospitals owned by one conglomerate, excluding the rest of the providers. As a result, their inflow has been perceived incidental.

of the local supply side with English; interviewees are typically fluent speakers of the language while most commonly their webpage has a Greek and an English version. In a smaller scale German, French and Italian are spoken, and last but not least, Greek. In few cases, communication is facilitated by multi-lingual health care personnel, such as nursing stuff and midwifes. Patients visit Greek private practices most commonly for care, which is excluded by insurance at home, including dental care, aesthetic procedures, reconstructive plastic surgery, eye surgery, bariatric surgery, and fertility treatment. The latter is in some cases covered at home but expertise cannot be accessed for various reasons, including long waiting time coupled with an expensive local private sector. In addition, inability to choose MD within the framework of the British NHS, or a prohibitive legal framework in Scandinavian countries and Italy motivate patients seek care far from home. For American citizens cost is an important factor according to interviewees. At last, patients sometimes visit Greece to consult specific medical doctors with international reputation in their field.

> […] it is special for each country and since I have many [foreigners] I can tell you that each of them has her own reasons. Australia: laws and cost, Canada: it is the cost, US: it is the cost, UK: it is the law, cost and vacation. And my sub-specialisation fits actually to all. Then it depends on the needs of each patient' (Medical Professional 07).

The findings indicate that other types of illnesses such as cancer or cardiac problems are not treatments foreigners seek in the *private* sector in Greece. That

could be due to a selection bias of research participants nevertheless, two cardiac surgeons, one thoracic surgeon and an anaesthesiologist were also formally or informally interviewed. None of them referred to cases of foreign patients in need of such medical care, other than emergency cases of people visiting Greece for other purposes or foreign people living in Greece.

The socio-economic profile of patients varies according to type of treatment and country of origin. For example, according to interviewed fertility treatment experts, most European patients visiting for assistance are often from the upper or middle class who are not necessarily interested in price levels; whereas American or British patients are most often middle or low class citizens and are motivated by cost savings.

> 'It is a profitable sector. Namely, people that usually visit are of high financial status, they have high purchasing power' (Medical Professional 20).

As far as dental care is concerned, price in combination to professionals' credentials seems to be the basic incentive to seek treatment in Greece. This implies that patients most possibly belong either to the middle or low social class of the origin country. In addition, plastic surgery appears to attract most often low to middle class patients. A plastic surgeon notes, for example, that his British patients seem to be used to facilities of lower standards than his own practice and the clinic where they undertake operations. He suggests, however, that expensive facilities in the UK can only be more modern so he concludes his patients cannot afford

expensive providers back home. Another plastic surgeon is certain that it is the price that brings in his practice clients from UK.

> 'We have brought 30 to 35 patients from UK for surgery. It is the price. How much they will pay for the operation. This is what they basically care about. Neither the 'palace' they are staying at, nor the high class destination they are going to' (Medical Professional 09).

As a result, it does not come as a surprise that the 2008 crisis followed by devaluation of the Sterling hurt some Greek practices depending on British patients. Appreciation of the euro made their services considerably more expensive for British patients who possibly turned to other destinations. Even though information on the socio-economic profile is limited, it appears that patients often avoid the expensive private sector at home for dental care, eye surgery, and plastic surgery (e.g. in US and UK). As a result, patients are mainly from middle or lower classes who afford, however, the trip and prices Greece can offer.

Experience

Notwithstanding the complexity and increased demands of transnational health care provision, medical professionals report, overall, increased levels of satisfaction. They appear confident and excited and reflect upon their foreign patients as well-informed and empowered individuals. While evidence and theory depict professionals as reproducing paternalistic and authoritative behaviours, this section demonstrates that interviewees largely enjoy interacting with 'savvy' clients.

Self- Reflections: Confident and Excited

Interviewees demonstrate high levels of confidence over their medical training, experience but also their language and cultural skills. They reflect on themselves as competent medical doctors that have little concern over communication problems and patient handling when it comes to foreigners. Most refer to prior exposure to a multi-cultural environment during their training and working experience in other Western countries.

> 'Since there is no language barrier and the language barrier is very important, then it is something particularly easy to take place, it does not worry me, I have lived [abroad], I know how Europeans behave, I know also well [how people from] East behave, because in Belgium that I worked, there were patients of Arabic origin. In that sense I can say it is not something difficult given that you respect the patient' (Medical Professional 14).

A participant trained in Scotland shares similar experiences.

> 'I am used to that [treating foreign patients]. I have done my training, part of my training, abroad, in UK, in Scotland more specifically, so all right, there I have come into contact with what you call Anglo-Saxons, Europeans, etc. The region I had my training was a pretty international region because it is oil producer, I took my training in N. Sea…I had Dutch [patients] there, I had French, I had…many Moroccans' (Medical Professional 20).

When it comes to their patients, health professionals discuss in a positive manner about their interactions. In general, they describe foreign patients as well informed and educated individuals.

> ‘I want to show you their emails…to see how they come more or less, how…they have a problem, how they come, what they are telling you, they are very conscious patients. Very much, nothing with what you would imagine, […] these people know what they want and I am happy to work with them. It is not how they present it abroad, a stupid action of stupid people. I can tell you that they are much more conscious, much more open-minded than some conservative British, because I also know the situation of the NHS and I know how the system works… ’ (Medical Professional 07).

> ‘They are very friendly, really up to date and informed in everything they are looking for…they know what they seek, what they are going to encounter, I see then that they come, they take what they want and stay satisfied’ (Medical Professional 22).

In theory, the power relation in the doctor-patient interaction stems from information asymmetry. This makes the relationship between professional and client unavoidably an unequal and undemocratic one (Parsons, 1969). As such, it would be anticipated that medics would favour the perpetuation of asymmetry. In fact, the theory of professions suggests that knowledge indeterminacy has played a vital role in professional power legitimacy.

‘it will be harder for doctors to characterise patients' requests as 'inappropriate' if patients are well informed and can quote their sources. While doctors may not give patients the information they want and been about their medicines, widespread access to information about prescription and other medicines on the internet may facilitate the kind of challenge to medical expertise envisaged by Haug (1975)’ (Britten, 2010: 491).

In contrast, it is notable that interviewees stress the positive aspects of well-informed patients. Two observations account for this attitude. First, increased compliance with the therapy plan, and second, a feeling of pride for being ‘chosen’ amongst many other doctors in a range of countries. MDs highlight that patients coming from abroad show relatively high levels of cooperation; not only as far as the treatment is concerned but also with respect to treatment costs. Most participants emphasise that they are determined, easy-going, and follow instructions carefully. A reconstructive plastic surgeon from Athens says,

‘Well the patient that comes from abroad is willing and convinced to pay and put himself and his family under great hardship, because he has in mind that he migrates for a period of two weeks […]…great, great trouble…they are incredibly cooperative. Incredibly polite and they face you with great respect. You are happy to work with them. They are very obedient, they have incredible orientation – because this is what we fear, patients without orientation – not to have unrealistic expectation; to tell them this will happen and this to happen [..] this is where medicine stops. Unrealistic expectations are a red flag for us. Therefore,

these patients are the best we have, because they undertake incredible hassle, expenses, so that the best possible in their mind is realised' (Medical Professional 23).

Comparison to locals is actually taking place continuously during interviews, as it has become already obvious. Most, but not all practitioners highlight that their work is simpler with foreigners, perceiving locals relatively less compliant.

'I have shown to you the plan yesterday…the plan with the Norwegian…the first day she came, we discussed; she told us the answer is yes/no, they do not make me tired, making bargain, when, how, I will think about it, I will tell my wife. Indeed whoever [foreigner] came in our practice was a very, very pleasant experience for us' (Medical Professional 31).

Therefore, it is somewhat surprising to find out that despite the fact that communication is in English, practitioners feel these patients are easier to handle.

'Of course, because the foreigner has great difference from the Greek. In what he expects, what expectations he has, how cooperative he is in the therapy plan, what demands he has…he does not, normally, he does not raise strange demands, out of space. You explain right from the beginning what you want to do and you do it: if he participates in the treatment plan, he is very obedient let's say, and afterwards, much more cooperative' (Medical Professional 26).

The second observation is that being chosen by foreign (and savvy) patients fills practitioners with pride. Empowered patients make choices considering a large pool

of medical doctors in a number of countries. As the excerpts below indicate, consulting these patients is perceived as a form of distinction and recognition of their work.

> [A typical patient from abroad] visits internet looking for her problems, knows what she has and is looking to find the *real* expert' (Medical Professional 07).

> 'It feels you with satisfaction because these people do not go just to anybody, they do search [..] which means that if you gain their trust, eh, they are people with high living and intellectual level, so when you gain their trust you feel a great satisfaction' (Medical Professional 20).

> 'There is great care for these people. Because this is a way…we are proud as Greeks, we wish to pay back the honour they pay to us' (Medical Professional 23).

Except for the medical interaction, however, it appears that people from abroad enhance the work routine of a number of medical professionals.

> '... it entertains me, it is interesting, it is different. Therefore it is attractive to see people with another mood, another culture' (Medical Professional 24).

> 'Second, it is really interesting. I see people from other cultures, other countries and that is great' (Medical Professional 20).

The interaction has therefore two co-existing sides. First, patients being knowledgeable are at the same time very demanding. The hassle to undertake the trip makes their expectations at some instances challenging for practitioners.

'These people coming and therefore leaving their country are very demanding, really demanding, very demanding market. […] The come here from far and they want to have a result. And a good result' (Medical Professional 20).

'On the one hand they are more demanding, but on the other, once they know the plan and they feel that they participate, they are really cooperative' (Medical Professional 26).

A health professional explains that, in contrast to locals, foreigners seek the latest state-of-the-art technique; most often have a preference over the treatment and have read extensively about the health issue they have. When the doctor has another opinion, it is harder to convince them about the method. In addition, even though treating foreign patients is psychologically rewarding, organisational demands for the practice increase, according to most practitioners. That happens because patients become at the same time visitors, which places professionals in the role of the host. Tighter time frames, language barriers and the necessity of a person dedicated to the reception of foreign patients are perceived as necessary to meet increased demands. The practitioner below explains that it may cause more stress at work.

'Well, it is kind of more stressful, more pressing […] for us the difference is that there is time pressure, namely some things, there are procedures that need to be

done within a short timeframe, all these here have to be worked, well not separately, but we work on them [patients] in longer time frames (Medical Professional 22).

'Organisation is necessary, an office, a person who will be busy with patients from abroad. They need more care than the local patients. And the doctor is much more responsible' (Medical Professional 18).

Practitioners often stress that workload appears greater because of a feeling of greater responsibility towards the foreigners.

'I only have more work to do, I need to keep an eye on them. […] They do not know the space at all. They do not speak the language, these are the language barriers, they come [e.g.] from India, the nurses they do not speak fluently English, the administration, the finance department that they are going to pay. They speak English but the Greek English. Then there are people coming from the US, they did not have any problem, the patients are scared, they are alone. Imagine that a whole family might leave their home to come…and you as a doctor you are also their host, you need to keep an eye on them; do they take care of them at the hotel? (Medical Professional 23).

The distance between the home country and Greece causes at times worry. The practitioner below explains that he feels distance does not allow him to offer the care he would like to offer.

‘Very often I check the patients [locals] every two weeks for months [after treatment]…just so that I sleep calm at night. I cannot offer this to the other patient [foreigner]. I tell her and she knows and all these who left were happy, they faced no problem but I always have a fear; you come across many things while doing this job’ (Medical Professional 13).

Another professional explains that he does not take responsibility to undertake an operation unless the patients stay long enough to his judgement in Greece.

‘If you (the surgeon) are consistent in what you will tell [to the foreign patient] you do not have any problem [when treating foreigners]. Namely, there are surgeries that require seven days to understand if there will be any [after-surgery] problem and other surgeries that require two days. I keep him [the foreign patient] seven days. I tell him that if you do not stay seven days so that I cut the stiches myself you cannot go, simple as that. Or do not do it with me, go somewhere else. It depends on the personality of the doctor; his ethos’ (Medical Professional 29).

Despite concerns and increased responsibilities, interviewed professionals appear overall satisfied from their interactions with foreign patients. This feeling fits well with their inclination to engage in the practice, advertise abroad and attract foreign patients that has been elaborated in the previous chapter.

