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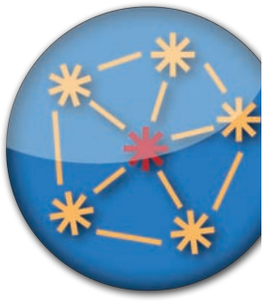

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Editorial

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The idea, if not the slogan "Think globally, act locally" originated in town planning in the early 20th century. It is very much alive today in the context of environmental challenges.

Used in health care, too, most often it is about both thinking and acting locally. Health care delivery, by its nature is local: people need the services close by when needed. But the situation is fast changing on different fronts, and hospital decision makers may find they have to think and act globally sooner than they think.

International travel by patients existed long before it became a media topic. What has changed is the scope of international travel by patients. Nowadays, many countries offer health care services to foreign patients. In some countries, it may be a limited activity and mostly for neighboring countries. The example of a Turkish hospital is a good example of this dimension. But this evolution means that, although hospitals may think locally, their activities are no longer purely local, but global.

Medical practice is shaped by national contexts but more and more practitioners consider how their practice compares to others. When such a comparison is done between Germany and Australia, it is obvious that, though well-rooted locally, the aspirations are global. The human resource market is becoming more and more global with individual mobility at world scale.

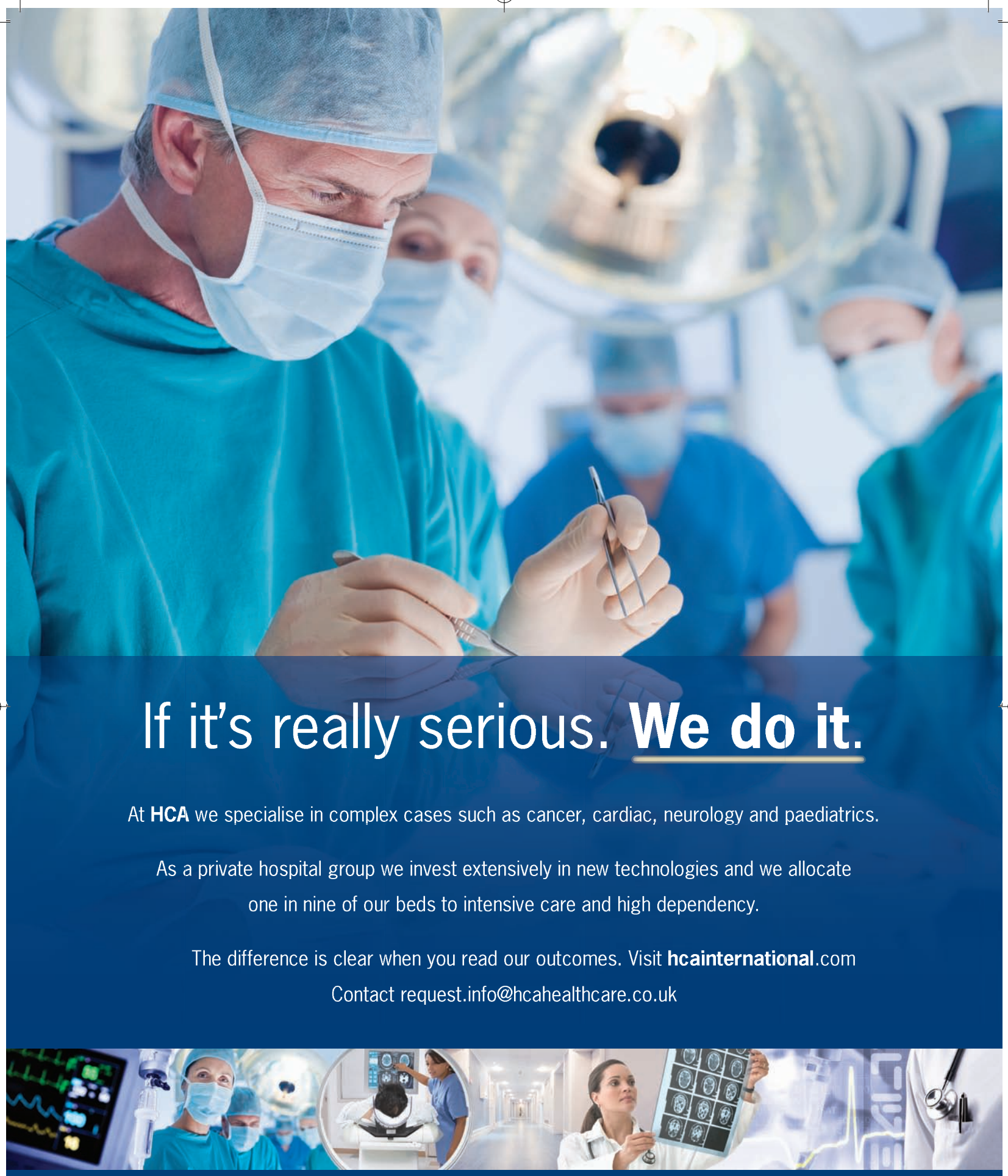
Regulating world trade is the task of the World Trade Organization. But in a globalized world how much attention is given to health care? Everybody knows about the TRIPS agreements for the drug industry (trade-related aspects of intellectual property rights and public health, the Doha declaration) but not many know how much WTO covers health care as a possible trade industry. In fact, from the article presenting the WTO health care role in this issue, it will be obvious that health care is not yet considered a major industry for international trade. On this matter, the atomization of the market explains why, from an international trade perspective, health care is still considered a mostly local market.

