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Financializing Healthcare and Infrastructures of Social Reproduction: How to Bankrupt a Hospital and be Unprepared for a Pandemic

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Introduction

This paper contributes to extending the empirical and conceptual scope of Social Reproduction Theory by bringing it into dialogue with debates on financialization. We call for the need to document and theorize the "lived" dimension of the financialization and marketization of Infrastructures of Social Reproduction, and of the healthcare sector in particular. Our argument draws empirically on the analysis of patient and staff safety and vulnerability issues related to the bankruptcy of the Slotervaart hospital in Amsterdam, the Netherlands.

Social reproduction theory and debates have a long, rich, and complex history[1], but received increased attention after the 1990s and again after the 2008 financial crisis. The significant changes that global economic restructuring and crisis brought to both the organization of social reproduction and the international division of reproductive labour (Federici, 2019) demanded new types of analysis and theorization (Fraser, 2016; Rodríguez-Rocha 2021; Hall, 2020). Infrastructures of Social Reproduction (henceforth ISR) debates were popularized after the 1990s when the fraying of the welfare state (Esping-Andersen, 1990) and the marketization and financialization of care practices led to diminishing provision of social reproduction services (Bakker, 2007); but also to increasing informality in the provision of services to those who cannot access the market proper (Mitchell et al., 2003). Katz (2008), for example, scrutinized the intricate connections between basic services provision and New Orleans' rebuilding efforts post-Katrina, demonstrating how undermining one social reproduction (henceforth SR) activity directly impacted others – the lack of childcare pushed nurses away from the city, which in turn hindered the full reopening of hospitals and other care facilities. However, these important debates on SR and ISR have thus far engaged very little with financialization

literature despite the fact that ISRs can potentially enact or destroy forms of biological citizenship (Netz et al., 2019), strengthening or weakening community and social ties and deeply affecting economic and productive practices.

Financialization literature for its part had equally limited engagement with social reproduction debates. Van der Zwan (2014) identifies three core streams in this literature: financialization as a new regime of accumulation; financialization as the rise of shareholder value; and financialization of everyday life. Within this last stream, Kaika and Ruggiero (2016) researched the shift from industrial to financial capitalism as a "lived" process and documented how the everyday lives of factory workers became fully intertwined with the restructuring of the economy. More recently there have been more systematic attempts to theorize a better understanding of how the infiltration of finance-led practices, metrics, and logics can transform citizens into financial actors (Langley, 2008; García-Lamarca and Kaika, 2016; Doling and Ronald, 2010).

However, this shift of attention from financial processes to everyday life within financialization literature has thus centered its attention mainly on households, mortgages, loans, and credit and has paid little attention to the infiltration of financial and market logics in the management of ISR: from hospitals, schools, and day-care facilities, to water, flood protection, and toxic waste disposal infrastructures. Even after the COVID-19 pandemic, issues related to ISRs and the "lived" dimension of financialization remains marginal or even ignored in debates around the economy and financialization (Bakker, 2007).

The COVID-19 pandemic, which broke out after this paper's submission, revealed the importance of researching how the financialization of everyday life is also enacted through the marketization and financialization of ISR – healthcare in particular. The Netherlands, on which this article focuses, is an interesting case since it has been a laboratory for the introduction of new financial instruments in healthcare since the 1980s. The pandemic found the Netherlands (like many other countries) with reduced capacity in Intensive Care Unit beds (ICU), something that became – literally – a matter of life or death in the design and implementation of national strategies[2]. The reduction of ICU beds was the direct outcome of the restructuring of the Dutch healthcare sector which began in 1986 when the government instated the Dekker commission to rationalize the cost of healthcare (Mosciaro et al., 2022; Kroneman et al., 2016; van de Ven, 1991).

In the report "Willingness to Change" (Roscam Abbing, 1987) the Dekker commission, which was almost exclusively comprised of economists, lawyers, and businessmen, proposed a new economic model for financing and delivering healthcare. They aimed to reduce costs and increase quality by introducing competition amongst healthcare providers, and by establishing client-provider relationships between healthcare sector workers and patients (Toebes, 2006; Zuiderent-Jerak, 2009; Enthoven, 1978a, 1978b). "This discursive shift towards

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'clients' instead of 'patients' was seen at the time as a progressive move; 'patients' was seen as a passive term whereby 'clients' was an activist term. People wore it with pride" (Doctor5, 15.01.22). After 2006, additional finance-led practices were adopted by the healthcare sector to increase "market efficiency", which included downsizing or even closing health care facilities, which in some cases culminated in hospital bankruptcies[3].

One of the most publicly debated hospital bankruptcies was that of the Slotervaart Hospital in Amsterdam, a former municipal hospital that was closed down on October 25th, 2018, after 43 years of continuous operation. This article unpacks Slotervaart's bankruptcy story, to show that this was not simply the case of a healthcare facility that failed to transition towards a market environment; it was the extreme outcome of the complete overhaul of the foundational principles that guide public healthcare provision. The case of Slotervaart's bankruptcy is not only a story about financialization, marketization, and commodification of healthcare; it is also (and we argue, more importantly so) a story about the financialization of the everyday life of doctors, nurses, and patients; and, about the broader results of the naturalization and the delegation of near-absolute power to finance-led institutions over key ISRs (De Goede, 2005).

Although the bankruptcy of Slotervaart was presented in public debates as an exceptional case, recent reports document an increasing number of healthcare facilities experiencing financial distress in the Netherlands (BDO, 2018, 2019). This paper sheds light on how financial concerns trumped both medical professionals' considerations and patients' wellbeing and destroyed an infrastructure that was significant for the local community and beyond (Luke and Kaika, 2019). Elsewhere, we outline the *causes* of the financialization of healthcare in the Netherlands (Mosciaro et al., 2022). In this article, we call attention to the social *effects* of a finance-led provision of healthcare (Henry, 2015b; Horton, 2019). By focusing on this case, we draw broader conclusions that apply to other types of ISRs faced with similar challenges.

Working definitions and methods

In the paper, we refer to financialization as:

> the organizational penetration by a set of metrics and values that are "carried" from the "outside" to the "inside" by financial specialists — bankers, accountants, real estate managers, economists, consultants — whose "logics" would immediately conflict with [the logics of long-standing professionals] (Engelen et al., 2014, p. 1073).