Discussion

Empowered patients are not perceived as challenging power balances in this particular case. In theory, the doctor patient relationship is a relationship which

involves complexity and power. The fact that professions anachronistically provide highly individualised services (Dingwall, 1983) and preoccupy themselves with personal problems sets them in a position of control over interpersonal situations (Larson, 1977: 236). Control is enabled by information asymmetry; in particular, lack of knowledge leads the patient to pass on decision making to the doctor and consequently become the weak part of the relationship. In an era of abundant online medical information, however, more and more people search for their health problems. Awareness diminishes information asymmetry and empirical work suggests that professionals and their higher educational institutions feel challenged by this development (McGregor, 2006). For example, some are found to directly reject patients' views (Henwood *et al.*, 2003) particularly in chronic illness care (Thorne *et al.*, 2007). Evidence coming from multiple studies shows that often,

> '…professionals cling to power in their engagements with patients, controlling information and dismissing efforts by patients to theorise or explain their condition' (Fox *et al.*, 2005: 1300).

The literature on international patient movement stresses that the patient travelling abroad 'epitomizes the empowered patient touted as critical to a patient cantered health care system' (Runnels and Carrera, 2012: 302). Research findings confirm the argument; participants talk about well-informed, 'conscious' patients, who have knowledge over their health status and actively engage in their health care decision making. Despite that, interviewees of this study do not feel challenged by informed patients. In contrast, MDs derive increased satisfaction. They reflect on

empowered patients as knowledgeable enough to evaluate their health problems, seek the right treatment, and choose the 'real expert'. The patient as a partner and the subsequent shift in 'the locus of power', where the doctor is not anymore 'acting as the sole manager of patient care' (Forkner-Dunn, 2003: 3), are positively experienced. High levels of compliance reinforce this attitude. In light of this, the informed patient is perceived as contributing to an 'improved partnership between patient and physician and strengthening the therapeutic alliance' (Wald *et al.*, 2007: 223).

Whether this attitude is linked to a perception over the patient as a consumer is ambiguous. Consumerism is often linked to the growing numbers of informed patients who think and act as demanding consumers (Wilson *et al.*, 2007, Fox *et al.*, 2005). In addition, the American literature discusses the implications of aggressive marketisation of health care (Relman, 1994), or the role of profit incentives in the patient-doctor interaction within managed care, as contributing to a supply-side reconceptualisation of the patient to a consumer (Mechanic, 1996). Modicums of such reconceptualisation among interviewees are also apparent. With the exception of one professional, however, such a perception is implicit rather than phrased. On the one hand, the majority of interviewees show strong commitment to their patients' health issues and well-being; they connect it to their professional reputation. A feeling of responsibility towards the traveller is also present. And while they talk extensively about the technical aspects of the treatment, they speak with respect about the initiative of their patients to search their health problems, the effort to find a solution, and their decision to visit Greece. In this sense, a perception of the

patient as a consumer is not evident. On the other hand, it has been already discussed that generally speaking, several professionals connect the development of 'medical tourism' to commercialisation and consumerism. Furthermore, the next section elaborates on the entrepreneurial spirit of professionals and their self-perception as both medics and entrepreneurs. It also refers to the case of an IVF expert stating that his patients should better be called clients instead of patients, due to the fact that infertility is not an illness. In addition, as Conrad and Leiter (2004: 161) note, in the private sector there is a direct financial relationship between the 'consumer' and the medical provider; as long as the patient affords the treatment, finds the provider and pays in cash. As such, a climate of commercialism and entrepreneurial reflexives are present. They create an impression of advanced marketisation, which would afford an inference of the doctor thinking of the patient as a consumer.

The next section examines a different aspect of professional power, one that is manifested with respect to actors in the supply side. It has been elaborated in the literature review that medical tourism agents emerge in the internationalised scene as an integral part of the new market. New services are required both from patients and providers. As such a new field emerges, one that is colonised by actors most often from the business instead of the health care sector. The next part exposes the inimical attitude of medical professionals towards the agency of intermediaries. The latter negotiate fees and routinely intervene between the doctor and the patient; acts which are largely perceived as an assault to medical power.

Medical Tourism Agencies and Professional Dominance

Arguably, almost all medical professionals interviewed embrace a commercial logic, even though some undertake more advanced entrepreneurial initiatives than others. Unsurprisingly, this commercial orientation coexists with an effort to maintain dominance in the new internationalised context, especially with regards to non-medical intermediating agents. Dominance is a term employed here to refer to subordination of other occupations in health care provision. It emphasises dominance in the division of labour where nurses, pharmacists, technical and often administrative personnel 'were obliged to work under the supervision of physicians and take orders from them' (Freidson, 1985: 13). Interviewees' accounts, analysed under the dominance narrative, are presented in three sub-sections. First, it is shown that after the initial contact between the agent and the practice a business relationship is often established. It is then highlighted that the attitude of professionals towards agents has two sides; on the one hand, agents are deemed necessary, and on the other, they are met with suspicion. Finally, it is demonstrated how suspicion soon turns to politics and professionals often deny or stop collaboration with intermediaries.

Establishing a relationship

When MDs describe the initial push factor to turn to foreign clientele it becomes obvious that medical tourism facilitators have played for several a crucial role. After some interviews it was clear that agents, mainly from the UK, have approached a

significant number of MDs in Greece who they consider competitive enough to include in their list of providers.

> 'They call you to international conferences for medical tourism, they inform you about exhibitions that you may join […] until 2008 the emails I would receive from such companies were almost more than the emails I would get from patients' (Medical Professional 01).

a dental surgeon explains. Actually, some depend solely on brokers for advertising.

> 'Yes, there is one [medical tourism portal] … you might know it, from there strangely enough most patients find us… My partner has put our website in several other portals […] She has put it in ten- fifteen [German and English] ones' (Medical Professional 13).

A plastic surgeon also mentions,

> 'I use a company […], I use it now for six years, seven years, perhaps even more…when they were starting, I was starting too. And it has helped me a lot…' (Medical Professional 02).

Necessary but Dodgy

Therefore, when asked about their perceptions over agents, medical doctors seem to recognise that their role is crucial in channelling patients to their practice.

> 'There was a need and they were created […] they simply facilitate the whole operation, because a website needs a lot of referrals from other sites to be found

in a good position in Google results. An independent site like ours, for example, by default cannot appear high. Theirs concentrates, I don't know, a thousand providers, it has many referrals so it appears higher and it is easier to find audience' (Medical Professional 02).

'So they are necessary. They are necessary to bring people in. A man cannot do everything. I am for example a doctor. And especially me […] imagine, I do 15 more things on top, I do not have the time, knowledge, the ability to do everything!' (Medical Professional 31).

Knowledge plays a significant role in professional politics as it defines the boundaries of work (Abbott, 1988; Fournier; 2000). In particular, professionals gain and maintain exclusive rights to perform tasks based on their recognised expertise in an area. Internationalisation of the market, however, demands a new set of skills that medical professionals realise they do not possess. Within the dynamic environment, thus, an occupational vacancy is created (Nancarrow and Borthwick, 2005), changing the established boundaries of work. In this case the vacancy is not related to medical skills; instead it concerns brokerage and marketing. In that sense core tasks such as drug prescription, diagnosis, or treatment are not contested. On the other hand, MDs appear reserved and cautious. Professionals refer often to unrealistic promises or exaggeration in the expected outcomes by facilitators. Scepticism particularly arises about the way most portals handle and direct inquires of patients, discouraging quite a few professionals from collaborating with them.

‘We’ve been approached by various portals, mostly from the UK, they have many there, which we preferred not to work with. Namely, alright, they wanted some fees that were, not irrational, obviously they do some work and need to be paid for that, but this work cannot be checked, it is something that is not countable’ (Medical Professional 22).

‘There is an issue with how they function. They say I advertise you, yes, but if you want to be advertised a bit better, you will have to give me more money, I will not be advertising you for free, you will pay, or I will advertise you for free but from all incidents you get you will give me 15% of the revenue, all these are a bit dodgy…it is not clear how it works’ (Medical Professional 26).

It is also notable that there was kind of a mismatch between mediators’ and medical doctors’ communication style. Despite the aspiration for business success most medical professionals are accustomed to common marketing practices. Facilitators on the other hand appear to be most often from the business sector outside the sphere of medical provision. Facilitators’ approach often proves out of context. The dental surgeon cited earlier explains that she considered the approach of facilitators aggressive and for long time did not wish to collaborate with them.

‘We have been approached by [name of facilitator] but I cannot hide to you that I was a bit…hesitant […] I did not continue with that. I found it very aggressive […]I think thus that these people I was talking on the phone with, without meaning to say something bad, triggered defensive mechanisms to me’ (Medical Professional 24).

It soon turns to Politics

This expression of hesitation and doubts soon turns to politics. Several MDs realise that a new actor may gain power and potentially threaten their position. The sociology of the professions elaborates how professionals strive to maintain control over the organisation, distribution, and trade of their production (Larson, 1977; Abel, 1988). In addition, the power stemming from the special relationship between the doctor and the patient has been also analysed (Hughes, 1958). It is exactly these balances that 'medical tourism facilitators' threaten to disrupt. The point is that these tasks, though non-medical, are related to control of demand and conditions of medical work. It is agents' role to intermediate between the patient and the doctor and through this they influence the rules of trade, the fees and to some extent the conditions of work of medical professionals. Unsurprisingly, most participants feel challenged by the necessary albeit intrusive new actor. A dental surgeon explains that agents are useful for his practice, but appears dismissive of mediating services that go beyond simple advertisement. The doctor-patient relationship is of strategic importance for MDs, and a third party intervening is not particularly welcome. The dental surgeon dismisses initiatives for patient handling and further involvement as irrelevant.

'For example, someone wanted to create a site; to choose specific MDs and provide specific services and be the manager of the whole thing. Because obviously wherever there is money everybody wants to get involved […] but to

my mind the level of doctor-patient is so personal that the success of such a thing is particularly difficult' (Medical Professional 13).

Several medical doctors explicitly address the issue of power and control and explain that denial to collaborate is related to their autonomy over work and fees.

'Since Greece has not established a brand name for medical tourism, you have to be involved in the process of collaborating with them (intermediary companies handling flows of patients) in terms that *they* define and *you* have to follow' (Medical Professional 02).

'They [colleagues] talked with some companies from UK and could not agree in prices. Namely, they considered the commission the office would take was extremely high; we do not want to work in dependence. Most MDs, this is how they work, and most MDs in [name of hospital]…this is why it [the hospital] was created, it belongs to doctors. We do not have agreements with insurance companies, funds etc, so that we define our price. If we get into the process that others define our price, our reward, eh, there we do not really like the thing...if we do not agree. And this is where collaboration stops' (Medical Professional 23).

Characteristic is the example of another surgeon that did not hesitate to stop a long-term collaboration with a representative in UK who had been his basic source of patients for several years. He suggested that the agent after the first years started secretly to charge high fees to the patient for his mediating services. What particularly irritated the surgeon, though, was that the broker's fee was higher than his own. He reacted by interrupting collaboration. Despite the fact that medical

professionals control the division of labour, efforts to maintain control must be constant (Abbott, 1988: 71 & 73). Medical professionals recognise the usefulness of the new type of services, nevertheless, their incompetence in performing them or the independency of agents do not allow the first to control the actions of the latter. At the same time, agents intervene in the health care process and may exercise control by channelling the demand that, ironically, to a large extent they facilitate. As a result, friction is often observed.

Discussion

The above quotes show that MDs are not willing to allow agents increase their sphere of influence. Imposing commission and other rules may appear particularly provocative for Greek private practitioners who are not used to control by third parties. Neither the hospitals, nor insurance funds have done so until today. A manager working in one of the two largest hospitals in the country explains that,

> 'Clients of the hospital are not the patients. The doctors are. They bring patients into the hospital and they get paid for that' (Senior Manager 32).

In other words, despite the oversupply of MDs, hospitals actually compete for medical doctors. In that sense it is not surprising that they feel threatened by the emerging actor. The question over what professionals ideally want from agents then remains. The overall impression is that they are happy to work with agents when their fees are low; when they do not intervene beyond bringing them into contact with patients (i.e. portals); or when agents are exclusive representatives. It is also

interesting to note that specialisation did not account for differences in response to mediators; both dental and plastic surgeons, as well as gynaecologists have been vocal in expressing their concerns. As institutional theorists would argue, professions are 'the lords of the dance' since they act as institutional agents (Scott, 2008) that shape the evolution of events and processes. The reaction of Greek MDs towards the new actor in health care labour division highlights how institutional inertia supports the continuation of professional dominance amidst contextual changes. Incorporation and subordination of other occupations and control over the division of labour is contested by agents in this very moment given the internationalisation of health care. MDs, however, clearly show that they are not willing to engage if it is not in their own terms. They attempt to disrupt the growing power of agents in its infancy. As Netting and Williams suggest 'old habits die hard' (1996).