There is no country in which policy makers are not reflecting on possible evolutions to improve delivery and reduce costs of hospital services. There is no universal model that has proven to be the most effective. But restructuring the hospital sector is a national challenge that cannot be accomplished without looking at what has been done in the rest of the world. The situation in Georgia shows how any option discussed for a country, regardless of its level of advancement, is inspired by others and will in turn influence others. This is an example of think globally, act locally.

Many other different kinds of examples could follow this pattern. For instance, when a country like Canada undertakes a study of a profession like physiotherapy, results can be useful all around the world. Optimization of the care model is a universal challenge in a global context of scarcity of health professionals.

Likewise, the development of information technology (IT) is evolving all around the world. For any support system, best use relies on a good knowledge of its possibilities relative to the various stakeholders. This development needs to be supported by adequate education, which most hospital executives do not have. Proper training for this can be achieved locally but with IT itself it becomes available to anyone in the world. A local resource can have a global use for local benefits.

If not yet convinced, we hope that reading the articles in this issue with a bifocal lens will increase your awareness of the fact that day-to-day activities related to a local dimension cannot be divorced from the global dimension. What is happening in the rest of the world may influence what is decided locally, and what is happening locally may influence decisions in other parts of the world. The scale does not matter; what matters is the nature of the interaction. The global dimension is never far from the local concern. ❑



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International patients in a Turkish hospital: A quantitative study on cross-border health care at the intersection of Eastern Europe, Asia and the Middle East

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ABSTRACT: This is the first attempt, to our knowledge, that aims to empirically quantify and characterize international patient flows to Turkey. A cross-sectional retrospective study was performed on consecutive patients seen at the International Services Department of a 209-bed private hospital in urban Turkey. Over six months, international patients represented 4 percent and 6 percent of all consultations and surgical procedures, respectively. Six hundred and fifty unique international patients received health care and represented 44 different countries. Among these 650 unique encounters, most patients originated from Bulgaria (37%), Romania (35%), Azerbaijan (6%), Iraq (3%) and Georgia (3%). International patients commonly required oncological (54%), surgical (13%) and neurological (7%) services. Although quantitative data on medical travel to Turkey is limited, significant patient flows exist from neighboring countries to Turkey.