We also refer to ISR as the set of facilities (hospitals, schools, elderly care homes, childcare units) that exceed domestic boundaries and provide fundamental support and care services that lighten the burden of social reproduction

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by taking care of the "fleshy, messy stuff of everyday life" (Norton and Katz, 2017, p. 1).

The article draws upon two phases of fieldwork. The first (June-September 2019) included desktop research in municipal and national archives (Tweede Kamer, Geemente Amsterdam, Rechtspraak); documents and reports by the Dutch Healthcare Authority, OECD, and the Dutch Safety Board; and newspaper articles and reports (HetParool, NRC, de Volkskrant). The second (September 2019 -February 2020[4]) included semi-structured interviews with three former Slotervaart patients, five doctors, one nurse, three administrative and support staff who used to work at the hospital before its bankruptcy; two experienced hospital managers; five healthcare specialists and economists working in Dutch universities or the private sector; and one journalist. Given the publicity the bankruptcy received, many key informants (and companies) were reluctant to take part in this research. We, therefore, applied a range of sampling methods, including: regular visits to Slotervaart's almost vacant building for on-site interviews; continuous observations of the surrounding area targeting former patients; mobilization of academic and social networks (Facebook and LinkedIn); and direct contact with citizens who had been publicly vocal about the case in the media. Insurance companies either ignored our repeated contact attempts or stated that they could not comment. Whenever possible, we triangulated interview data with archival material and further interviews with opposing actors, wherever possible. The voices of doctors, nurses, and patients who were affected by the hospital's bankruptcy tell a story about turning hospitals into competing organizations that is thus far untold; and it is very different from the often-told stories about market efficiency.

Slotervaart, the municipal hospital

The history of the Slotervaart Hospital is deeply rooted in Amsterdam's socio-democratic past. The facility was commissioned by the local government in the 1960s to showcase the city's social commitment to provide "optimum medical care ... in particular to the chronically ill, the elderly, and the poor" (Kaal et al., 2011, p. 13). Slotervaart was unique in several ways: it was the only municipal hospital in Amsterdam; it had no attachment to religious denominations; and all of its staff (including doctors) were employed as civil servants (Soetenhorst and Wester, 2015).

The Hospital's budget was fully covered by the Municipality of Amsterdam. Staff members recall how other facilities often transferred uninsured patients to Slotervaart, which acted as a care provider of "last resort" (Stoesz and Karger, 1991); "a hospital specialized in caring for groups that were forgotten by the existing system: the elderly, HIV patients, heroin addicts" (Journalist, 18.09.2019). A former employee recalls how the municipality would always

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cover the bills, no matter how high: "from 1976 to 1997 the [local] government, always pushed money in ... always money in." (Staff1, 10.07.2019).

In 1982, the Health Ministry deemed the number of hospital beds in Amsterdam "excessive" and proposed closing down Slotervaart (Gardeniers-Berendsen, 1982). The claim that there was a surplus of beds was then justified through the pressing "need" to cut down healthcare spending, by rationalizing care provision and clumping down on cavalier behaviours of certain medical professionals.

Within this logic, the high operational costs of Slotervaart made it the ideal candidate for closure (Kaal et al., 2011); but also, a case in point that healthcare rationalization models often end up targeting facilities in low-income neighbourhoods[5], even though these areas tend to be the ones with the highest demands for care (Henry, 2015b; Luke and Kaika, 2019; McLafferty, 1982). However, despite pressure from the national government, Amsterdam's City Council sustained its commitment to keeping Slotervaart open and thus prevented its closure in the 1980s.

A decade later, and following the Dekker report, the restructuring of healthcare provision started having strong supporters within Amsterdam's local government (City Council, 1990), and in 1997 the City Council finally conceded to privatize the hospital. This severed all direct ties (managerial and financial) between Slotervaart and the municipality of Amsterdam. The "Slotervaart Hospital Foundation"[6], that was then established, would manage the facility, select board members, and oversee budgets (City Council, 1997). The employment status of doctors, however, remained the same, their salaries were secured and independent of the hospital's financial performance.

The privatization, however, generated immediate and major financial distress, since Slotervaart continued providing social services as before and therefore continued running high costs and budgetary deficits. But these were no longer picked up by the municipality. From that point onwards, the "good intentions" of the Hospital and the work ethic of the staff came into direct conflict with budgetary practices (Kaal et al., 2011). When asked about the reasons behind Slotervaart's privatization, a former manager quotes financial concerns: "... there were losses; and the municipality paid for these losses every year, every year, for 25 years. They [the municipality] wanted to get rid of it" (Manager1, 08.11.2019). Reflecting on the same period a doctor commented, "For the City Council, it was a gain that they were no longer obliged to fix the finances. So, for that purpose, it worked. But it didn't work for the health system, and [it didn't work] for the patients" (Doctor1, 24.01.2020).

Although, as noted above, healthcare privatization was originally propelled by a set of concerns that were much more complex than profit maximization, the above two quotes represent how polarized the privatization debate became in later years. On one side, the manager understands healthcare provision as a

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business conduct; within this logic, they support the closure of a hospital that performs well in terms of healthcare provision but underperforms financially as a "rational" decision. On the other side, the doctor understands healthcare provision as a service to society that should be offered as needed, and not as an accountancy exercise (Engelen et al., 2014; Grootegoed and Van Dijk, 2012; Noailly and Visser, 2009). Juxtaposing these two points of view (see also online material) highlights the impacts of national directives for the creation of an ISR market and their direct effects on livelihoods.

Slotervaart the "unmanageable" hospital: introducing Diagnosis Treatment Combinations

In 2006, all hospitals in the Netherlands underwent further structural changes in their *modus operandi*. One year earlier, in 2005, the government had introduced a new financing scheme, the Diagnosis Treatment Combination (DBCs, *Diagnose Behandeling Combinatie*), as the key instrument for organizing, managing, and financing healthcare provision. The DBCs changed the landscape of managing healthcare provision but also changed the way medical staff became embedded in financial practices. The DBCs play a dual role: they operate as a "price tag" for each medical appointment, treatment, or service; but it also serves as a tool to determine and manage money flows (see Mosciaro et al., 2022).