Discussion and Conclusion

This chapter has examined aspects of power relations as they develop in the emerging market of transnational health care. In particular, it has examined the relations of medical professionals with patients and agents, and has demonstrated a differentiated approach towards the two actors. Theoretically, both could be perceived as challenging existing power balances. First, patients being well-informed and empowered disrupt the information asymmetry that makes them the weak part in the doctor-patient relationship. Nonetheless, in this particular case, informed patients are found to increase medics' work satisfaction. Patients'

increased awareness over medical issues improves compliance during treatment and is interpreted as a form of distinction by professionals. The latter recognise that their foreign patients have chosen them from a numerically immense pool of 'experts' across countries. Even though this attitude is specific to the country and internationalised context, it still comprises a striking finding that has a lot to say about professionalism in a marketised environment. It shows that further research is meaningful for a deeper understanding of conditions and mechanisms in operation.

Collaboration, however, with agents is not unproblematic. Here, the argument that professional dominance epitomises control over other health professionals' working tasks and responsibilities (Freidson, 1985) is reinforced. In particular, new services are necessary in the emerging sub-market, a development that coincides with a new jurisdiction. The organisational needs of the provider increase, travel services towards the patient are often required, and general advertising that targets a particular segment of clients is deemed necessary. The issue of who provides these additional services creates tension. The majority of MDs are neither qualified, nor have enough time to dedicate on non-medical services, therefore, they need to collaborate or bring in expertise. The field opens up to new actors and these actors are often agencies which go after what is deemed as a business opportunity. While, then, tourism agents are recognised as necessary and useful, MDs remain suspicious towards their potential power within the supply side. The influence over patients and their negotiating power over fees and terms challenge medical authority. In most cases, their style of promotion, which is generally perceived as aggressive for the health care market, is also questioned. Agents come from a

different ‘world’ outside the sphere of the health care. This implies that they do not share a common background or practices, and they do not necessarily recognise medics’ authority; it is just business they are after. MDs in contrast cannot accept agents on an equal to equal basis. MDs engaging in medical travel walk on the path of entrepreneurship but as it evolves in the context of health care. As such it is framed in a way that it can co-exist without unsurpassed tensions with the medical environment, the medical identity and professional dominance. It is not argued here that MDs’ business practices are not aggressive. In contrast, MDs are notorious for making money often at the expense of people’s health (Relman and Reinhardt, 1986). The difference lies in the style; their practices are most often indirect and covert so that an image of medical morality towards patients and the public is carefully maintained. Interviewees seemed to incorporate entrepreneurial attitudes, but obviously not unconditionally. Baulieu *et al.* note that,

> ‘to preserve its autonomy, identity and internal equilibrium, the professional system absorbs elements coming from outside in its own way, in accordance with its professional logic and the requirements of its own tasks’ (Baulieu *et al.*, 2008: 1155).

As Evetts (2011) would expect, the modern professional self and behaviour includes elements of both continuity and change. Entrepreneurship is thus related to change, however, protection and fortification of authority plays out as an integral part of inertia and continuity in professionalism.

CHAPTER 9

ENTERPRISING PROFESSIONALISM

Entrepreneurship as a Professional Value[10]

The research findings presented in this chapter focus on perceptions over work and success at work expressed by MDs in conjunction with the perceived opportunity of expanding service provision to foreign patients. The chapter is divided in two parts. A range of motives closely related to medical professionals' agency as presented in the chapter 7 are examined in the first part. The findings highlight the importance that MDs place on entrepreneurship and call for an analysis of the potential impact on professionalism. Concepts such as professional individualism (Marshall, 1939), professionalism void of service ethic (Brint, 1994), and commercial professionalism (Hanlon, 1998) are useful in conceptualising the attitudes of interviewees. Enterprising professionalism is a phrase that captures the essense of research findings. The second part of this chapter explores how MDs construct their identity and reconceil their entrepreneurial with medical self.

[10] The analysis is part of the paper 'The Internationalisation of Health Care and Business Aspirations of Medical Professionals', submitted to the peer reviewed journal *Sociology* in June 2013.

Selling services in the marketplace

Throughout the interviews MDs discuss health care as a market. This reflects to an extent the very nature of private health care provision but also MDs' perception of health care as a business sector. It is indicative that the language employed by participants reflects a business orientation. The majority of interviewees would adopt terms from the fields of economics and business since working in an international environment carries challenges and opportunities that they need to address. The 2008 financial crisis, the Greek debt crisis, the overvalued euro, as well as the potential impact of "emerging economies", are all phenomena that seem to preoccupy MDs interested in the international market. "Market", "competitiveness", "cost reduction", "price and quality mix", "trade" and "exchange rates", are terms MDs frequently use to describe perceptions at the macro-level. Words and phrases like "clients", "business", "value for money", "venture", "profitable", "product", "what I sell" are also commonly used to refer to their efforts in attracting patients. Additionally, interviewees draw on marketing and advertising terminology such as "target groups", "promotion", and 'marketing campaign". Often these terms are used in English; broadly perceived as language of business. Most, but not all, referred to their patients as clients and to health care as a market. The exceptions verify the importance of listening to most practitioners expressing themselves in business terms. The attitude connoted by this goes well beyond professionalism as "a third logic" presented by Freidson (2001). The market forces within which MDs offer their services in solo practices or medium partnerships influence medics into developing a business mind set.

Taking a closer look at the research participants it can be noted that almost all are well respected MDs in Greece receiving generous fees for their services. Practitioners work in the private sector by choice, as most MDs have the option to work for the Greek NHS, if not in large cities, at least in the countryside. In that sense, once practitioners decide to work in the private sector, they distance themselves from community service. The NHS, however, is not always a particularly attractive choice; not only because remuneration is low, but also because of perceived inefficiencies (Economou, 2010) and widespread corruption (Liaropoulos *et al.*, 2008). Looking at the organisation of the private sector, an MD typically runs practice alone or in partnership with colleagues and offer services on a fee-for-service basis. MDs typically define their fee themselves and their clientele is based on word of mouth or media appearances; as advertising is not allowed within the country. MDs are in close collaboration with one or more private hospitals and use their facilities (operation theatres, medical equipment, health professionals' support such as nursing staff, anaesthesiologists, etc.). Private hospitals on the other hand, benefit from the MDs' clientele coming for examinations and treatment and hire a relatively limited number of practitioners.

MDs are therefore accustomed to "selling their services" in a market and paying fees to hospitals for using their facilities or buying medical material and equipment from suppliers. They essentially run their practice as a business. In that sense, given the possibility of broadening their clientele with patients from abroad, it is not surprising that many practitioners are enthusiastic about the potential that

international markets offer. ‘I have a great interest in health tourism, indeed. I think it is an amazing field […]’ (Medical Professional 24).

Business Success Requires Entrepreneurship - Motives

As discussed above, the market forces within which MDs offer their services in solo practices or medium partnerships influence medics into developing a business mind set. Nevertheless, as it has been established in the first part of data analysis, MDs cannot be perceived as neutral receivers of a new order; in spite of market pressures, it involves their own initiative for business enterprises. A doctor involved in setting up a new practice in Greece explains that his investment decision is related to increased international flows of patients.

> ‘[The clinic treating foreigners] is what I wish to create and the reason I came to Greece. I have already bought the building to make something on my own’ (Medical Professional 07).

The vast majority of participants discuss the profitability of expanding their clientele with foreign patients as the reason they get involved in the sector of medical travel.

> ‘I consider it as a way to increase activity; this is basically the reason [of attracting foreign patients]’ (Medical Professional 25).

An IVF expert in Athens explains,

> ‘First and foremost, it is profitable. Those patients have usually high income, they have high purchasing power’ (Medical Professional 20).

Dental surgeons especially highlight that when patients visit their practice from abroad they require extensive treatment, therefore, earnings are significant. Both empirical and theoretical contributions to the literature highlight potential savings as a basic driver of patient travel. At least for treatment paid out-of-pocket like dental care, price differences are believed to play a significant role in patient decision making (Svantensson, 2008; Cortez, 2008; Glinos *et al.,* 2010; Connell, 2006; Carrera & Lunt, 2010; Abdullah, 2006; Barrowman *et al.,* 2010; de Arellano, 2007; Carabello, 2008). Similarly, interviewees explain that simple procedures would not justify the trip; it is extensive work that has to be done abroad. That makes foreign clientele very attractive for their practice.

> 'The reasons are financial. Most possibly the foreigner will do a much more expensive procedure in his mouth than the Greek. That's the reason' (Medical Professional 26).

> 'Definitely the procedures will be extended when they [patients from abroad] come. Namely, one will not come for hygiene, one will come for implants, to do things more extensive, which means that one will pay the corresponding amount' (Medical Professional 13).

Incentives are very often layered. Most MDs mention next to increased revenues motives such as desire for business success; recognition of their expertise; prestige; and insecurity due to the Greek debt crisis. The medical professional below bears aspirations to develop a 'medical tourism' unit with an international impact.

‘I have put too much effort in it…I have been to Doha, to Moscow, I have been to Berlin. […] If we want to be competitive – because all right, here, as a small clinic I can play this game and bring in 50 people. But this does not make any difference to me. *Here we should create a medical city*’ (Medical professional 30).

As it has been suggested earlier, patients visit Greece often due to the reputation of a specific doctor. This offers high levels of satisfaction to medical professionals, which ties back to increased work satisfaction while treating foreign patients and the feeling of honour. This sentiment is elaborated in the previous chapter as one than stimulates the engagement with the international market. At instances, efforts to approach clientele from abroad are justified as a “proactive” action. Given the turbulent environment of the marketplace such actions are considered a necessity, even when believed to be contradictory to the philosophy of a medical professional. A young dental surgeon explains why marketing his practice (in an international scale) is essential: ‘…we (the MDs) are anymore part of the economy therefore one cannot pretend to be ‘above’ marketing’ (Medical Professional 13). The debt crisis which has led to severe income cuts for locals has crippled the domestic demand for private health care as well. Medical professionals have experienced significant slowdown of their clientele’s visits and purchasing power, motivating them even more to adopt marketing strategies and pursue the development of a clientele from abroad. An IVF expert suggests that,

> ‘Because of the slowdown that occurred during the last few years, we started investigating more on the possibility [to attract foreigners from abroad]’ (Medical Professional 08).

In some cases the pressures are described as high and advertising as a realistic necessity forced by the adverse economic conditions in Greece.

> ‘It is Friday and we do not have work in the practice. Aren’t we going to mobilise whatever mechanisms we can so that we have? We will not care about the medical association and the possibility that it will object to it [marketing practices]. When this will be done by many [MDs], because it does not concern only us, then we will be led to new things’ (Medical professional 23).

The negative impact of the crisis is a topic discussed in all interviews. Even those MDs, who are not affected by the crisis till the moment the interview takes place, are particularly worried for the future. The above excerpt, however, merits further examination for another reason; the dental surgeon appears determined to challenge the local association and embrace advertising. She is ready for a new time of increased commercialisation, especially in light of economic growth. The fact that other interviewees express similar views reveals that as an idea official commercialisation has matured among Greek medics involved in medical travel. In contrast, few participants claim they do not commit themselves to non-medical activities. For example, some argue that medical doctors do not possess the know-how, or that it is not their role to do business. They prefer to focus exclusively in practicing medicine or research. Preoccupation with business activities would

restrain their time in the medical work and the shift to other activities may cause loss of medical dexterity (Hughes, 1958: 134). Nevertheless, reluctance to dedicate their own time does not mean they are indifferent to the potential of services' exports. When it comes to foreign patients they reveal preference over bringing in advice of other professionals specialising in the fields of management, advertising, and marketing.

> '[The MD] has to hire a person to organise the [patient] reception. The MD cannot do those things. The MD might give the idea and find the relevant person to be in reception and also be salesman' (Medical Professional 18).

> 'A manager is necessary if a doctor wants to be an entrepreneur. The doctor may have good ideas of course, but it is necessary to hire a manager and let him do his thing' (Medical Professional 27).