Medical travel or medical tourism is the process of travelling for the purpose of receiving medical care. Medical travel has grown significantly over the past 30 years and the term medical tourism has become common around the world. Despite its popularity, a review on global medical travel was unable to retrieve accurate data on the volume of health consumption abroad (Smith et al. 2011). While medical travel is therefore not quantified exactly, the number of Americans travelling abroad for health care is estimated at more than 500,000 (Herzlinger and Green 2009). Medical travel within the European Union Member States is known to be minor (Baeten and Glios 2006, De Neve 2010). Based on differing reports, Turkey would serve over 40,000 to 100,000 international patients annually, predominantly from Northwestern Europe and the United States due to lower medical costs and vacation opportunities following recovery (Aydin et al. 2011, DEIK/Health Tourism Business Council 2012a; 2012b). Furthermore, Turkey has been projected to serve 1 million international patients in 2015, to the tune of US$8 billion, and has the most Joint Commission International accreditations worldwide (Woodman 2009, pp 65-66). The current study provides original data on the volume and profile of international patients seen in a private hospital in Turkey.

Materials and methods

A single-center cross-sectional descriptive study was performed based on a retrospective review of consecutive patients seen at the International Services Department. The study was performed at a 209-bed private hospital in urban Turkey. All international patients were included. Those foreign nationals of Turkish descent and patients transferred from other institutions were included. Expatriates were excluded. Patient data were retrieved from two unrelated sources: the electronic medical record system of the study site (Soarian® MedSuite 4.0.300) and daily international patient lists from the International Services Department (Microsoft Excel). December 1, 2009 to May 31, 2010 was chosen because it was the most recent data available. Hospital data from the electronic medical record system was obtained for number of consultations and surgical procedures. Country of origin, date of visit, department and in- or outpatient status were identified from international patient lists. Patient lists were unavailable for weekends and Turkish national holidays. Outcome measures included consultations, surgical procedures, in- or outpatient status, dates of visit, departments visited, country of origin and gender of international patients.

Results

During the 6-month study period, international patients accounted for 2,666 of all 69,481 outpatient consultations (4%) and 162 of all 2,595 surgical procedures (6%). Six hundred and fifty unique international patients were encountered. Among these 650 unique encounters, the average amount of inpatient days and outpatient days was 1.5 days and 4.8 days, respectively. Fifty-six percent of them were female. The number of visits of international patients increased from 595 to 960 visits per month (Figure1). International patients originated from 44 different countries, including from Bulgaria (37%), Romania (35%), Azerbaijan (6%), Iraq (3%) and Georgia (3%) (Figure 2). Patients from European Union Member

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Figure 1: Number of visits of international patients per month, Dec 2009 – May 2010