With the introduction of DBCs doctors' and hospitals' incomes became dependent on the regular "turnover" of patients. The new scheme required substantial adjustments not only in the hospitals' managerial and IT departments but also in the way caregivers acted on the work floor. At Slotervaart, however, doctors' salaries remained fixed, and not dependent on the number of DBCs they would "produce" on a daily basis. Many interviewees claimed that the different employment status of the staff was at the heart of Slotervaart's financial problems: "[the staff] were not interested in making money because their salary was fixed" (Manager 1, 08.11.2019). A journalist who followed the process closely observed, "all the employees were civil servants, so there was sort of a lack of competition, a lack of urgency to work efficiently. From day one that was in the genes of the hospital" (Journalist, 18.09.2019). According to a former manager, "the people who went to work there believed that they were working for poor people, for older people. They did it well, but not enough" (Manager 1, 08.11.2019).

The normalization of the demand to work "efficiently" or "enough" is critical in the market-led turn in healthcare provision. As SR literature documents, financial models and charts cannot incorporate the nurturing and caring aspects that are fundamental in the daily tasks, if professionals are asked to fit care work into quantitative outputs (Henry, 2015a, 2015b; Horton, 2019).

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During our interviews, managers and independent commentators labelled the Slotervaart staff "unmanageable" because they refused to follow market efficiency demands. Former employees themselves did not refute this label; but they interpreted it differently: "you had a financial ward doing financial things, and doctors and nurses doing the medical things. People worked in their strong [medical] field and [were] not doing administrative things all day" (Doctor 1, 24.01.2020). They were hired into an organization originally envisioned as "horizontal, aimed at serving people with as little administrative and bureaucratic burden as possible" (Kaal et al., 2011, p. 159). The mentality behind Slotervaart's conception was also a reflection of the ongoing debates and tensions of the Dutch medical sector at the time. As a doctor recalls her formative years,

> In the late '70s, many medical practices were outdated [. . .] there was intense discussion about the low-level quality of healthcare and the arrogance of the medical sphere. As medical students [at the time] we were standing up against doctors who, because they were self-righteous, they thought they knew what was right for the people (Doctor5, 15.01.22).

Slotervaart wanted to challenge this tension between arrogant "know it all" practitioners and their patients. There, the patient was at the centre of the discussion (Kaal et al., 2011). Hence, it is not surprising that the staff resisted this drastic turn that, in effect, demanded from them to take time away from their "strong field", i.e. providing healthcare, and put it into managerial and financial tasks.

But the "unmanageability" of Slotervaart's staff only became a real issue after 2006. Since the 1960s hospital financing schemes had gone through various arrangements in the Netherlands. At times they were led by the national government; in other moments the Ministry of Health or a newly created body such as the Agency of Hospital Tariffs would take the lead. In any case, until recently, a public body was always in control of the process. After 2006, the Dutch healthcare reform made insurance companies the main and direct financers of hospitals. Thus, for hospitals to receive funding, they have to fully document and report to insurers each step taken toward patient healthcare. This means that salaries and running costs are directly determined by the "efficiency" and "productivity" of staff. It also means that the staff's diligence when it comes to filling in the appropriate forms became crucial in order for the insurance companies to be able to set budgets and directly finance hospitals.

Three Slotervaart staff members recall that they never got used to filling all the forms required. Some forms would slip the recording/reporting process and since productivity and budgets were based on these forms, Slotervaart appeared – falsely, according to them – to be less productive than it was.

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> In other hospitals, the specialists were more aware of the importance of writing down what you do and writing bills for it [. . .] that was not really a strong thing for us [. . .] the directors they call us unmanageable [but] we tried to follow the regulations, we really did, but it was an incredibly stupid system and we refused to do it in the most commercially attractive way (Doctor 1, 24.01.2020).

Soetenhorst and Wester (2015) also record that Slotervaart was labelled "unproductive" because of neglect in issuing invoices. The hospital's key assets – namely the informal atmosphere, and the priority on patient care – became operational obstacles under the demand to follow new financial and managerial procedures (Soetenhorst and Wester, 2015). The highly praised culture of care at Slotervaart clashed with the new management requirements.

Slotervaart the entrepreneurial hospital: the New Healthcare Act

Since 1997 the Slotervaart hospital had been operating as a foundation. But in 2006, when the new Dutch Healthcare Act was implemented Slotervaart came under the ownership of a private entrepreneur (*Meromi B.V.*). This made it the first general hospital in the Netherlands to be owned by a private entrepreneur.

Before 2006, the Dutch healthcare sector operated under a dual system: mandatory *public* healthcare insurance ("*ziekenfonds*") for residents earning below a certain income threshold (around 33,000€ gross, 65% of the population); and, for those above that threshold, healthcare insurance was optional, and had to be taken privately (van Egmond and Zuiderent-Jerak, 2010). In addition, *ziekenfonds*' premiums were determined by people's income. Under this configuration, healthcare was paid for by a combination of public and private healthcare insurers and the state played a regulating role (Helderman et al., 2005).

The Healthcare Act represented a significant shift in the *locus* of power in the healthcare sector. The *ziekenfunds* were abolished and only private insurers remained active. Private health insurance became compulsory for all residents of the Netherlands, and the insurance premiums were set at the same level for all, regardless of income. A healthcare allowance scheme was established to support healthcare insurance payments for those earning below 31,138€ for single-income households and 39,979€ for couples.

Even though the 2006 Act unified a series of changes that were already underway since the late 1980s, it would still take a few years for all actors involved to understand and claim their new roles. Insurers needed time to adapt to their new task as leading actors of the care provision landscape (Schut and van de Ven, 2011). And healthcare staff also had to adapt to new managerial tasks. In early 2013 the clear clash between the old and the new healthcare roles and cultures came to a peak when Slotervaart and Zilveren Kruis (hereafter ZK), the biggest health insurance company in the region (Achmea, 2018), had their first

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public disagreement. The price paid by ZK for the care provided at this Hospital was at the centre of this disagreement (Gerechtshof Amsterdam, 2015).

