Health & Place 16 (2010) 1145–1155

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

A typology of cross-border patient mobility

Irene A. Glinos [a,*], Rita Baeten [b], Matthias Helble [c,1], Hans Maarse [a]

[a] Department of Health Organisation, Policy and Economics, Faculty of Health, Medicine and Life Sciences, University of Maastricht, Universiteitssingel 40, 6229 ER Maastricht, P.O. Box 616, NL-6200 MD Maastricht, The Netherlands
[b] Observatoire Social Européen (a.s.b.l.), Rue Paul Emile Janson 13, B-1050 Brussels, Belgium
[c] Trade and Environment Division, World Trade Organization, Rue de Lausanne 154, CH-1211 Geneva, Switzerland

ARTICLE INFO

Article history:
Received 27 March 2010
Received in revised form
27 July 2010
Accepted 2 August 2010

Keywords:
Patient mobility
Cross-border health care
Access
Travel
Health funding

ABSTRACT

Based on systematic observation and analysis of available evidence, we propose a typology of cross-border patient mobility (rather than the so-called 'medical tourism') defined as the movement of a patient travelling to another country to seek planned health care. The typology is constructed around two dimensions based on the questions 'why do patients go abroad for planned health care?' and 'how is care abroad paid for?' Four types of patient motivations and two funding types have been identified. Combined in a matrix, they make eight possible scenarios of patient mobility each illustrated with international examples.

1. Introduction

Any observer of patient mobility is bound to notice the diversity of movements and practices taking place within and across continents. Patients in search of immediate, affordable or unusual treatments travel long distances; inhabitants of certain border-regions access health services in the neighbouring jurisdiction, while people who reside 'abroad' return to their home country or country of affiliation to receive medical care. The aim of this article is to make sense of this variety by proposing a typology of patient mobility with global relevance. Such a systematic classification is useful to scholars, policy-makers and health care actors who deal with the conceptual or empirical implications of cross-border health care. By capturing the nature of patient movements, the typology is intended to clarify what patient mobility is (and is not), identify patterns and shifts in patient flows, and generate new ideas for research.

The typology is built around two dimensions: why do patients go abroad for planned health care, and how is care received abroad paid for? At the heart of both questions lies a cornerstone of health systems: that health care be organised, delivered, consumed and financed within the boundaries of a single territory. The *principle of territoriality* has been the logic behind health systems to make planning and sustainability of services possible (Cornelissen, 1996). While the concept has been developed and described in the context of (European) social security systems (see Ferrera, 2005), territoriality arguably also applies to other forms of collective funding. A predefined territory makes it easier for funding bodies, whether public or private, to organise health services efficiently as they know the size and characteristics of the population they cover, how many providers deliver care and what care is needed and supplied. Contracting with providers can be a way to ensure sustainable services and control expenditure. If patients can get 'any' treatment 'anywhere' this will affect costs. Private health insurers often operate with a defined network of providers, which patients should go to or face financial penalty. The effect is similar: to delimit the sphere in which health care is funded, consumed and delivered.

Patient mobility goes beyond conventional territorial logic; it functions according to different incentives, rules and structures. By answering the questions 'why do patients go abroad for planned health care, and how is care received abroad paid for?', we present a typology with two dimensions: *types of patient motivations* according to the reasons for seeking health services abroad and *types of funding* that allow patients to do so. This implies a demand-side approach focusing on the users of health care. The result is a matrix of four types of motivations and two types of funding combined into eight possible scenarios of patient

* Corresponding author. Tel.: +31 43 38 81 727.
E-mail addresses: i.glinos@beoz.unimaas.nl, igl@obs.euro.who.int (I.A. Glinos).

[1] Disclaimer: The author previously worked as Technical Officer for the World Health Organization. The findings, interpretations and conclusions expressed in this article are the sole responsibility of the authors. They do not purport to reflect the position of the World Health Organization or of the World Trade Organization or their Members.

1353-8292/$ - see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.healthplace.2010.08.001

mobility. International evidence will illustrate each scenario to test the applicability of the typology and demonstrate its relevance.

This endeavour comes at an opportune time. Patient mobility is high on the agenda at EU level and in international agencies including the OECD, World Health Organisation and World Bank. The European Commission and EU Member States have since 2004 been exploring the options for creating a new legal framework for patient mobility between the 27 EU countries (European Commission, 2004, 2008; RAPID Press Release, 2009; Council of the European Union, 2010). A slow and thorny political process has highlighted the intricacy of the issues at stake. At the OECD, attention to patient mobility focuses on the growth of 'medical tourism' and the trade in health services as a promising, expanding industry, which is not sufficiently understood or monitored (Morgan, 2009; Warner and Jahnke, 2010). The OECD is currently working on integrating more fully the cross-border flows of patients into the System of Health Accounts.[2] At the WHO, the risks and opportunities of trade in health services have been examined for over a decade with research being commissioned[3] and the organisation recently focusing its work on cross-border patient mobility.[4] The World Bank has undertaken similar efforts and published papers on patient mobility's potential impact (Mattoo and Rathindran, 2005; Arunanondchai and Fink, 2007; Cattaneo, 2009). One of the few international agreements that could provide guidance for the definition of cross-border mobility of patients is the General Agreement on Trade in Services (GATS) of the World Trade Organization. According to GATS Article I, the treatment of a patient abroad would be considered as a trade in services "in the territory of one Member to the service consumer of any other Member" (WTO, 1995). As GATS covers all types of services, this definition is rather general and leaves many questions open from a health perspective.