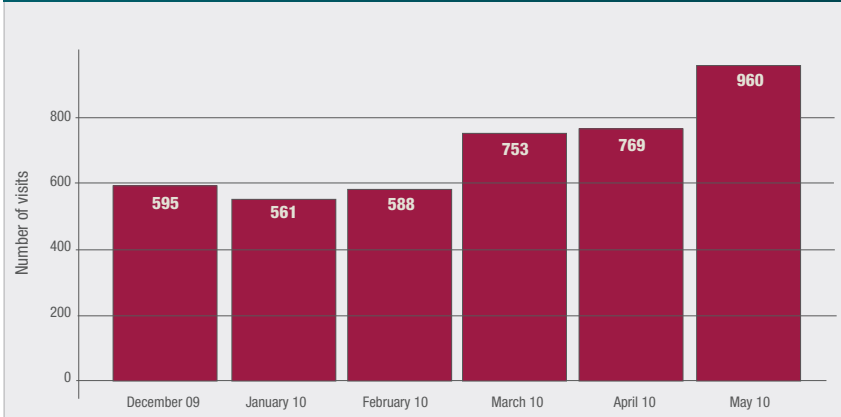

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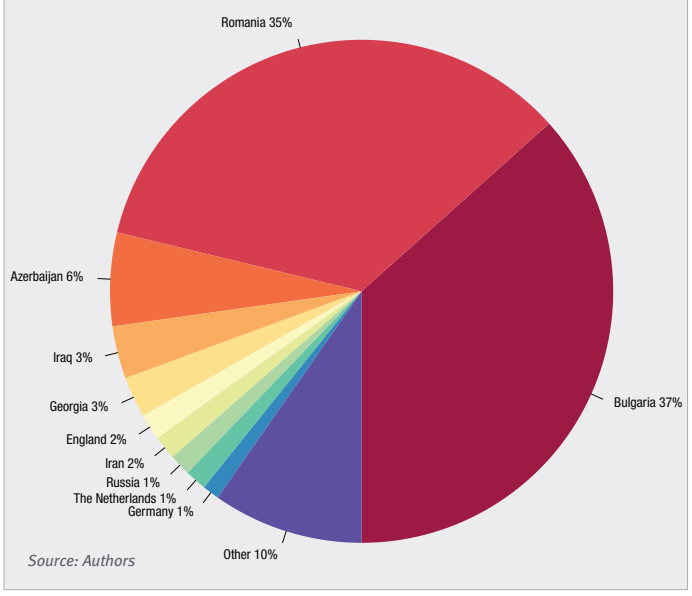
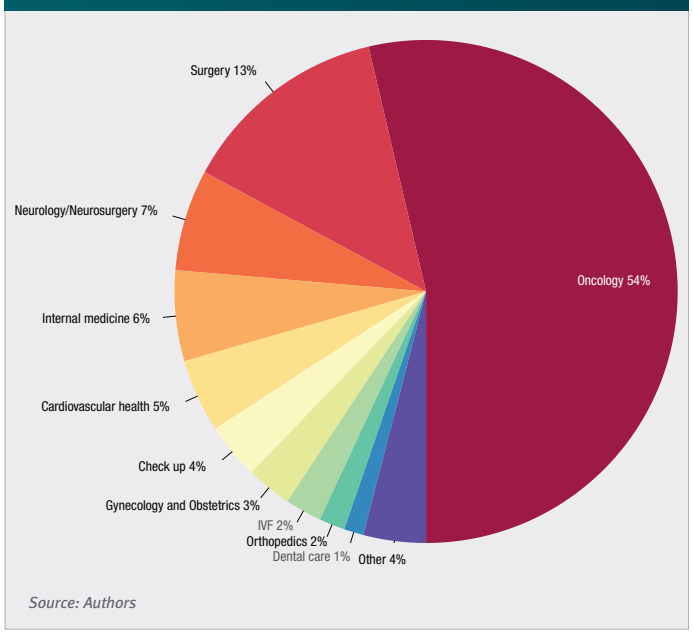
Figure 2: Country of origin of international patients, Dec 2009 – May 2010



Source: Authors

Figure 3: Departments visited by international patients, Dec 2009 – May 2010



Source: Authors

States accounted for 77 percent while those from North America for 1 percent. Patients from Australia, Canada, Israel, Japan, New Zealand, the United States and Western-Europe, combined, accounted for 5 percent. Most international patients required oncological (54%), surgical (13%) and neurological (7%) services (Figure 3).

Discussion

This study is the first attempt, to our knowledge, that aims to empirically quantify and characterize international patient flows to urban Turkey. Previous studies characterized non-Turkish citizens in an emergency department and tourists with traveller's diarrhea in a Turkish coastal region (Ziegenhagen et al. 1992, Eray et al. 2008). In reverse, two studies investigated Turkish citizens travelling abroad for organ transplantations and cross-border reproductive care (Gürtin 2011, Yakupoglu et al. 2010). Although the medical travel industry asserts that significant patient flows to Turkey arise from Northwestern Europe and the United States due to lower medical costs, a review of the medical literature revealed no documentation in support of this claim. The current study therefore stresses the significant number of international patients seen in Turkey. In particular, international patients from Eastern Europe.

This was a single-center study and results may not be generalizable to other Turkish institutions. However, the study site offers an extensive array of specialties and subspecialties and is known as a pioneer in international patients among other private health care facilities in Turkey (General Management, Bayındır Healthcare Group 2010). As the study period covers six months, there is the additional possibility of a seasonal bias if international patient flows differ depending on season. The authors have no reason to believe such bias exists as medical travel in this study tends to arise out of medical need. In addition, bias in the proportion of different nationalities could arise due to international marketing campaigns that are focused on patients from specific countries. The International Services Department, however, builds on campaigns that have proven successful in the past. Previous campaigns targeting Western European and North American markets, for example, were largely unsuccesful.