The new market logic of the Dutch healthcare system dictated that each hospital had to negotiate with insurers how much they were willing to pay for each service provided. Although Slotervaart's director tried to negotiate prices in favour of the hospital arguing that finances should not be the main determinant in care provision, the fact that 65% of Slotervaart's patients were insured by ZK meant that the hospital did not have much bargaining power; breaking the contract with them would be fatal (Visser, 2013). "Slotervaart was the first hospital that refused to bow [to insurers] so there was a lot of fuss about it [. . .] This conflict with the insurance company led to her fall as a director, to her leaving the hospital" (Journalist, 18.09.2019).

Mulligan (2016) documents that in the healthcare insurance business model, profit is made mainly by reinvesting the premiums paid by clients (and the government), and not by adding value/reinvesting in the healthcare system. This means as Stolper et al. (2019) argue, that the insurers' main interest does not necessarily lie in providing better (and possibly more expensive) healthcare. Slotervaart's director's position obstructed this accumulation process, and after she was dismissed, Slotervaart and ZK were able to reach an agreement and the contract was renewed (Gerechtshof Amsterdam, 2015; Soetenhorst and Wester, 2015).

Nonetheless, later, in 2013, Slotervaart was resold, from Meromi BV to the MC Groep (Gerechtshof Amsterdam, 2015). The MC Groep already owned the IJsselmeer Hospital[7], as well as shares in laboratories, clinics, and mental health institutions (COFZ, 2020). Upon acquisition of Slotervaart, they hired experts and consultants to increase the Hospital's productivity. The MC Groep also organized trips for staff to learn from "successful" examples abroad (Soetenhorst and Wester, 2015). Yet none of these efforts were sufficient to salvage Slotervaart's finances. The hospital filed for bankruptcy on October 23rd, 2018, and was permanently closed three days later (CMS, 2019; COFZ, 2020).

The closure of Slotervaart was presented in the media mainly as the outcome of years of bad management, due to its tumultuous financial past. Nonetheless, a report from the Committee for Investigation into hospital bankruptcies (*Commissie onderzoek faillissementen ziekenhuizen*) confirmed what Slotervaart's employees had been saying for years, "[ZK paid] an average price level 4% below the basic price. Since 2016, the hospital's price level is below that of surrounding hospitals" (COFZ, 2020, p.28).

> MC Slotervaart was constantly underpaid for the care it provided. Sometimes it was a difference of 20,000 euros for the same treatment [compared to what other hospitals in Amsterdam charged]. How is that possible? It is not the hospital that should be declared bankrupt; [it is] the functioning of the market [that should be declared bankrupt]. The power of the health insurers has gone way too far (City Council, 2018).

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This pricing disparity was possible because since 2006 each hospital has to negotiate directly with insurers what fees they can charge for each treatment (Zuiderent-Jerak and van der Grinten, 2011). Under this system, the financial survival of small facilities, and facilities with an above-average concentration of patients (like Slotervaart), became heavily dependent on the level of prices they could negotiate with the insurers for the services provided (COFZ, 2020; Mulligan, 2016). As an interviewee concluded "the problem of the Slotervaart was an acute financial problem because they [ZK, the insurer] stopped paying. Every hospital in the Netherlands would have to shut down if they [insurers] stop paying." (Doctor 2, 05.11.2019). Some interviewees also noted that this was not the first time an insurer threatened the hospital.

> In the time that I was there [1990s], the health insurance companies were against keeping [Slotervaart] open. They didn't say so in the newspapers, but they told me there is one hospital too many. And when one should be closed it should be Slotervaart. [. . .] in the health reform period the health insurance companies got more power to do things like that (Manager 1, 08.11.2019).

A medical staff member painted a similar picture. Describing a reconciliatory meeting in the early 2000s between Slotervaart, ZK, and Labor and Social Democratic party representatives, the interviewee recalls the arrogance of the health insurance representative and their clear position regarding the future of Amsterdam's health care landscape.

> 'if you look left in Amsterdam you see a hospital, if you look right you see a hospital. So, according to us, we can close [Slotervaart]'. That was [back in] 2001. But [the insurance companies] were not in the position to close it [then] because the politicians wanted to keep it open and they succeeded. That possibility, and also the responsibility of the politicians, vanished in 2006. (Doctor 1, 24.01.2020)

The 2006 Healthcare Act[8] was indeed a turning point in the Dutch healthcare sector. It reduced the role of the government and increased the power of health insurers who were supposed to assure affordability, accessibility, and quality, by introducing a new rationality to the sector (Helderman et al., 2005; Schut and van de Ven, 2011). As mentioned above, due to their key role in distributing healthcare funds, these companies became the main actors in the healthcare sector (Toebes, 2006; Zuiderent-Jerak, 2009), and acquired enhanced powers that enabled them to enforce crucial decisions on healthcare provision.

In 2018, after assessing the healthcare landscape in Amsterdam, the health insurer ZK supported the immediate closure of Slotervaart. Studies conducted by the insurer suggested that surrounding facilities would be able to absorb Slotervaart's patients and staff (COFZ, 2020). At the time, the Health Ministry hardly questioned the facts and figures of these reports (COFZ, 2020). Moreover, under the new healthcare law, the government had its hands

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tied anyway, since insurance companies were no longer obliged to maintain their contracts with all hospitals, even if this could lead to serious hospital underfunding and closures (Schut and van de Ven, 2011). Some interviewees noted that "[the insurers] were gambling with lives [...] they took risks for patients" (Doctor2, 05.11.2019).

Slotervaart the bankrupt hospital: the lived dimension of financialization

After 2006, Dutch hospitals became directly dependent on the timely transfer of funds from private insurance companies. Therefore, soon after ZK, the main insurance provider for Slotervaart's patients, decided to cut financial transfers to this hospital the facility had to be abruptly shut down. After all, Slotervaart could no longer pay salaries nor purchase medical supplies (COFZ, 2020).

The seizure of financial support caught everyone off-guard – staff, patients, and even the Health Ministry (COFZ, 2020; OvV, 2019). This financial decision had a very significant "lived" dimension, and very severe implications. "Mess" and "chaos" were the words used by interviewees to describe what happened after the Hospital was abruptly shut down. At the time of the bankruptcy 98 patients were hospitalized in Slotervaart. Of these, 23 were transferred immediately to other hospitals, 12 to nursing/care homes, and the rest were discharged (OvV, 2019). 18.000 appointments that had been scheduled for the period October-December 2018 were automatically cancelled (OvV, 2019) and patients did not know where to go for their treatment; GPs also did not know where to refer their patients (COFZ, 2020).