1.1. Definitions

At a minimum, cross-border patient mobility involves a patient who travels to another country for the purpose of receiving planned health care. This implies a deliberate movement outside the *country of residence* where the patient lives and where he/she may or may not have health care coverage. By *health (care) cover* we imply the entitlement a patient has to access health care services by virtue of being affiliated to a health insurance scheme, whether public or private. The precise range of health care services the patient has right to will be referred to as *benefit package* and is defined by the competent funding authorities in statutory, public health systems and by private health insurers in privately funded systems. The country where the patient is treated will be referred to as the *country of treatment*.

The typology focuses on deliberate movements across international borders of patients seeking planned health care. This implies that variants of patient mobility taking place within the same country, e.g. from one region or federal state to another or from the public to the private sector, are not included because no country borders are crossed. Tourists, expats and migrants accessing care in a foreign country are, on the other hand, not included because either they do not travel with the purpose of obtaining care but make use of health services in the country where they find themselves.

It also follows from our definition that we only consider the obtainment of health services abroad, thereby excluding movements related to the purchasing of products such as pharmaceuticals or medical devices, as well as trade in services where the patient is not travelling between countries as in the case of tele-medicine.

It is a conscious choice of terminology to refer to 'patient mobility' and not 'medical tourism'. The former is a wider, more diverse and more nuanced phenomenon than the latter. Our typology takes a demand-side approach centred on patient motivations rather than focusing on the suppliers of health care and their interests in patient mobility. Finally, the industry-driven term 'medical tourism' insinuates leisurely travelling and does not capture the seriousness of most patient mobility.

2. Materials and methods

The typology has been created based on the observation, systematisation and analysis of practices of patient mobility. The evidence base stems from the results of an European research project on patient mobility[5] in 2004–2007 (Rosenmoller et al., 2006) and from continuous research in the area since then.

A literature review stretching across 11 languages[6] and 23 European countries[7] was carried out in 2005–2006 (Glinos and Baeten, 2006). Material was found through country expertise and snowballing. The review proceeded as a search for material from secondary sources. Data collection was done using a 'snowballing' method by which experts, public officials and stakeholders were contacted to identify documentation. These sources provided new research paths which lead to new information, and so forth. Systematic internet searches revealed documentation in national languages. In 2009–2010, evidence was updated and collected at the international level including consultations with experts from the World Health Organization and the World Bank.

Common for both European and worldwide patient mobility is the generally poor data availability. Written material is rare and of variable quality (Rosenmoller et al., 2006a, p. 5). This is particularly true for patient mobility of commercial nature and when no public bodies are involved. While the Internet provides abundant information and can be the main communication channel between potential patients and providers, the quality of information is often dubious and the approach biased.

Patient mobility being rapidly evolving and under-researched, grey literature and media reports have been used to document developments not covered elsewhere and local experts consulted to provide specific insights.

3. Results

3.1. Towards a typology

Based on our findings, patient mobility practices have been analysed and regrouped according to two dimensions: *types of*

[2] The so-called *System of Health Accounts* (SHA) is a manual developed by the OECD in collaboration with the WHO to collect comprehensive data on health expenditure and financing at the national level. The first version of the SHA from 2000 is now used by a large number of OECD and non-OECD countries as the standard accounting framework for health financing statistics. Currently, the OECD is leading efforts to update and revise the current SHA. (More information can be found on http://www.oecd.org/health/sha).

[3] http://www.who.int/trade/resource/tradewp/en/index.html.

[4] In February 2009, the WHO organised an international workshop in Kobe, Japan, on the topic of the international movement of patients across borders. The workshop contributions are available upon request.

[5] By its full name, 'The Future for Patients in Europe' was a European Research Project part of the Scientific Support to Policies component of the EU's 6th Framework Programme, financed by DG Research. Carried out at the Observatoire Social Européen in the framework of the 'Europe for Patients' project (2004–2007).

[6] Danish, Dutch, English, French, German, Greek, Italian, Norwegian, Portuguese, Spanish and Swedish.

[7] Initial material collected and analysed at the Observatoire Social Européen in the framework of the 'Europe for Patients' project (see Rosenmoller et al., 2006).