Further research should keep track of patient flows and consequences of cross-border health care for both international patients and Turkish health care system alike. While the proportion of private hospitals rises, Turkey will increasingly offer an alternative to international patients (Aksan et al. 2010, Republic of Turkey Prime Ministry, Investment Support and Promotion Agency of Turkey, 2010). Turkey, with a 9 percent GDP growth rate at times of global crisis, is geographically located at the cross-roads of three continents and encircled by low-performance health care systems (World Bank 2012, Mladovsky et al. 2009). Private health care providers in Turkey have created platforms to develop incoming patient flows, ranging from industry associations to international medical travel conferences (Turkish American Chamber of Commerce and Industry – Midwest 2010, Association of Health Tourism, Turkey 2011). The consequences of incoming international patients to Turkey have extended beyond its health care system already (Turkish Airlines, 2009).

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Furthermore, the long-standing Turkey Health Transformation Program, created by the Ministry of Health to develop the Turkish health care system, addresses international patients in its recent evaluation report. Under the 2023 Vision of Health, it is claimed that, in regard to global medical travel, Turkey will be "at the center of Europe, Middle East, Africa, Central Asia and Russia" (Ministry of Health Turkey, 2011). The Turkish Ministry of Health expressed interest in international cooperation, development and quality improvement, to further boost international recognition and incoming patient flows. Despite these changes, how international patients in Turkey compare to international patients in other emerging countries, remains yet to be determined.

Lastly, based on the unexpected profile of international patients seen at the study site, several implications may arise that could be relevant to regional health care providers, regulators and policy makers dealing with cross-border health care. In particular, (1) How international patients are referred to Turkey, including the possible involvement of unregulated, remunerated third parties; (2) The financial burden of treatment on impoverished international patients; and, finally, (3) The appropriateness of medical treatment and follow up of international patients, given their frequently complex or multi-disciplinary treatment plans. As a result, it may seem uncertain if international patients in urban Turkey are indeed medical "tourists", if not medical refugees (Milstein and Smith 2006).

"We feel very confident. The only bad thing is that we feel isolated from the world. We have nowhere to go. And the other problem is, as we stay at the hospital for five days, all the doctors speak English, we have translators during the business days. During the weekends, there are many nurses that do not know English and it is hard to explain yourself. You end up talking like this and that [displays hand motions used in communication such as "thirsty", "my head hurts"]. You have to then use Google Translate, which is impossible to use." ❑

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World Trade Organization activity for health services

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ABSTRACT: Since the establishment of a multilateral trading system and the increasing mobility of professionals and consumers of health services, it seems strongly necessary that the World Trade Organization (WTO) undertakes negotiations within the General Agreement on Trade in Services (GATS), and that WTO's members attempt to reach commitments for health-related trade in services. How important is the GATS for health policy and how does the GATS refer to health services? What are the current negotiations and member's commitments?

In 1995, the World Trade Organization (WTO) was established, and the importance of international trade law to public health and health care has become very clear. At the beginning, the multilateral trading system regulated trade in goods between nations, but expanded it into new areas, such as intellectual property protection and trade in services. The provision and consumption of services have become an increasingly important part of modern economies. The incorporation of services into the multilateral trading system through the General Agreement on Trade in Services (GATS) represents one of the most important developments emerging from the creation of the WTO.

The objective of this article is to understand the way the WTO is approaching health services in general in its agreements and how the question is treated by the WTO's members and in their discussions.

Main economic features

"While health and social services have been considered as (a) non-tradeables to be provided by (b) public institutions, there has been a change in policy perception in a number of countries" (WTO 1998, p.2). The mobility of professionals and consumers is enhanced by efficient transport and communication technologies, enabling the use of new modes of supply. "At the same time, new forms of private sector involvement have opened breaches for increased domestic and foreign participation" (WTO 1998, p.2).