The staff was also deeply impacted, the closure meant the termination of 1.118 jobs (CMS, 2019). The expectation was that the unemployed staff would be quickly absorbed by other healthcare facilities, given the growing demand for health care workers in Amsterdam (OECD, 2019). But this turned out not to be the case. According to five interviewees, the net result was an overall reduction in the number of healthcare professionals available in the city. "Some of our employees did go to work in the OLVG [another main hospital in Amsterdam]. But a lot of them went to work in the North of Holland, or Utrecht because that is where they lived anyway. They [came] to Slotervaart because they loved to work there, not because they really wanted to work in Amsterdam" (Staff 3, 29.10.2019).

As Katz (2008) notes, the living arrangement of care professionals is an important parameter in the geographies of ISR provision. One of our interviewees directly linked healthcare provision to housing affordability: "you need the nurses and that is a problem in Amsterdam because the nurses cannot live here, they don't have the income to live in Amsterdam" (Doctor 1, 24.01.2020). Under

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a financialized healthcare sector, the SR of care workers is threatened at multiple levels, as individuals, as citizens, and as professionals (Henry, 2015a; Horton, 2019).

The fact that a public hospital was sold (2006), resold (2013), and finally went bankrupt (2018) demonstrates the social vulnerability created by the privatization of ISRs since one event might unleash a chain reaction whose consequences are much broader than initially envisioned through rational planning scenarios (Katz, 2008). It was not "just" thousands of patients that were left unattended when Slotervaart went bankrupt. More than a year later, former employees mentioned that the MC Groep (former owners) still owes them money for their last weeks of work at Slotervaart (CMS, 2019). "We didn't even get our salary at that point [after the bankruptcy]. I didn't know how to pay my rent and I was working there day and night for my patients, to find a place for them in another hospital" (Nurse, 07.02.2020). Lastly, the bankruptcy also impacted the overall accessibility of healthcare in the broader Amsterdam region since the remaining hospitals could not easily accommodate the sudden flow of new patients (City Council, 2018; OvV, 2019). "I hear that the waiting lists are incredibly long now in Amsterdam. There is a shortage of personnel, so it is very hard to get into the health system now as a patient" (Nurse, 07.02.2020).

Slotervaart is not a unique case. International literature documents that hospital bankruptcies have become routine in contexts where financial rationalities dictate the provision of care (Henry, 2015b; Levine, 2010). Smaller facilities are particularly vulnerable as they cannot rely on economies of scale (BDO, 2019; COFZ, 2020). Ultimately, what became the main area of contestation, in this case, was not that Slotervaart went bankrupt, but how the closure was handled. There was a splintering (Graham and Marvin, 2002) of the infrastructures of healthcare between insurers (who finance care), hospitals (who provide services) and the government (who oversees transactions). It can be seen as a key driver of undesirable outcomes (Kroneman et al., 2016).

Care and Patient safety *vs.* healthcare entrepreneurialism

Slotervaart's case exposed the fragility of healthcare provision under financialized and marketized models of healthcare. Although insurers are committed to quality, affordability, and accessibility (van Kleef et al., 2014) they also have their own companies' interests to safeguard, and it needs to be acknowledged that sometimes those interests might be at odds with broader social goals. An independent report conducted after the closure of Slotervaart confirmed that unnecessary risks were inflicted on patients due to the way the bankruptcy was handled (OvV, 2019). In the last months, the Hospital's board presented plans to ZK on how to transfer care in an orderly and timely manner (soft landing). Nevertheless, the suggestion for a controlled dismantling was discarded, not

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least because ZK was unsure about the costs this might incur (COFZ, 2020; OvV, 2019). Furthermore, insurance companies were themselves not fully equipped to organize the safe and smooth transfer of patients to new facilities, and this jeopardized treatment continuation and created even bigger waiting times in other institutions that were themselves dealing with staff shortages.

> There were a lot of patients I knew, and I had to really hear their stories. This guy said, "yeah, I should have had my chemo in December but I didn't hear anything" . . . and it was March and he had bladder cancer and he said, "I don't even know where to go, nobody contacted me . . . I don't know how to find my doctor" (Staff3, 29.10.2019).

The emotional stress inflicted on patients and staff was also significant.

> When you break your bone, it is not so important which orthopaedist takes care of you.[. . .] But when you have cancer, a life-threatening disease, then your relation to your caregiver will be very different [. . .] I had a patient, and she was suffering from breast cancer [. . .] About 2-months ago she passed away and in the last year every few weeks I called her. Just to stay in touch and to give her the feeling that I would not let her down (Nurse, 07.02.2020 - for full quote, see online materials).

Quotes of this nature exemplify the unique nurturing and caring role played by care professionals. In situations like this, it becomes clear that "goals of efficiency are in competition with common expectations of nurses" (Henry, 2015a, p. 171).

The 53.000 treatment appointments scheduled at Slotervaart for the months that followed its closure had to be automatically cancelled. These patients were distributed over twelve hospitals in the Amsterdam region (OvV, 2019). But this process was not simple, and mistakes were made:

> They had lists: if you have this disease you should go there. The Antoni van Leeuwenhoek Hospital is an oncology hospital. This means breast cancer, colon cancer . . . no hematology. No leukaemia, no lymphoma . . . But the insurance companies made a list for hematologic cancer patients that they should go there. And then the patient would call [for their appointment], and they would tell them, "We don't treat hematology patients here". "So where should I go?" "We don't know. Call your insurer". The academic centres said they would like to see them, but they didn't have the capacity . . . . Then they were spread all over to other hospitals, it was really chaos (Doctor 1, 24.01.2020).

As patients became dependent on the decisions of insurers for the continuation of their treatment; the opinions of doctors and other care professionals were often disregarded. The case of Slotervaart serves as a cautionary example of how system-wide changes facilitating the infiltration of market and finance-led logics in the management of ISR can erode the very same standards they are supposed to reinforce: accessibility, efficiency, and affordability.