It becomes clear that MDs stress the necessity of entrepreneurial skills (Hanlon, 1998) in addition to technical expertise. That is related to the perception over (the admittedly highly desired) success. In essence, an entrepreneurial spirit is considered a cornerstone for success. An IVF expert claims that "most successful gynaecologists are successful more due to entrepreneurial inspiration. They promote themselves better" (Medical Professional 14). For any reason that entrepreneurship might be pursued, (ambition, necessity or realism) success is conceptualised to a great extent in business terms. Entrepreneurship, therefore, emerges as a new value linked to success. "The tension between medicine as a scientific profession and medicine as a business", to paraphrase Stone (1997: 536),

seems to be reconciled, indeed non-existent. How success is defined reflects the values that inspire and guide professionals, i.e. in terms of excellent medical results which enhance patients' lives and benefit community broadly, and/or the increased prestige that a professional enjoys among their colleagues and/or by increased profits generated by an extended clientele (due to either excellent results or successful promotion of services). The quote above illustrates that success is perceived with reference to an extended clientele: it is not medical doctors with best medical results who are most successful but these who can promote their services better. Entrepreneurship and the advantages stemming from it are highly valued.

Professional Ethics void of disinterestedness

In the private sector health care is offered on the basis of purchasing power instead of need (Hanlon, 1996). It has been established by now that during the interviews most MDs have been explicit about their interest in profit making. Nevertheless, as Anderson-Gough *et al.* note for accountants, the commercial character of medical services does not mean it is an overall void of "service ethic" (2000: 1152). The medical ethics and moral concerns in the private sector simply start after the patient is admitted to treatment. In this case, a call for high quality of service provision dominates the professional ethic; most MDs might not aspire to serve all members of society according to need but do aspire to offer highest quality of service to their clientele. The practitioner below resents considering the possibility that the country exits euro as drachma devaluation would result in losing access to

high quality medical material which would unavoidably force her to compromise quality.

> ‘There are medical materials which, if we enter drachma, we will not be able even to access [due to] prices […] I want everything to look natural [after treatment]. This is possible only with one or two materials’ (Medical professional 12).

The statement shows dedication to highest quality of service; it is not perceived as exclusion of most citizens from her services, or an expensive product of high standards provided to a segment of the population. The dental surgeon appears dedicated to providing highest quality of service as she has been taught at university. Her aim is to deliver what she is supposed to (with reference to her teachers and the profession) and satisfy patients that decide to pay the price. For the rest, who only visit the dentist ‘of the neighbourhood’ no obligation is assumed. Of relevance are the considerations of a fertility treatment expert over his services and patients. The expert perceives fertility treatment as an elective, non-medicalised state-of-the-art procedure.

> ‘They can be better called clients […] because these people are not patients. They undergo a therapy that is not related to a health problem, it is an issue with fertility that they have…’ (Medical professional 20).

The gynaecologist explains later on that foreign patients undergo the difficulties of the trip to visit his practice due to his reputation and relatively low prices. The participant’s view openly de-emphasizes the role of the medic in favour of the role of the expert. At the same time, this view arguably undermines the social importance of

the service. As Brint has discovered through interviews with professionals in US, professionalism is centred on good medical results, whilst only but a few professionals 'remark on the social importance of their work' (Brint, 1994: 10).

Patient welfare remains, nevertheless, important for a number of reasons. First of all, there are psychological reasons related to MDs' work satisfaction, self-esteem and ego. Second, high quality of services means serving not only the interests of the patient but also those of the doctor, whose reputation is based upon medical results. Reputation is of great importance for an MD '[…] for his career is his ultimate enterprise' (Hughes, 1958: 135). Patient's welfare in these terms is translated into a marketable attribute; it increases the value of the service offered within a competitive market place (Anderson-Gough *et al.*, 2000: 116). Satisfied clients set in motion the word of mouth mechanism which is important not only for the domestic clientele but also the international one. As it has been illustrated in the first part of data analysis satisfied clients comment positively in patient forums but also to family and friends about medical skills and this is what brings in patients from abroad. The fact that reputation is connected to career may function, thus, as a quality standards' mechanism. Even though some medical mistakes can be relatively easy to conceal or responsibility easy to divert away from the medical doctor, establishing reputation would require relatively good medical results and high success rates. In a competitive international environment high standards of services along with reasonable (if not low) prices are expected.

Discussion

The work structure of medics practicing privately in Greece resembles to a significant extent the 19th century solo-practitioners in the US (Starr, 1982). They run small (or less often medium) businesses and despite their attachment to large organisations for their facilities and medical equipment (large private hospitals) they remain independent from any sort of managerial control. Given the opportunity to increase their business with clientele from abroad, related to international trends (patient outflows from leading economies), medical professionals exhibit considerable activity. In line with theories over human agency (Archer, 2000), research findings highlight that medics, basically spurred by a desire to increase profit, explore ways to attract clientele from abroad. This agency is reflected in their value system which is grafted by an aspiration for success, largely perceived in business terms. Brint's (1994) and Hanlon's (1996) work over lack of disinterestedness and commercialised professionalism, correspondingly, is particularly relevant here. Research findings show, however, that, simultaneously, medics' value system reflects commitment to results and clients. This ties back to a professional ethic void of concern over social welfare, a construct of the 20th century, and instead resembles the 19th century professional individualism (Marshall, 1939; Muzio and Flood, 2012). Back then, as much as now, career is of utmost importance and as such career choices shed light to changes in professional work (Leicht and Fennell, 1997: 217). Leicht and Fennel (1997) suggest that careers have been most recently constrained by organisations, but arguably careers are also facilitated or constrained by arising opportunities or threats within the environment

more broadly. In Greece, even though MDs enjoy status, income, and protection based on the 'law of silence', organised medicine in the private sector is weak, and professionals largely operate as individuals. As a result they are prone to show sensitivity to market conditions, such as internationalisation of health care and crises. Here the Greek debt crisis has also a role to play. It is acknowledged that it cannot account for the preoccupation of MDs with the internationalisation of health care, since the research findings show that there were practices both in Athens and Crete with established flows of foreign patients before the crisis hits in 2009. Nevertheless, it has been illustrated that the crisis has caused uncertainty among practitioners about the future due to a crippling domestic demand. For as long as the domestic market was strong, the demographic pressures of the overpopulated private practice were latent. Instead, a supply-induced demand ensured a steady (if not increasing) flow of income from the hands of clients to the hands of providers. The deep debt crisis, however, unleashed the creeping competition forces. Young professionals are increasingly migrating to Western Europe, Northern America, and Scandinavian countries (Papapostolou, 2012; Ta Nea, 2013) while the supply-induced demand cannot be ministered by the severely damaged income of citizens any longer. While the younger are hit the hardest, established professionals are particularly worried. In light of this uncertainty the interest in inflows of patients is intensified and professionals who would otherwise not consider the option now increasingly do so.

Overall, this part has attempted to expose the interplay between external forces conditioned by the environment (international patient movement alongside the

Greek crisis) and the professionals' craving to seize the related arising opportunities (international patient movement) and mitigate threats (crisis). The following part draws attention to the way professionals understand their work and selves amidst this commercialised endeavour, and illustrates that the entrepreneurial spirit reflected in their value system is for the majority the outcome of an internal struggle. The reconciliation of the entrepreneurial with the medical self illustrates a process of change, which coincides with the international patient movement.

The Entrepreneurial And Medical Self

There is a close relation between the content of professional work and identity of professionals (Halford and Leonard, 1999), as content of work relates to the roles that professionals assume. It logically follows that at times of change in the work environment the content of work may also shift, resulting in renegotiation of professional identity. Abel (2003) for example, successfully illustrates that political pressure on the legal profession during 1990s had a significant impact on professional identity. Similarly, after examining the entrepreneurial agency of MDs, it will be here explored how the sense of self is renegotiated (Halford and Leonard, 1999; Doolin, 2002) to allow the enactment of an entrepreneurial role in addition to the medical one.

Empirical studies in the literature of the professions capture significant changes in the values and identities of professionals engaged in differentiated additional tasks. Whilst during periods of change individual and collective resistance is often observed, research findings stress that professionals adopt new roles and undergo

mutation to adapt to the changing environment (Adler and Kwon, 2007). Adaptation of new values and self may be smooth or resisted but smooth adaptation is of interest here. For example, Dent (1993) observes that when clinicians in managerial positions feel that they 'own' a problem (i.e. have a managerial concern) it is easier for them to adapt to managerial values and ways of thinking, and finally to adopt a managerial identity. The growth in international patient movement comprises a significant change in the organisation of the health sector. It coincides with loss of the territorial character of health care and the introduction of different 'incentives, rules and structures' (Glinos *et al.*, 2010: 1145). It has been already emphasised that patient movement is strongly connected to commercialisation of health care (Chee, 2010). Medical care of foreign nationals is high in financial rewards and, therefore, desired by private providers. As such, international patient movement is not an externally imposed condition to encounter with defensive strategies, as i.e. the new public management in a number of countries or the modernising of medical careers in the UK (Bolton and Muzio, 2011). Medical doctors running their private practices in Greece, but also in Singapore, Costa Rica and Hungary, have strong incentives to attract foreigners. They see themselves as competent professionals who can be part of the emerging international health care market; and therefore explore ways to do so. (In contrast MDs in origin countries appear defensive towards the phenomenon). Requirements, however, for attracting international clientele are not negligible. It has been already demonstrated that MDs (need to) draw on managerial and entrepreneurial skills in order to succeed. The practice requires international promotion which can be achieved through marketing

techniques. In addition, foreign patient handling has differentiated organisational demands for a medical unit. A lot of units need to improve efficiency and employ personnel with advanced language skills. Administrative services also increase, including translation of documents, assistance with visa application, or hotel booking. As demands for non-clinical activities increase, the boundaries of work content, the worries, and the roles assumed by medical professionals change. At times, these external changes have an impact on self-understanding and identity (Gleeson and Knights, 2006). Research findings indicate that identity issues arise as medical professionals embrace entrepreneurialism and marketing practices that seem against the medical identity and association rules. While some MDs have a clear orientation to business, for others it is less easy to construct and frame their entrepreneurial identity along their professional one. Halford and Leonard (1999) highlight that 'what we do' influences 'who we are', and at the same time the reverse also holds true; the sense of self one has influences actions and activities. Research findings of this study indicate three basic types of professionals; first, those who demonstrate a strong business profile; second those who express a form of inconsonance between the medical and business role and who often embrace entrepreneurial activities reluctantly; and third, those few who feel completely alienated from an entrepreneurial self. Most often entrepreneurial activity is undertaken while MDs' training and socialisation abstain from a business mentality. Modicums of this training are present and create some tensions even though it appears that work setting is more influential overall (Hafferty and Light, 1995). Medics in this study may find themselves in a position that they feel like justifying

their entrepreneurial self (to themselves and others) but actually do not deny it. This tension between 'should' and 'do' epitomises the process of change under way given that action follows will.

The Eager and the Reluctant: The Process of Change

Type 1: Medical Doctor and Entrepreneur

A number of medical doctors interviewed have a strong business outlook. These participants openly discuss their business plans, their successes, but also problems encountered and failures. Some discuss an adverse investment environment in Greece that does not allow them to invest in new infrastructure for 'medical tourism'.

> 'Laws change constantly at the moment, I am not sure if there is a stable framework to create a health unit […] nobody knows what, how etc, nothing is tempting at the moment' (Medical Professional 25).

> 'I want a framework, a legal framework within which I can function as a private investor. If I as a private investor I invest 10 million euros, and you suddenly change the tax […] it is at risk. Why should I be investing here?' (Medical Professional 30).

> [Problems] are too many, way too many, I do not like thinking about it…until then [return to Greece] I was estimating that, ok, I will collaborate for a year [with a clinic] until I have my own ready… it is almost five years now! Strange place for business, strange for everything…' (Medical Professional 07).

Instead of a struggle with the entrepreneurial self, these participants have a clear understanding and exhibit clear affiliation with business. Medical doctors with a strong entrepreneurial profile (and some of them with apparently significant amounts of accumulated capital) would typically have large modern facilities with expensive state-of-the-art medical equipment and carefully managed public relations to promote their services domestically and abroad.

Type 2: Since I run a private practice, then I am entrepreneur

Most MDs comment that practicing privately includes by default a variety of management and business related tasks. Activities such as employing administration personnel or medical assistants, the purchase of medical supplies and equipment are recognised as non-clinician tasks.

> 'We are all businessmen. Since I pay for my assistant, pay for my equipment, since I make my living every day, this is a part of the practice' (Medical Professional 13).

In contrast to the first group of doctors, the second one makes a special mention to the distinction between the managerial and entrepreneurial role. That is partly because even though they recognise a managerial/entrepreneurial self**,** it feels more of a pressure and less of a choice. In fact, quite a few MDs drawing on their experience abroad express a type of nostalgia over the division of roles and tasks elsewhere. They often compare the role of the doctor in Greece with that in foreign

countries, such as the US or the UK, to explain that in Greece entrepreneurship is imposed by the very organisation of the private health care provision.

> 'Since one is not working in a public hospital, one is in some ways an entrepreneur. In US for example, doctors have their private practices but they are always in a space, in a hospital, a centre…most of them…This helps them in organisation and they are preoccupied […] much more with the medical part. […] Here, you are forced to become entrepreneur, if you do not you are not going to survive' (Medical Professional 22).

Indeed, physicians in the US have started substituting the traditional solo provision of healthcare with collaborative arrangements where more than one doctor offers their services together or work under managed care. According to Domagalski (2007: 134), this increase is as high as 350% for the US. Another participant compares the Greek situation with practices in the UK.

> 'We are all forced to be [entrepreneurs]. […] Unfortunately we do not have, namely what we had in the practice in England, a practice manager. But I repeat, to do that you need a practice with two, three doctors to be able to justify a practice manager, who is going to take over the part of public relations and the promotion of the medical doctor' (Medical Professional 26).

Other professionals, in contrast, seem to engage in a process of redefining their role and identity vis-à-vis the perceived opportunity. This is expressed by resentment over time pressure which hinders their intention to give more attention to business

activities. The medical professional below explains that his tight work schedule does not allow him time to assume the role of an entrepreneur appropriately.

> 'I am very bad [as an entrepreneur]. But it should be different […] a doctor cannot function absolutely as an entrepreneur, a doctor that works from morning till night, I work since 7 until 9-10 at night and then I have my family, I want to spend time on it, but it is not possible. Someone else has to take this over for me' (Medical Professional 14).

The practitioner's view highlights that the tension is not between the role of an entrepreneur with that of a medical doctor, but the highly demanding requirements in time of both. Despite that, it is not only a matter of time. As Preston and Price (2012) note for academics in managerial positions in UK, several MDs in this study feel incompetent or lacking skills and training over enterprises. This has been highlighted in the previous part, when practitioners explain that agents are necessary to take over particular tasks. It is also illustrated earlier in this chapter, when they explain that the doctor may have good ideas but need a manager or a sales' person to 'do his thing' (2012: 267). The benefits of managerial and entrepreneurial skills, are recognised, more so in attracting foreign clientele, nevertheless, several professionals feel to a significant extent incompetent.

Hotho's (2008: 736) empirical work on medical doctors confronted with managerialism is that individuals often perceive change as challenge to their identity, however, 'take the opportunity to revise and rewrite it'. The above excerpts illustrate a similar process of change and the one below offers an illustrative

example of identity revision. It shows the case of a practitioner who is initially surprised by the business attitudes she encounters when she starts looking for ways to engage in medical tourism, but who eventually revises her expectations to adjust to the situation.

> '...then I understood that the offices [intermediary companies] expect to have a percent of the revenue for referring the patient to the practice. This I could not…I did not know at this point where to categorise it; I thought, is it bad? This is how it is, how it should be? I could not decide and then I contacted [name of another angency] […] yes, there is a commission indeed, 15-20%. […] In the end I found it normal…it scared me in the beginning because I thought what is the job of this person? An intermediary, this is an intermediary' (Medical Professional 24).

The considerations of the practitioner resemble the process described by Niemi (1997) to a significant extent.

> '…contradictory and ambiguous situations and experiences usually stimulate self-reflection and questioning of one's personal views. The earlier ways of thinking and matching no longer match the situation at hand, but the individual is faced with a need to consider alternative resolutions and views' (Niemi, 1997: 409).

Though quite a few participants reflect on their lack of skills and time, in fact, it is significant how their desire to engage in medical travel fosters their entrepreneurship. Within the country most would retain a careful promotion of their image (for example some would do so through TV shows or 'scientific' newspaper articles), basically for two reasons. First, advertising is prohibited by the state and at

least the association of dentists is strict in enforcing restrictions. At the same time, domestically, medical doctors recruit patients in the traditional way of word-of-mouth, which at least until the crisis hit the country, crippling the disposable income of Greek households, it run well as a model. Most practices would do remarkably well after the first few start-up years. Promoting services to foreign clients is, however, a game they are not used to play. Advertising amidst international competition and re-organisation of their practice are necessary. Willingness to engage in 'medical tourism' accentuates an entrepreneurial rational and, therefore, self. For example, a plastic surgeon describes that he needs a representative to advertise his services in foreign countries and 'collect cases' to be directed to his practice. Another surgeon comprises an excellent example of entrepreneurial ingenuity; he manages to escape the restrictive Greek law on advertising since he realised that a medical webpage could have a commercial character when it is not in the Greek country code domain.

> 'The website you have seen on internet is illegal according to the essence of the Greek law. Just the Greek law cannot touch me because it is not attached on a Greek site. […] It is .com, therefore, as it is not .gr the Greek law is not applicable […] this is the oxymoron. How is one supposed to attract [people without advertisements]?' (Medical Professional 01).

The surgeon suggests here that advertising restrictions and the positive stance of the state towards the development of medical tourism in Greece are incompatible. Therefore, he devised a way to overcome the ban, showing little ambivalence over

the dual role of medic and entrepreneur. Attracting foreign clientele is the supreme goal and given the benefit for the economy this is a legitimate priority. Similarly, condemnation of a considerable number of practitioners over advertising restrictions was vocal. MDs, therefore, shape an entrepreneurial self and employ advertising techniques, representatives abroad, and strive for business success. The emergence of international patient movement stimulates a commercial logic which is not rejected based on what many scholars working on the sociology of the professions would refer to as *professional ethics*. In contrast, in anticipation to financial rewards, most medical participants are willing to renegotiate the practices and their role. This positive response to the call of international patient travel for entrepreneurship is closely related to a smooth change in the sense of self. As Halford and Leonard note,

> 'identities are not fixed in a transcendental human subject…they are continually in the process of being constructed, continually subject to change as the relations, practices and discourses which surround individuals change' Halford and Leonard (1999: 109).

Type 3: Not an entrepreneur…

Before closing this section, it is interesting to refer to two cases of participants who maintain a negative stance to entrepreneurship. One clearly states that promoting services to foreign patients 'sounds like trade'; the practice does not allow continuity in care; and therefore it is not in his interests. It is notable, however, that phrases in the (English version of the) website promote his practice as the leading in

Greece revealing a marketing style. There are also newspaper articles that refer to professional achievements and life stories of his. Furthermore, it is noteworthy that during the interview he refers to an unsuccessful attempt of his, long ago, to create a clinic that would attract foreigners to one of the Greek islands. It is interesting thus, even self-contradictory, that he expresses an aversion to 'business'. Promotion of his image is attributed to a personal vanity to become known and respected instead of a desire for business success it self. This relates to the status of the profession of medicine (Freidson, 2006; 1993; Light, 1993) and the identification of the members with their profession (Larson, 1977). While Polanyi (1947) stresses that financial incentives could never be the only motivation accounting for the interest of people in their work (as neoclassical economics contend), it is interesting to consider that medical doctors seek professional status through business success (e.g. the establishment of a hospital treating foreigners). Their practice is strengthened and their career advances, and though enterprising behaviour is contradictory to a duty towards society it is not contradictory to the duty towards their patients (Relman and Reinhardt, 1986). Lack of disinterestedness, however, is a slippery slope as it justifies trust in the patient-doctor relationship (Parsons, 1969; Marshall, 1939). Notwithstanding that most participants appear to neglect the importance of disinterestedness, few maintain a distance from an appeal to financial incentives in justification of their entrepreneurial initiatives.

The other 'exceptional' interviewee appears consistently all too dedicated to her teachers and profession and she mostly talks through the interview about the satisfaction she gets from her work and 'happy patients'. Interestingly enough,

however, she is also not immune to commercial practices. The market environment within which MDs work, and the omnipresent enterprise culture, affects most professionals to an extent. The surgeon describes how a family member tries to promote her practice in ways she does not necessarily approve. In her view marketing undermines her excellent training and quality of work. Despite the fact that this particular professional exposed a genuine medical identity throughout the interview, she mentions that she is actually engaged in advertising. Interesting is the narration that a commercial initiative of a family member taken on her behalf, provoked the reaction of the medical association. She resents recalling that in the end she was threatened with expulsion from the association.

Discussion

The Adverse Effect of Entrepreneurship on Collegiality and Professional Cohesion

Entrepreneurial initiatives may be understood in the framework of developing a career and a micro-level tactic to adapt to challenges and opportunities (Evetts, 2011). Evetts (2011: 417) gives the example of professionals such as nurses, midwives, medical doctors and teachers who obtain degrees in management, an initiative which she interprets primarily as a micro-level strategy to adapt to introduced managerialism. Similarly, entrepreneurialism may be interpreted as a tactic to respond to an opportunity amidst increasing insecurity experienced by solo practitioners. Nonetheless, it is important to note at this stage that entrepreneurial

attitude on the side of MDs might have an adverse effect on the profession overall. Fragmentation among MDs may become exacerbated in two levels; domestically and internationally. During the interviews quite some comments of participants on their peers made apparent a modicum of segmentation in the medical profession. Though it is not the purpose to make here a full analysis of the issue, it seems that elitism is apparent in the local community of MDs. Some participants would distinguish themselves from the 'doctor of the neighbourhood', referring to doctors holding practices on densely inhabited neighbourhoods instead of locations downtown. In essence, the first aim at gaining clients based on proximity to their house, whereas the latter based on their fame.

'Truth is that not all MDs are capable in Greece to do this [medical tourism]… to be honest with you' (Medical Professional 07).

explains a participant considering the overall competences of local MDs. MDs trained abroad are considered by some interviewees more skilled vis-à-vis inbound patients. This perception is not attributed (only) to technical expertise obtained abroad but to advanced language skills and long experience of living in another culture. MDs that prove more active towards the new phenomenon in Athens are indeed MDs with practices at expensive neighbourhoods, the centre of the city, or the 'silicon valley' of medical providers in Athens - located in close proximity to the two large private hospitals. For one reason or the other, some of the MDs have the capital or interest (or both) to invest time and money to the emerging 'opportunity' of patient movement. Social class may be an explanation but a better understanding

would merit further research. A broader success of these MDs would potentially strengthen their financial and status position, increasing the rift between the two tiers. A strategy to adapt to opportunities and advance one's career renders the risk of further segmentation within the profession.

Beyond national borders, an informal opposition among MDs has emerged in the epic centre of patients' initiative to travel for health care. As we have seen, MDs in Greece consider the phenomenon as beneficial for the patient, the provider and the local economy. In addition, it is highlighted by the majority of participants that such development advances the public benefit. Greece is envisioned by some participants as the 'Florida' of EU. Therefore, most are proponents of patient travel despite scepticism expressed for potential health risks and technical problems. In contrast, MDs in origin countries apparently look at the dark side of the phenomenon. The literature review refers to the opposition of members of the medical community in a number of countries. The basic arguments refer to personal, family and public health risks but also to increased costs for the national health care system (for the countries that run one) and/or the individual. Argumentation on the grounds of public health and the overall public benefit is in this case reversed; it is not a win-win situation for all stakeholders but a development rising concerns on multiple levels. While, scepticism is justified, it becomes obvious that at least some MDs in origin countries count losses from the outflows of patients and arguably have an interest in reversing the trend. As a result, international competition among privately working MDs of same specialisation is fostered due to international patient movement. As the latter grows competition is exacerbated. The considerations of

Dezalay over competition in expert communities are of relevance. The scholar considers that conflict of interest within professions is for the time being concealed by the overarching professional ideology. Nevertheless, he wonders about the impact of international competition on the imminent professional crisis:

> 'Are we dealing with a recent phenomenon, brought to light, but also aggravated by, international competition? Is the crisis of the professions a corollary of the economic crisis? Is the revival of tribal wars in the world of expertise an effect of the dismemberment of the State?" (Dezalay, 1995: 334).