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Conclusion

This paper focused on the "lived" dimension of the bankruptcy of the Slotervaart Hospital, to shed light on the everyday effects of the financialization of Infrastructures of Social Reproduction. By bringing together debates on social reproduction with debates on financialization we produce an in-depth analysis that takes the problematic around marketization and financialization of healthcare systems beyond economic debates and quantitative metrics (Engelen et. al, 2014). At the same time, building on a strong case study we contribute to the financialization of life literature by documenting the effects of the hospital's bankruptcy on patients, healthcare staff, and the broader healthcare provision at Amsterdam.

Our work showcased how the "rationalization" of the healthcare sector, which started as a discussion to reduce costs at the same time as improving quality of care, evolved into a system that had severe shortcomings in terms of accessibility, care provision, and even, safety. The power imbalances created in the sector are reflected in the growing influence of insurers and in the decreasing power of healthcare professionals and facilities, who are relegated to a new role: that of mere service providers in constant search for maximized production output. This new organizational structure, we contend, prioritizes financial rationalities over care-related concerns, while it reduces the ability for public policy interventions, as the role of national governments is also purposefully reduced to that of an overseer with limited authority.

The qualitatively data-driven gaze that this article offers, reveals that Slotervaart's bankruptcy did not simply do away with a (financially) "underperforming" hospital. In the name of reducing expenses, it also did away with a significant number of beds in the Amsterdam region, which were desperately needed when the COVID-19 pandemic hit. Additionally, letting Slotervaart go meant silencing a hospital that did not and would not conform to a new finance-led healthcare system; in effect, it was a decision that diminished the bargaining power of health care professionals, especially nurses, by sending the message that no hospital is too big or too important to fail if they do not comply with the management regimes.

The Slotervaart bankruptcy was often presented in the Dutch media as a tale of a poorly managed facility that got what it deserved. We tell a different story here. It is the story of the significant lived effects of the financialization of healthcare provision. Many of the processes related to the closure of this hospital are also present across different countries and political economies, where public and private-led healthcare systems operate with the aim of not only providing excellent healthcare; but also, of turning profit for a now marketized and financialized sector (Eren Vural, 2017; Hacker, 2004; Moon and Brown, 2001).

The COVID-19 pandemic, which broke out soon after this paper was first submitted, raised further questions about the shortcomings of a financialized

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healthcare sector. The case we present here shows how central these questions had already been to medical professionals, care facilities, and patients: the reduction of the number of professionals (and consequently beds), the lack of adequate equipment, the diminishing capacity of doctors and nurses to provide excellent healthcare for their patients, etc. Although the social vulnerability that this created went unnoticed or unrecorded for a long time, the pandemic exposed what the Slotervaart bankruptcy indicated: the social vulnerability created by decades of marketization and financialization of healthcare, associated with the weakening of the state's role (Lambert and Rimbert, 2020; Levine, 2010).

In this paper, we opened a dialogue between Social Reproduction Theory and financialization of healthcare. We hope this dialogue will be picked up and continued with more in-depth empirical and conceptual work. When we embarked on this research project, in early 2019, we considered this dialogue to be very important; the COVID-19 crisis proved that it is not simply important, it is urgent.

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We would like to thank all our interviewees without whom this research would not have been possible. When we started this research project, we were already confident in the importance of telling this story. However, a few months later, when the COVID-19 pandemic hit we were sure that this story was even more important and that discussions of this sort could no longer be overlooked. The research conducted for this paper was funded by the Center for Urban Studies, at the University of Amsterdam and followed the integrity and data management protocols of the University of Amsterdam's Institute for Social Sciences Research (AISSR) (https://aissr.uva.nl/our-research/ethics-and-integrity/ethics-and-integrity.html.) This research did not engage with socially vulnerable, minor, or in any way less able adults. All participants provided written consent prior to the interviews. All views and perceptions they expressed are their own. Their details and current professional affiliation were fully anonymized in the paper as well as in the supporting material. All interviewees consented to having the interviews recorded.

Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/S004727942200023X

Competing interests

The author declares none.

Notes

1 Charting the history of the field lies beyond the scope of this article. For recent reviews, see Bhattacharya (2017) and Rodríguez-Rocha (2021).

2 In Sweden, sufficient ICU numbers led to lenient measures. In Greece, low ICUs numbers led to strict lockdowns. The Netherlands stood in between, having lost 18% of its ICUs between 1990-2009 (Kroneman et al., 2016). Projections by Hansen et al. (2008), based on demographics, personnel, and other variables, deemed that by 2016 the Netherlands should have 1,352 ICU beds. In reality, in 2020 this number was only 1,150.
3 Den Hartog et al. (2013) documented a 12% reduction in the number of Dutch hospitals between 1978-2010, not taking into consideration hospital mergers. BDO (2018) reported poor financial conditions in fourteen out of sixty-four hospitals, alerting for more bankruptcies.
4 One additional interview (Doctor5) was conducted in January, 2022.
5 68% of residents around Slotervaart are non-Dutch https://data.amsterdam.nl/datasets/DMknRs8hEH-CtA/bevolking-wijken/, accessed 14-01-2021.
6 Under Dutch law a foundation (*stichting*) is a legal person with social goals, comprising a board of directors overseen by a supervisory board. Foundations have no members or shareholders and cannot pay dividends (Groenendijk, 2018).
7 The IJsselmeer Hospital, also bankrupted in 2018.
8 https://english.zorginstituutnederland.nl/about-us/healthcare-in-the-netherlands, accessed 20.05.2020.