In fact, all these points add to the current analysis. The withdrawal of the state from society's welfare is arguably a factor that encourages patient travel, and under these lines, international competition. At the same time, the shrinking support of the state towards professions diminishes their market shelter. The entrepreneurship of MDs aggravates competition with adverse implications on the solidarity of the domestic and international medical community. A vicious circle is encouraged. Brint notes that anticompetitive practices have 'supported the sense of collegiality' and have 'served as the model of professional behaviour' (1994: 43). Advanced commercialisation, however, exacerbates domestic segmentation and internationalisation of health care divides peers along the national border lines. The consequences are not merely economic, as Freidson (1984) suggests in his critique of the de-professionalisation thesis. For example, the loss of solidarity among peers may challenge their image in the eyes of the public. Criticising the hygiene practices of Polish dentists may convince British patients to be treated domestically, but at the

same time it starts an international conflict, with internal solidarity being damaged. But solidarity is crucial as it has a key role to play in protecting professional boundaries and control over the content of work (Hafferty and Light, 1995). The ascertainment of an enterprising profession, therefore, is unavoidably accompanied with scepticism about the future of professionalism.

CHAPTER 10

CONCLUSION

The current research seeks to shed light on the role medical professionals play in the internationalisation of health care through the case of physicians practicing in Greece. In this endeavour it fruitfully combines two distinct bodies of knowledge; the sociology of the professions and the literature on the international patient movement. Their intersection offers new avenues for exploration and new insights for both fields. On the one hand, the thesis presents conceptual and empirical insights on the phenomenon of international patient movement. It places the development within the internationalisation of health care, closely linked to the reconceptualisation of health care from a public good to a commodity. Commodification is here critically examined. It is argued that the consequences of commercialisation fall on health equity. Combined with lack of regulation, it disadvantages populations in destination countries, patients seeking care abroad and negatively affects social justice. More importantly, it is suggested here that the reconceptualisation of health care influences the attitudes of key actors and transforms them into market agents. The study examines this process through the example of medical doctors. Bringing insight from the rich framework of the sociology of the professions, medics are recognised as an empowered actor, interdependently connected to the environment; influenced by contextual factors and

at the same time able to influence them too. Sometimes through collective agency and at others through individual action, professionals are depicted as actors that protect and fortify their privileged position in the division of labour and society. Professional behaviour, as captured by the current research, manifests strong elements of commercialism and entrepreneurship, at least with regards to patient movement. In light of this, this piece of work unveils medics' perspective and initiatives. Following their thoughts and descriptions, it allows the reader to enter their world and listen to their ambitions, concerns, and aspirations with regards to an emerging field; a field primarily perceived as a promising development for their career.

At the same time, it gives the opportunity to consider the contextual factors that professionals recognise as constraining or encouraging their initiatives (i.e. the international movement of patients or the initiatives of the state), and the way they perceive the social and economic environment within which they work and act more broadly (i.e. the Greek debt crisis or the 2008 international crisis). Furthermore, the study considers potential implications for professionalism. Change in professionalism amidst contemporary trends is a commonly debated topic within the academic community. The internationalisation of health care, however, and in particular the international movement of patients, is for the first time studied empirically within the framework of the sociology of the professions. The internationalisation of healthcare offers an exemplary case of marketisation and the solo practitioners in Greece an intriguing actor in this process. Unfolding the implications for professionalism is, therefore, a significant contribution of the current

study. The concluding chapter summarises the main research findings and thereafter comments on the major contributions to knowledge with regards to the literature on transnational health care and the sociology of the professions.

Main Findings

National Setting

Professional power of medical doctors within the Greek setting is not negligible. They have long maintained their autonomy within the public sector, controlling resource allocation and escaping managerialism or any form of assessment. In the private sector, medical doctors have managed to control supply by manipulating private expenses. Working independently from large private hospitals, solo practitioners have control over patients and therefore the domestic demand. As far as their collective power is concerned, conclusions are difficult to draw. On the one hand, political party segmentation divides the profession. On the other, it is suggested that organised medicine has influenced health policy by blocking national reforms. The research findings of this study suggest that at least in the private sector organised medicine is non-existent, while medical professionals maintain antagonistic instead of collegial relations. Economic power, however, is evident at least among study participants. In contrast, younger professionals face unemployment and in the aftermath of the debt crisis migrate increasingly in search of a work place. The crippled domestic demand and the heavily indebted state create an unpromising future for all.

Transnational Health Care Provision: Structure, Logic and Incentives

International patient movement takes place most often at the centre of multiple forms of commercialisation. Internationalisation of health care is a development endorsed by international regulatory bodies as a form of trade and embraced by some states as an increasing returns business sector. As such it is conceived and inextricably linked to marketisation. In some cases bilateral agreements between countries, as is the case for specific bordering regions in EU (Rosenmöller *et al.*, 2006), form an exception to marketisation. Most often, however, the publicised empirical research on various aspects of the development depicts key actors as market agents; including providers, agents, and patients. In particular, providers are for-profit organisations that employ marketing techniques to reach their potential clients overseas; specialised agencies advertise health services and intermediate between patients and clinics; and patients take health care in their own hands and decide on providers based not only on quality of service but, often, on cost, proximity, and cultural familiarity. Medical providers are often small and medium practices operated by medical doctors on a solo basis or small partnerships. This is evident in Greece, but it seems that in Hungary, Costa Rica, Singapore, South Africa and other destinations, small and medium providers attract a significant part of inbound patient flows. Physicians are key actors in the delivery of health care and simultaneously a key pull factor in patient decision making process in medical travel. Moreover, the current research gives an example of where their role is pivotal in the emergence of transnational health care in itself The resemblance to the market characteristics of any other ‘commodity’ is striking; quality, price, sales, marketing,

international ventures and international trade dominate. The commercialised character of the sub-sector of health care coincides with a wider contemporary trend of enterprise culture in public policy. Closely related to neo-liberalism, state policies prioritise managerial practices and collaborations between the public and private sector in the provision of social goods. As a result, internationalisation of health care takes place in a historical context where private ventures are intellectually favoured by policy makers as a superior mode of organisation and production. Marketisation is continuously expanding and currently plays out as socially acceptable (Scott, 2008) and the unavoidable final destination of every human interaction. Practice and ideology, private and public sector strongly favour it.

Professional Initiative and Activity

It is suggested that medical professionals in Greece organise their activities in small and medium practices. A number of these practices have an export orientation which results in attracting patients residing in foreign countries. Against the backdrop of substantial efforts by large private hospitals to attract patient flows in Greece and elsewhere (e.g. Turkey, India, Thailand), demonstrating that small practices take such initiatives is an important research finding. More importantly, it draws attention to the fact that medical doctors are at the centre of these initiatives. Research findings of the current study suggest that medical doctors in Greece deploy reputational capital, existing cross-border networks, newly established collaborations with intermediaries, and marketing techniques to increase their share in the international market. These methods indicate then the co-existence of two

basic fashions of professional engagement. The first is closely related to work as usual, albeit expanding across borders; it includes referrals from colleagues and former patients to their relatives and friends (word of mouth). The characteristic albeit important difference lies to the fact that patients are referred to overseas doctors. An important factor is the cosmopolitanism of these doctors with most spending a considerable period of their training/career in Western countries. During those periods connections with local patients and professionals create networks that endure after moving to Greece. This finding is also important in that it establishes a link between the international movement of patients and the international movement of medical professionals. The second way of developing clientele, entails elements of novelty; new methods (including direct advertising of services), novel means (the internet plays a conspicuous role in the process), and new types of 'referees' (including brokers rewarded with fees, and the word of the mouth effect through online patient forums). Involvement to international patient movement is therefore opening–up new venues for communication and public relations, which appear strongly related to medical marketing (a formerly limited practice among Greek medical professionals). This 'new way of doing things and their exploitation' lies in the heart of innovation, a basic aspect of entrepreneurship in itself (DTI, 2003).

Perceptions and Politics

Medical professionals discuss the phenomenon of international patient movement in the framework of an arising opportunity beneficial for patients, themselves, and the country in financial and political terms. International patient

movement is perceived as an inevitable development owing to increasing costs, long waiting lists, law restrictions and easiness in travel. A few participants contextualise it within the framework of health care marketization, commercialism and consumerism. It is notable that the perception of patient travel as an inevitable global development depicts professionals as individuals who have no power or means to influence the evolution of events. Although conceptualised as an external condition, it is envisaged by and large as a unique opportunity. At the same time, international patient movement is conceptualised as a chance to achieve high value-added growth and boost the economy. Amidst the dramatic debt crisis that Greece is undergoing, growth of such a business sector is indispensable. The role of medical professionals is then advanced as central in supporting the economy; a rhetoric which potentially legitimises MDs' involvement (Suddaby and Greenwood, 2005). In this light, state support is deemed essential not only because of trade balance benefits but also because disaggregated efforts could only slowly (if at all) fulfil the potential of Greece to become the 'Florida of Europe'.

Patients visiting the study participants are mostly from advanced economies, most often Europe and the US. They may be both of a high/middle income, visiting for fertility treatment, or middle/low income visiting, for dental care, plastic or eye surgery. Quite a few are of Greek origin or Greek nationals living abroad. The medical professionals describe their foreign patients as well-informed individuals who show high levels of compliance during therapy. An interesting finding is that empowered patients result in higher levels of satisfaction for medical doctors. The research outcomes of other studies stress that most professionals, instead of

focusing on improved collaboration, feel challenged by knowledgeable patients. This feeds back to the dominance paradigm of the sociology of the professions, suggesting that information asymmetry constitutes the patient as weak and the doctor as the strong part in the relationship. In contrast, the research findings highlight a marketised picture in which professionals see themselves as experts offering services to knowledgeable clients. At the same time, as medics they feel particularly honoured by patients travelling from far for consultation, increasing the overall experience. In contrast, the research findings highlight a problematic relation with the intermediating agents who take over the task to bring professionals into contact with foreign patients. Though MDs recognise they fill a gap in the market, they also think of agents as untrustworthy. In addition, they are challenged by the power of agents to intervene in the doctor-patient relationship and their effort to negotiate fees. The latter, who are used to dominating the division of labour, do not hesitate to stop collaboration with agents in some cases even when it is at the expense of their foreign clientele.

Motives, Value System, and Identity Issues

Both in terms of activity and conceptualisation medical professionals appear attached to the notion of entrepreneurship. This argument is advanced here in four ways. First, professionals see a business opportunity in the emergence of international patient movement. Recognising business opportunities, however, is a cornerstone of entrepreneurship and, in theory, incompatible with the professional mentality (Freidson, 2001). The research findings, however, do not show significant

tensions between the two. As we have seen above, medical professionals conceptualise the development as a win-win situation and reflect on it as beneficial not only for the entrepreneur, but also for the patient coming from abroad, and the domestic economy. The idea that commerce fosters 'douceur' is an old one, nonetheless, it is mostly repeated during times of growth in capitalist societies (Hirschman, 1982). It is here conveniently, albeit implicitly, put forward by study participants. Second, the research findings stress that medical professionals do not only realise there lies a business opportunity. They exhibit entrepreneurial agency in an attempt to seize it. A few participants move to Greece counting on their established reputation internationally, while others do not hesitate to engage in commercial practices for the first time. They experiment with online marketing and try out collaborations with tourism agents. They invent ways to escape the law restrictions on advertising or simply ignore them. When success is limited, they are not discouraged; it makes them think that business require skills they have not obtained or exercised. Third, the justification for this entrepreneurial attitude is basically profit generation. Although it may appear remarkable that professionals openly share their knavish motives, it is also a pragmatic consideration expressed by solo practitioners who are not protected against macroeconomic changes. Research findings show that motivation of professionals is layered. Competitors, even if not personally, know one another because the domestic market is small. Pride should not be underestimated; it has been demonstrated that participants express a feeling of honour for having foreign patients visiting them. Quite a few reflect on foreign patients as recognition of their expertise. This gives prestige to

practice with regards not only to future clientele but also to their peers and competitors who watch their successes and failures.

Despite significant changes underpinned by experimentation with new marketing techniques, elements of continuity are also discernible (Evetts, 2011). Most remarkable is perhaps the continuous effort to maintain power in the supply of health care provision (MacDonald and Ritzer, 1988) and subjugate countervailing powers (Light, 1993; 1995; Mechanic, 1991, Abbot, 1988). This is expressed here by the negative stance towards agents. Medical professionals interrupt or turn down collaboration which plays out as a tactic for disempowering agents. It is also interesting that this occurs repeatedly albeit in an uncoordinated way. Notwithstanding the fact that professionals do not maintain links with one another, their responses appear similar; they collaborate with agents only when they feel their fees are low and their intervention in the doctor-patient relationship is insignificant. In this way they maintain without deliberation a relatively similar line of action.

Fourth, an entrepreneurial spirit infiltrates their value system. It is already demonstrated by Brint (1994) that professionals reflect on their scientific expertise and not on a perceived duty to society. The findings of this study suggest that entrepreneurialism comprises a logical second step to lack of disinterestedness combined with accentuated competitive forces. The research findings also illustrate how actions and motives are reflected on professional identity; in fact, participants reflect both on their duty to individual patients and the future of their practice. Next to

their medical stands an entrepreneurial self, either it is exercised successfully, unsuccessfully, wholeheartedly or reluctantly. Only a small minority are found to be denying it, and actually that takes place independently of whether they employ marketing techniques (domestically or abroad). For most participants, however, professional ethics are not breached since commerce is no longer dishonourable (Marshall, 1939: 326). Marshall suggests that professional ethics rest on the premise that trust does not exist in the buyer-seller relationship. The professional-client relationship instead promotes trust. What becomes evident here is that since professionals claim trust on the basis of scientific expertise, disinterestedness becomes redundant, especially as the information asymmetry gap closes. Informed patients understand their medical condition, are able to find the right expert, and comply in a mature way during therapy. A vibrant interplay between continuity and change in professionalism emerges out of the analysis. Medical professionals exhibit a tendency to absorb new elements from the commercialised environment and combine them with existing attitudes and perceptions. The omnipresent enterprise culture infiltrates professionalism and contributes to hybrid forms of professionals.

Discussion

The Nature of Professionalism

The debate over the nature of professionalism and its relation to bureaucracy and the markets is has been already analysed (chapter 4). While Freidson (2001) presents a model of professionalism as distinct to the logic of commercialism and

managerialism, other scholars observe co-penetration of logics (Hanlon, 2004; Adler *et al.*, 2008). The findings here show a case of enterprising professionalism with elements of commercialism and entrepreneurship clearly manifested. In practice MDs exhibit an exports' orientation and in ideology an inclination to profit making and business success. This shows attachment to commercialism. It does not mean that MDs do not strive to offer the highest quality of care. Quality remains a priority as study participants are devoted to high standard clinical outcomes. Patient's welfare is translated into a marketable attribute; it increases the value of the service offered within a competitive market place (Anderson-Gough *et al.*, 2000: 116). It is linked to reputation, which is of great importance for an MD '[…] for his career is his ultimate enterprise' (Hughes, 1958: 135). In addition, it is important to note that quality in services is not simply a matter of a successful long-term career or business plan. Though this is crucial, MDs' oath to 'benefit and do no harm' is formally institutionalised through legal liability. Commitment to high end results survives.

Therefore, evidence presented here suggests that commercialism (expressed through entrepreneurship and self-interest) and professionalism (dedication to high end results) penetrate each other. In light of this, the contention that disinterestedness comprises the soul of professionalism (Freidson, 2001) deserves re-examination. Terms such as path dependency (Kirkpatrick et al., 2009; Muzio and Flood; 2012), mutation and adaptation (Larkin, 1993: 89; Adler and Kwon, 2007), continuity and change (Evetts, 2011) are employed in the literature to express new meanings and understandings of hybrid forms of professionalism. Another strand of

research is preoccupied with occupational change as an endogenous process generating significant spill-overs to the environment (Suddaby and Viale, 2011; Scott, 2008). Professionals are perceived not just as responding to external pressures but as agents that deliberate change in their environment. The current work, correspondingly, offers a tangible example of solo practitioners who try to change the boundaries and nature of practice of the sector.

Professional Entrepreneurship and Opportunism

The literature on the sociology of the professions elaborates strategies and tactics deployed by professionals in response to external changes. Resistance to managerialism is observed for example in the British NHS, 'colonisation' of management in Denmark (Kirkpatrick *et al.*, 2009) and 'hybridisation' of professionals who acquire accounting techniques in Finland (Kurunmäki, 2004). Similarly, acquisition of managerial skills is noted for lawyers in large law firms (Muzio and Ackroyd, 2005) and a 'symbiosis' between medics and the drug industry in the US (Timmermans and Oh, 2010). The conclusion is that professionals evaluate the circumstances and, independently from the tactic employed, battle to maintain privilege and power. At a micro level, they also seize opportunities that benefit their career. Currently, despite the multifaceted changes disturbing long-standing organisational arrangements alongside the position of professionals, Henriksson *et al.* (2006: 185) suggest that members of traditional professions are provided with new opportunities. In their opinion, it is the lesser occupations that depend upon the welfare state who are particularly weak in the current context. In

that sense, professionals may cope quite well within the private (or public-private mix) sector, at the expense, however, of deeper segmentation. The elites discern and seize opportunities easier and count the least loses.

This line of argumentation may enlighten the research findings of the current study. Specifically, it is demonstrated that a particular group of medical professionals, mostly with training/work experience abroad, observe the international movement of patients, conceptualise it as an opportunity, and attempt to seize it. The commercial character of necessary activities for the endeavour is not a major concern. On the contrary, medical professionals working in a competitive and insecure environment develop an entrepreneurial spirit which gradually infiltrates their identity. In addition, the findings show that professionals respond to internationalisation in an individualistic way. They consider the possibility to collaborate with colleagues limited but at the same time they are highly sensitive to their career path. The latter is observed in the solo practices of the 19th century (Starr, 1982; McCullough, 2002), the public provision of the 20th century, and the large organisations and managerialism of the late 20th and 21st century (Muzio and Flood, 2012; Stone, 1997). Solo practitioners today form no exception. Amidst increasing commercialisation, the shrinking of an historical ally, the state, and the advancement of the enterprise culture, it is not surprising that professionals acquire entrepreneurial attitudes. Hafferty and Light (1995: 139-140) conclude that the work setting influences professional choices and actions more than university training and socialisation. The interplay between external conditions and individual action is evident here. Medical professionals are following the flow of the river; they are not

forming a stronghold against contemporary trends. They attempt to seize opportunities and keep afloat.

Entrepreneurship and Professional Power within the Broader Context of the Enterprise Culture

If it is accepted that collegiality and professional values lie at the heart of autonomy and claims to power and influence, then the practices and values described above carry an important weight for professional power. At the same time, the argument of flexibility and 'diplomacy' deserves a deeper examination as such changes may actually be a better fit to the current and future context and may allow professionals to preserve power. For example, if values of other individuals and groups move along the same lines, then medical professionals' power might not be challenged but perhaps differentiated. Abercrombie (1991) suggests that the enterprise culture observed [in British society] is not the result of political initiative but instead the result of 'fundamental changes' in society itself. Even when the enforcement of market practices in health care are understood as a top down process, it can be argued that market values are increasingly diffused within society. Certain groups and individuals clearly oppose neoliberal practices and market mechanisms permeating every sector; nevertheless, entrepreneurship is advanced as a feature connected to wealth and success, personal achievement and is praised for moving the economy forward. Universities increasingly include entrepreneurship in their student programmes and partners are partly transformed into business enterprises. In Greece, entrepreneurship is recently depicted as a way out of the

crisis with various programmes announced to support young entrepreneurs with innovative ideas. Such initiatives are widespread in Europe and elsewhere. Correspondingly, in the US Blank (2012) argues, the health care problem remains unresolved partly due to individualistic societal values which prioritise unlimited health care to those who can afford it. In fact, this occurs at the expense of a more communal solution, which would afford universal coverage. Blank (2012: 420) suggests that Americans are 'hesitant to sacrifice perceived individual needs for the common good'. What is argued here, then, is that professions are indeed enterprising, nevertheless, the change occurs within an increasingly enterprising culture and, therefore, professional change cannot be evaluated based on a previous societal value system or paradigm. The environment is actually open and more 'friendly' than ever to entrepreneurial attitudes. 'Professional culture meets enterprise culture' in the public sector of numerous states and professionals are expected to be 'more enterprising, business-like, and customer focused' (Boyce, 2008: 78). This occurs even when not all professionals within the public sector are open to the enterprise culture (Ennew *et al.,* 1998). Overall it is suggested that there has been a deep change towards a more positive perception of private gain at the expense of public service values and morality (Scott, 2008: 233). Scott relates this to the expansion of neoliberalism and the legitimation of the rule of the market in the social sphere of life (Scott, 2008: 233). The international movement of patients, therefore, coincides with symbolic changes in the penetration of commercial practices in health care. This next section examines the research findings and

attempts to highlight how the academic audience may abstract from the particular case study.

Contribution to knowledge

Enterprising Professionals Reinforcing the Enterprise Culture

In large organisations professions can barely if at all be distinguished from the market and bureaucracy; commercialisation is advancing and professions are increasingly working under managerialism (Evetts, 2011: 407). While attention has been drawn to the 'organisational professionalism' emerging in large professional firms or organisations, the literature has somewhat neglected the shrinking albeit significant segment of professionals working on a solo basis. Commercialised professionalism as described by Hanlon (1996) is also examined within large accounting firms. The effects of major changes such as the advancement of marketisation and commercialisation are, therefore, not explored in depth within the context of solo practices. In Greece the model still dominates in health care provision but in most countries high percentages of solo practices also endure. At the same time, the internationalisation of health care serves as an exemplary case of advanced marketisation and a macro-level change that offers a unique opportunity to understand occupational change. As such the enterprising professionalism observed among solo practitioners comprise a significant contribution to the literature.

At the same time, contemporary macro-level changes are presented as externally imposed on professionals who respond by deploying strategies either at a collective or individual level. An important finding of this study, however, is that a number of medical professionals explore ways to engage with internationalisation. While business attitudes among physicians in the US are cultivated by insurance companies in a top down fashion, medical professionals in this study make an opening to marketing techniques; challenge the Greek law restricting advertising and push for a bottom-up change. Except for traditional ways to increase their clientele basis, they experiment with new methods that allow them to respond to the differentiated requirements of an international demand.

Market Creation

Solo practitioners engage actively in market creation. Greer and Rauscher (2011) suggest that there is no market of health care services across the EU as yet. The EU Health Services Policy, which is expected to facilitate trade, has accomplished little more than 'negative integration' (Greer and Rauscher, 2011: 797). Removing barriers differs significantly from market creation, the scholars note. As a result, progress in that direction depends on the initiatives of various stakeholders, such as patients, providers or governments. The research findings of this study show how medical doctors as a stakeholder not renowned for entrepreneurialism contributes actively to the internationalisation of health care. Market creation is enabled by reputational capital; networks in foreign countries with patients and peers (social capital and skill); financial capital available for investment; collaborations with

intermediaries; and novel marketing practices - novel at least for most medical specialisations within a country that advertising is restricted. The shrinking of the social welfare state means the loss of a traditional ally and at the same time the pragmatic opportunity for the creation of a new field of action. MDs are engaging in its formation and are working on the extension of their work to the emerging international field. In other words, the current work gives an example of how professionals develop and build markets.

Practical Implications

The entrepreneurial agency of MDs may have significant practical implications. Professionals' initiatives reinforce commercialisation. Though the group of MDs interviewed is considered different in comparison to the majority of practitioners, their initiatives may lead to lifting the advertisement ban. The influence may remain latent for the time being but might play a prominent role in the future when other conditions pushing for abolishment of advertising restrictions mature enough. The consequences will be detrimental for the domestic provision of health care. They may be relevant to the position of the profession with regards to other actors or may be relevant to the broader population. In particular, commercialisation is accused of contributing to deterioration of health equity outcomes. The rule of the market down prioritises equality in health care access by weakening the principle of universality. Cream-skimming is favoured and disadvantaged or vulnerable groups within society are left with minimal or no protection. The current debt crisis in Greece has weakened the public provision by cutting down services and increasing costs (e.g.

entrance fees for hospitalisation). At the same time, rising unemployment leaves more and more people without health insurance increasing thus the pool of disadvantaged citizens. Reinforcement of commercialisation coincides with a focus on financially advantaged groups that afford medical expenditures. Therefore, reinforcement and legitimisation of commercial rules and incentives in health care is expected to have adverse implications on social cohesion.