References

Achmea. (2018), *Achmea annual review 2018*. https://www.achmea.nl/SiteCollectionDocuments/Achmea-Annual-Report-2018-part-2-EN.pdf [Accessed on 20.08.2019]
BDO. (2018), *Benchmark Ziekenhuizen 2018*. BDO Accountants and Adviseurs.
BDO. (2019), *Benchmark Ziekenhuizen Zorginfarct afgewend? 'Duurzaam herstel nog niet binnen bereik*. BDO Accountants and Adviseurs.
City Council. (1990), *Nr. 344. Toekomst van het*. https://amsterdam.raadsinformatie.nl/document/4460278/1/000000329-19900223 [Accessed 28.09.2019]
City Council. (1997), *Nr. 262 Privatisering van het Slotervaartziekenhuis*. https://amsterdam.raadsinformatie.nl/document/4472528/1/000003481-19970515 [Accessed 19.09.2019]
City Council. (2018), *Council commission report, October 31, 2018*. https://amsterdam.raadsinformatie.nl/document/7081355/1#search=%22slotervaartziekenhuis%22 [Accessed 15.10.2019]
CMS. (2019), *Faillissementsverslag Slotervaartziekenhuis B.V. En I.S.M – Nederland B.V. 1* (No. 1; pp. 1–20), CMS Law Tax. https://cms.law/nl/NLD/Publication/Bankruptcies/Slotervaartziekenhuis-B.V [Accessed 07.10.2019]
COFZ, (Commissie onderzoek faillissementen ziekenhuizen), (2020), *De aangekondigde ondergang: Onderzoek naar de faillissementen van het MC Slotervaart en de MC IJsselmeerziekenhuizen*. Rapport van de Commissie onderzoek faillissementen ziekenhuizen.
Gerechtshof Amsterdam. (2015), *Gerechtshof Amsterdam Ondernemingskamer*. https://linkeddata.overheid.nl/front/portal/document-viewer?ext-id=ECLI:NL:GHAMS:2015:1758 [Accessed 08.05.2020]
Bakker, I. (2007), Social Reproduction and the Constitution of a Gendered Political Economy. *New Political Economy*, 12(4), 541–556.
Bhattacharya, T. (Ed.) (2017), *Social Reproduction Theory: Remapping Class, Recentering Oppression,* London: Pluto Press.
Doling, J. and Ronald, R. (2010), Property-based welfare and European homeowners: How would housing perform as a pension? *Journal of Housing and the Built Environment*, 25(2), 227–241.

https://doi.org/10.1017/S004727942200023X Published online by Cambridge University Press

den Hartog, M., Janssen, R., Haselbekke, B. J., Croes, R. and Klik, M. (2013), Factors Associated with Hospital Closure and Merger: A Survival Analysis of Dutch Hospitals from 1978 to 2010. *Health Services Management Research*, 26, 1–8.

Engelen, E., Fernandez, R. and Hendrikse, R. (2014), How Finance Penetrates its Other: A Cautionary Tale on the Financialization of a Dutch University. *Antipode*, 46(4), 1072–1091.

Enthoven, A. (1978a), Consumer-Choice Health Plan: Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance. *New England Journal of Medicine*, 298(12), 650–658.

Enthoven, A. (1978b), Consumer-Choice Health Plan: A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector. *New England Journal of Medicine*, 298(13), 709–720.

Eren Vural, I. (2017), Financialisation in health care: An analysis of private equity fund investments in Turkey. *Social Science & Medicine*, 187, 276–286.

Esping-Andersen, G. (1990), *The three worlds of welfare capitalism*. Princeton: Princeton University Press.

Federici, S. (2019), Social reproduction theory. *Radical Philosophy*, 2(4), 55–57.

Fraser, N. (2016), *Contradictions of Capital and Care*. New Left Review. https://newleftreview.org/issues/II100/articles/nancy-fraser-contradictions-of-capital-and-care [Accessed 30.04.2020]

García-Lamarca, M. and Kaika, M. (2016), 'Mortgaged lives': The biopolitics of debt and housing financialisation. *Transactions of the Institute of British Geographers*, 41(3), 313–327.

Gardeniers-Berendsen, M. (1982), *Brief van de Minister van Volksgezondheid en Milieuhygiëne*. http://resolver.kb.nl/resolve?urn=sgd%3Ampeg21%3A19811982%3A000 4876 [Accessed 16.10.2019]

Goede, M. d. (2005), *Virtue, fortune and faith : a genealogy of finance*. Minneapolis, Minn.: University of Minnesota Press.

Graham, S. and Marvin, S. (2002), *Splintering urbanism: Networked infrastructures, technological mobilities and the urban condition*. Routledge. http://www.myilibrary.com?id=31904

Groenendijk, M. (2018), *Vraag bij het nieuws: Van wie zijn de ziekenhuizen?* AD.Nl. ~https://www.ad.nl/dordrecht/vraag-bij-het-nieuws-van-wie-zijn-de-ziekenhuizen~a142fa60/ [Accessed 23.04.2020]

Grootegoed, E. and Van Dijk, D. (2012), The Return of the Family? Welfare State Retrenchment and Client Autonomy in Long-Term Care. *Journal of Social Policy*, 41(4), 677–694.

Hacker, J. S. (2004), Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform. *British Journal of Political Science*, 34(4), 693–724.

Hall, S. (2020), Social reproduction as social infrastructure. *Soundings: A journal of politics and culture 76*, 82–94.

Hansen, J., van der Velden, L. and Hingstman, L. (2008), *Behoefteraming Intensive Care voor volwassenen 2006-2016*. Nivel. https://www.nivel.nl/nl/publicatie/cijfers-uit-de-registratie-van-verloskundigen-peiling-2008 [Accessed 12.05.2020]

Helderman, J., Schut, F., van der Grinten, T. and van de Ven, W. (2005), Market-Oriented Health Care Reforms and Policy Learning in the Netherlands. *Journal of Health Politics, Policy and Law*, 30(1–2), 189–210.

Henry, C. (2015a), Time and the social reproduction of American health care. *Women's Studies International Forum*, 48, 165–173.

Henry, C. (2015b), Hospital Closures: The Sociospatial Restructuring of Labor and Health Care. *Annals of the Association of American Geographers*, 105(5), 1094–1110.

Horton, A. (2019), Financialization and non-disposable women: Real estate, debt and labour in UK care homes. *Environment and Planning A: Economy and Space*.

Kaal, R., Besseling, N. and van Rooij, G. (2011), *Slotervaartziekenhuis: 1976 een modern gebouw, 2011 voor nieuwe zorg*. Amsterdam: Slotervaartziekenhuis.

https://doi.org/10.1017/S004727942200023X Published online by Cambridge University Press

Kaika, M. and Ruggiero, L. (2016), Land Financialization as a "lived" process: The transformation of Milan's Bicocca by Pirelli. *European Urban and Regional Studies*, 23(1), 3–22.
Katz, C. (2008), Bad elements: Katrina and the scoured landscape of social reproduction. *Gender, Place & Culture*, 15(1), 15–29.
Kroneman, M., Boerma, W., van den Berg, M., Groenewegen, P., de Jong, J. and van Ginneken, E. (2016), *Netherlands Health system review* (18 (2); Health Systems in Transition), The European Observatory on Health Systems and Policies. http://www.euro.who.int/__data/assets/pdf_file/0016/314404/HIT_Netherlands.pdf [Accessed 20.12.2019]
Lambert, R. and Rimbert, P. (2020), *Marktlogik und Katastrophenmedizin—LMd*. Le Monde diplomatique. https://monde-diplomatique.de/artikel/!5672009
Langley, P. (2008), *The everyday life of global finance*. Oxford: Oxford University Press.
Levine, M. (2010), *Why St. Vincent's Is the Lehman Brothers of Hospitals—New York Magazine —Nymag*. New York Magazine. https://nymag.com/news/features/68991/ [Accessed 05.01.2021]
Luke, N. and Kaika, M. (2019), Ripping the Heart out of Ancoats: Collective Action to Defend Infrastructures of Social Reproduction against Gentrification. *Antipode*, 51(2), 579–600.
McLafferty, S. (1982), Neighborhood characteristics and hospital closures. *Social Science & Medicine*, 16(19), 1667–1674.
Mitchell, K., Marston, S. A. and Katz, C. (2003), Introduction: Life's Work: An Introduction, Review and Critique. *Antipode*, 35(3), 415–442.
Moon, G. and Brown, T. (2001), Closing Barts: Community and Resistance in Contemporary UK Hospital Policy. *Environment and Planning D: Society and Space*, 19(1), 43–59.
Mosciaro, M., Engelen, E. and Kaika, M. (2022), Seeing like an economist: using the case of dutch health care reform to bring professions and their epistemologies back in the field of new economic sociology. *Socio-Economic Review*, forthcoming.
Mulligan, J. (2016), Insurance Accounts: The Cultural Logics of Health Care Financing: The Cultural Logics of Health Care Financing. *Medical Anthropology Quarterly*, 30(1), 37–61.
Netz, S., Lempp, S., Krause, K. and Schramm, K. (2019), Claiming citizenship rights through the body multiple. *Citizenship Studies*, 23(7), 637–651.
Noailly, J. and Visser, S. (2009), The Impact of Market Forces on Child Care Provision: Insights from the 2005 Child Care Act in the Netherlands. *Journal of Social Policy*, 38(3), 477–498.
Norton, J. and Katz, C. (2017), Social Reproduction. In D. Richardson, N. Castree, M. F. Goodchild, A. Kobayashi, W. Liu, and R. Marston (Eds.), *International Encyclopedia of Geography: People, the Earth, Environment and Technology* (pp. 1–11), John Wiley & Sons, Ltd.
OECD. (2019), Netherlands: Country Health Profile 2019. OECD. https://www.oecd-ilibrary.org/social-issues-migration-health/netherlands-country-health-profile-2019_9ac45ee0-en [Accessed 18.12.2019]
OvV. (2019), *Faillissement MC Slotervaart en MC IJsselmeerziekenhuizen: Risico's voor patiëntveiligheid*. Onderzoeksraad voor Veiligheid.
PropertyNL. (2006), Het Oosten en De Key kopen Slotervaartziekenhuis. *PropertyNL*. https://propertynl.com/Nieuws/Het-Oosten-en-De-Key-kopen-Slotervaartziekenhuis/5c31221d04cc4b708ee36f14f560c6fd [Accessed 01.08.2019]
Rodríguez-Rocha, V. (2021), Social Reproduction Theory: State of the field and new directions in geography. *Geography Compass*, 15(8), e12586.
Roscam Abbing, H. (1987), De weg naar een gezond bestel; het advies van de Commissie Dekker. *Ned Tijdschr Geneeskd*, 131, 1136–1140.
Schut, F. and van de Ven, W. (2011), Effects of purchaser competition in the Dutch health system: Is the glass half full or half empty? *Health Economics, Policy and Law*, 6(1), 109–123.
Soetenhorst, B. and Wester, J. (2015), *De kraak van het Slotervaartziekenhuis en de avonturen van Aysel Erbudak*. Bertram + de Leeuw Uitgevers.

Stoesz, D. and Karger, H. (1991), The Corporatisation of the United States Welfare State. *Journal of Social Policy*, 20(2), 157–171.

Stolper, K., Boonen, L., Schut, F. and Varkevisser, M. (2019), Managed competition in the Netherlands: Do insurers have incentives to steer on quality? *Health Policy*, 123(3), 293–299.

Toebes, B. (2006), The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands. *Health and Human Rights*, 9(1), 102–127.

van de Ven, W. (1991), Perestrojka in the Dutch health care system. *European Economic Review*, 35(2–3), 430–440.

van der Zwan, N. (2014), Making sense of financialization. *Socio-Economic Review*, 12(1), 99–129.

van Egmond, S. and Zuiderent-Jerak, T. (2010), Analysing Policy Change: The Performative Role of Economics in the Constitution of a New Policy Programme in Dutch Health Care. In *Science and Policy in Interaction on Practices of Science Policy Interactions for Policy-Making in Health Care* (pp. 133–154), Rotterdam.

van Kleef, R., Schut, E. and van de Ven, W. (2014), *Evaluatie Zorgstelsel en Risicoverevening Acht jaar na invoering Zorgverzekeringswet: Succes verzekerd?*. Erasmus University Rotterdam. https://web.archive.org/web/20160304205218/http://www.bmg.eur.nl/fileadmin/ASSETS/bmg/Onderzoek/Onderzoeksrapporten___Working_Papers/2014/Eindrapportage_Evaluatie_Zorgstelsel_en_Risicoverevening_Amcham-Clingendael_project_maart2014.pdf [Accessed 14.08.2019]

Visser, J. (2013), *Slotervaart versus Achmea*. Medisch Contact. https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/slotervaart-versus-achmea.htm

Zuiderent-Jerak, T. (2009), Competition in the Wild: Reconfiguring Healthcare Markets. *Social Studies of Science*, 39(5), 765–792.

Zuiderent-Jerak, T. and van der Grinten, T. (2011), *Markets and public values in health care*. Wetenschappelijke Raad voor het Regeringsbeleid. https://www.wrr.nl/publicaties/publicaties/2011/01/07/markets-and-public-values-in-health-care—57 [Accessed 27.08.2019]