With regards to politics within the domestic health care sector, MDs' entrepreneurial attitudes may prove strategic in maintaining control in the emerging market. The internationalising sector entails dynamic changes which could potentially alter power balances at the expense of MDs. To be more specific, if large hospitals owned by businessmen sign agreements with foreign insurance funds they will secure control over the inflow of numerous foreign patients. Hospital owners will be able to channel them to individual MDs and/or partnerships of their choice. In the medium or long term, they may have an incentive to increase employment contracts with unemployed or younger MDs, fostering dependence upon large organisations, and leading to ground-breaking rearrangements within the sector. In contrast, if it is the MDs through their practices that attract foreign patients then they will have control over the inflows. Similar to the case of local patients, MDs will manage to fortify their position in the new market. Both scenarios are plausible. Though MDs are currently building the market, progress takes place at a slow pace. The individualised efforts owing to strong competition and the lack of a representative association may only withhold acceleration. In contrast, large hospitals owned by businessmen may make fast moves and within a relatively short period of time sign

agreements with foreign funds. Indeed, during the third year of this research and only after the completion of data collection, an extraordinary rush of hospitals to acquire international accreditation specialised in medical tourism is observed. This movement signals that large hospitals have practically started exhibiting an exports' orientation. The latter makes the scenario of high level agreements, which may overturn power balances within the next few years, plausible.

Implications for professionalism may also relate to the internal cohesion of the profession. Antagonistic instead of collegial relationships are developed within the market, where individualism and a career focus characterises medical professionals. For example, medical professionals expose to the public view the prevalence of internal competition forces with statements against MDs in foreign countries. Others accentuate competition by advertising abroad. International competition, however, is much stiffer and may require the lowering of prices. These may prove to be significant challenges for the profession on an international scale or in the long-run. For example, it has been demonstrated in the literature review how the rise of patient movement has divided professionals across national borders. While MDs in (prospective or established) destinations embrace the development of patient movement, several MDs in origin countries fall in the trap to publicly accuse peers of low quality standards that put patients' health in danger. Western medicine in the long run may only be harmed by such publicised oppositions.

Limitations of Research Study

Despite its contribution, this study faces a number of limitations which are here examined. Considering the research design, the criterion to approach participants may have limited access to all cases of MDs who attract foreign clientele. Given that online presence, most often through a website, was instrumental in identifying participants, practitioners deploying other ways of action to attract foreign patients are not interviewed. For example, formal and informal interviewees mention cases of individuals or groups of MDs that have special agreements with foreign insurance funds. These are not broadly known. There is no form of evidence publicised; neither through the press nor through other sources. Therefore, exploration of the conditions under which such agreements are signed and through which patient flows are established has not been possible.

Furthermore, the research study could have been richer by listening to views and perspectives of representatives of the intermediary companies. MDs' accounts reveal cases of miscommunication which would be potentially better understood if a small number of agents would also share their experiences. At the same time, while the study is in many senses timely and consequently captures nascent processes, it is preoccupied with a development that is not fully formulated. Key actors such as the large private hospitals or the state have not developed a clear strategy as yet. It is only towards the very end or actually after the completion of the study that they officially positioned themselves, leaving many of what appear to be ground-breaking initiatives and interactions unexplored. This does not undermine the contribution of

the current work that emphasises the pioneering role of MDs in market development at a practical level and the co-penetration of commercial and professional logics at a theoretical level. As it has been already stressed, MDs have been the first mover in various countries while the conditions of this eventuality have not been properly explored elsewhere. Initiatives of other actors, however, necessitate a shift of the focus from MDs as the key actor to MDs as *one* of the key actors. Simultaneously, it encourages the consideration of multiple interactions between the actors with regards to more than one issue and processes (Micelotta and Washington, 2013). This elevates the analysis of interactions between two actors (the professionals and each one of the other actors) into interactional analyses among multiple actors. Neo-institutional theoretical accounts examining professional change as institutional change could provide, for example, useful analytical tools (Muzio *et al*., 2013) for understanding how interactions between different actors may lead to the reorganisation of the health care sector. The theory of fields (Fligstein and MacAdam, 2012), in particular, would allow fruitful international comparisons between different countries as separate health care fields which at the same time jointly comprise the international one.

In this vein, it is recognised that the focus on a small geographical area such as Greece limits somewhat the ability for broader theorisation. Particularities and idiosyncrasies of the medical field and the national context are taken under consideration and explicated to offer a rich understanding of the case study. While it is wrong to suggest that qualitative research aims to generalise, comparative studies would enable the refinement of processes of change with regards to professionalism

and the internationalisation of health care. And while practical limitations in time and funding did not allow comparative work, future research in that direction would strengthen the theoretical contribution of the current study.

Implications for Future Research

Considering the dearth of data on the international movement of patients, multiple aspects of the topic may require further research. Notwithstanding the necessity for hard data, collection of data on the quality of care provided and the implications for national health care systems, alongside social justice is deemed imperative. With regards to the research findings of the current thesis, a number of issues would gain insight by expanding this research in different destination countries. For example, the case of Hungarian dentists appears particularly intriguing considering that they act in an entrepreneurial albeit coordinated way. An exploration of the terms of collaboration and conditions of their entrepreneurial initiatives would allow fruitful parallelisms with the research findings presented here. Moreover, the perceptions and attitudes of medical professionals who treat patients in large hospitals (e.g. in Thailand, Turkey or India) would also yield interesting comparisons. Considering that foreign patients are attracted by the marketing / public relations' department of hospitals, attitudes towards entrepreneurship are anticipated to be different. Perceptions over foreign patients or their daily work demands may also vary substantially. Of utmost importance is additionally the exploration of the doctor- patient relationship. In particular, considering the positive accounts of the study participants, it is deemed necessary to juxtapose views with

those of their patients. At last but not least, as mentioned above, future research could take place on field level. Taking the field as the level of analysis, interactions between multiple actors at the same time would broaden our understanding of the emergence of global health provision as a new international market.

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APPENDIX 1: PARTICIPANT INFORMATION STATEMENT

Research Project

Title: **Internationalisation of Health Care and the Medical Travel Sector in Greece: The perspective of Greek Medical Professionals**

Responsible investigator: **Kalliopi Skountridaki**
Strathclyde University Business School,
Department of Management,
199 Cathedral Street,
Glasgow G4 0QU.

Email: Kalliopi.skountridaki@strath.ac.uk

Chief investigator: **Professor Sharon Bolton**
Strathclyde University Business School,
Department of Management,
199 Cathedral Street,
Glasgow G4 0QU.

Email: Sharon.bolton@strath.ac.uk

Sponsor: University of Strathclyde.

In order to decide whether or not you would like to be part of this research study, you should understand what is involved. This form gives detailed information about the research study. Once you understand the project, you will be asked to confirm your agreement to participate via email in advance of our meeting. When we meet I will again seek confirmation that you remain happy to be involved.

WHAT IS THE STUDY ABOUT?

Within the framework of my PhD dissertation I wish to conduct a research study that explores the following questions:

How do Greek Medical Professionals perceive the changes taking place in Health Care provision internationally?

How do Greek Medical Professionals perceive the development of Medical Travel sector in Greece?

What impact does the development of Medical Travel sector in Greece have for the medical profession and professionals?

WHO IS CARRYING OUT THE STUDY?

Kalliopi Skountridaki (MSc) is a post-graduate student at the Department of Management, Strathclyde University Business School, Glasgow, UK. She has studied Economics at the Athens University of Economics and Business and the University of Amsterdam. Her research interests include the internationalisation of health care, medical travel and the

professions. Before starting her PhD studies, Kalliopi has worked for Quality Control and Accounting Departments in the private sector in Germany and Greece.
Sharon C. Bolton (BA, PhD) is Professor of Organisational Analysis at Strathclyde University Business School, Glasgow, UK. Her research interests include emotion in organisations, public sector management, nursing and teaching, gender and the professions, dignity in and at work, the human in human resource management. In her previous life, Sharon worked as a senior administrator in the public and private sectors. http://www.gsb.strath.ac.uk/staff/showprofile.asp?staffid=68

WHAT DOES THE STUDY INVOLVE AND WHAT ARE THE TIME COMMITMENTS?

I wish to hear physicians' views and perceptions as far as the phenomenon of increased flows of patients internationally is concerned. I would like to understand what physicians think their role is given the spread of international regulations facilitating trade in health care internationally, especially in reference to international trade that takes place through the movement of people/patients to foreign countries. Moreover, I would like to hear phyisicians' views on what would the development of medical travel sector within the country mean for Greek Medical Professionals and Greece as a whole, given the current crisis. To achieve this I would like to meet with you to discuss your views and perceptions. I am also keen to hear of any areas that you believe may be of interest to the topic.

I will be located in Athens until the beginning of October 2012 with the plan to visit Crete and Rhodes during the spring time for one week each. I would like to meet you during that period, at a time of your convenience. I can visit you at your office space if this is most convenient for you or else at a quiet place I could arrange for the interview as suitable. The meeting will take anything from an hour depending, to a large extent, on how the conversation evolves – and, of course, your time constraints. I will be guided by you. I may wish to talk to you again to clarify or elaborate on your experiences.

With your permission I would like to tape our conversations – I will send you a copy of our conversation if you request me to do so.

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your identity will remain strictly confidential and only Kalliopi and Sharon will have access to information about you. Reports of the study submitted for public presentation and publication, which may include some of the content of our discussions, will not include any information identifying you unless specific permission is obtained from you.

The information you give Kalliopi will be anonymised and stored safely for the duration of the study. With your consent, it will also be kept for the duration of any follow-up comparative studies.

CAN I WITHDRAW FROM PART OR ALL OF THE STUDY?

Yes, your participation is voluntary and you may withdraw at any time without giving a reason. This may include withdrawal from our conversations or choosing not to answer a specific question. You may also choose to have the contents of your conversation removed

from the study at any time. You will also have the opportunity to amend any information anytime during or after our conversation/s.

WHAT IF I REQUIRE MORE INFORMATION?

When you have read this information, Kalliopi is happy to further discuss the research with you and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Kalliopi or Sharon at the University of Strathclyde:

Kalliopi Skountridaki: Kalliopi.skountridaki@strath.ac.uk Mobile: +44 (0) 7580 428 319 & +30 6946416324
Professor Sharon Bolton: Sharon.bolton@strath.ac.uk Tel: +44 (0)141 553 6004 Mobile: +44 (0)7756126630

APPENDIX 2: PARTICIPANT CONSENT FORM

Internationalisation of Health Care and the Medical Travel Sector in Greece: The perspective of Greek Medical Professionals

Kalliopi Skountridaki
Strathclyde University Business School

I (the participant) have read and understand the Participant Information Statement, and any questions I have asked have been answered to my satisfaction. I understand that my participation is voluntary and I agree to participate in this research, knowing that I may withdraw at any time. I acknowledge the role I will take in the study and the time involved has been explained to me. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity. I have been given a copy of the Participant Information Statement to keep.

Please also delete as appropriate:
I **agree/disagree** to have my interview audio-recorded.
I **agree/disagree** for my data to be retained by the researcher for comparison purposes for later studies.
I **agree/disagree** to preview results of research if requested before they are used.

Participant's Name:……
(block letters)

Participant's Signature:……Date: ……

Please return this page to:

Kalliopi Skountridaki
Strathclyde University Business School,
Department of Management,
199 Cathedral Street,
Glasgow G4 0QU
or
60 Lampaki Street,
11143, Athens
Greece

APPENDIX 3: INTERVIEW GUIDE

PART A: THE INTERNATIONALISATION OF HEALTH CARE

- How do you conceptualise/understand the phenomenon?
- What is the role of the MDs within that framework?
- What is the role of internet in the internationalisation of health care;
- What is your own experience?
- Are there differentiated organisational demands with regards to foreign patients? Which are these?
- Are there differences in the doctor-patient relationship? Which are these?
- In what ways foreign patients come into contact with you?
- What is the role of the state? What is the role of the medical/dental association?

PART B: ENTERPRENEURSHIP

- Do you think of yourself as an entrepreneur to some extent?
- Do you have consultants to make decisions on your practice? Who are they?
- What was the initial idea/thought to engage with the treatment of foreign patients?
- How was it initiated?
- Why are you interested in treating foreign patients?
- Which are the strengths and weaknesses of Greece as a destination for medical/dental care?
- What is the current status of the sector in Greece?
- What is the future of the sector in Greece?
- What is the role of the Greek crisis?