There is an important degree of regulatory intervention for the provision of health services, even if we are in a very "liberal" system. Measures may be aimed at the individual health care providers (doctors, physiotherapists, nurses, etc), companies and organizations operating in the system (clinics, hospitals, nursing homes) as well as in commercially related sectors (suppliers of medical equipment and pharmaceutical, insurance funds, etc). There is extremely diverse intervention concerning these measures and the policy intentions. These measures and the underlying policy intentions may be extremely diverse.

A number of countries are competing to become key exporters of health services. More particularly, there is the growing phenomenon of health tourism, which appears in many developing countries where clinics servicing foreign clientele are increasing.

The GATS and health policy

The General Agreement on Trade in Services (GATS) mandates WTO member governments to progressively liberalize trade in services through successive rounds of negotiations. The latest round of negotiations began in January 2000. In March 2001 the Guidelines and Procedures for the Negotiations on Trade in Services were adopted by the Council for Trade in Services. At the Doha Ministerial Conference in November 2001 the services negotiations became part of the "single undertaking" under the Doha Development Agenda, whereby all subjects under the negotiations are to be concluded at the same time.

The importance of GATS to health policy

The protection of public health and the delivery of health care to individuals is really important and that is the reason the creation of and the important role of different services. "GATS affects health-related services in many ways that are essential for health policy makers to comprehend. In addition, GATS establishes a process designed to progressively liberalize trade in services. Health policy makers must be prepared to participate in this process to ensure that such liberalization unfolds in a way sensitive to the needs of national governments in ensuring the provision and regulation of health-related services" (Drager and Fidler 2004, p.1).

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Table 1: What do we mean when we talk about trade in the health sector?

	Trade in health services	Trade in ancillary services	Trade in goods associated with health services
Mode 1 Cross-border supply	- Telemedicine, including diagnostics, radiology	- Distance medical education and training - Medical transcription, back office - Medical research tools and databases - Medical insurance	- Health care equipment - Drugs - Medical waste - Prosthesis
Mode 2 Consumption abroad	- "Medical tourism", i.e., voluntary trip to receive medical treatment abroad - Medically-asisted residences for retirees - Expatriates seeking care in country of residence - Emergency cases (e.g., accident when abroad)	- All activities associated with health tourism (e.g.) transport, hotel, restaurant, paramedical, local purchases, etc) - Local medical education and training of foreign nationals	
Mode 3 Commercial presence	- Foreign participation or ownership of hospital/clinic or medical facilities (e.g., capital investments, technology tie-ups, collaborative ventures)	- Foreign-sponsored education or training centers - Foreign-sponsored medical research facilities	
Mode 4 Presence of natural persons	- Movement of doctors and health personnel for the purpose of commercial medical practice	- Movement of doctors and health personnel for other purposes (e.g., education or training)	

Source: Cattaneo 2009, p.3.

Health opportunities and challenges are created by GATS, and it accords countries considerable choice, discretion, and flexibility. The process of liberalization of health-related services is then correctly protecting health. The GATS allows enough flexibility for countries to maintain regulations that are essential to the pursuit of important policy objectives, such as the protection of public health. The main advantage of GATS commitments is to anchor domestic reforms into the international system, and to preserve the government from later pressures of interests groups. Multilateral negotiations also adequately supplement regional ones: beside the economies of scale of negotiations, topics that are set aside in regional negotiations can be more easily addressed within the WTO.

The GATS objectives are also directly linked to the health-related Millennium Development Goals and could contribute to reaching it. Regulation is necessary to protect patients and to promote adoption of higher quality standards for hospitals and clinics. "Similarly trade promotion is not about challenging the public health sector, which often plays a crucial role in the supply of health services, but about designing efficient services in a more competitive environment" (Cattaneo 2009, p.4).

The main challenge of the GATS would be then to find adequate accompanying policies "that aim to maximize the positive domestic spillovers and minimize the negative domestic spillovers of trade in health services"(Cattaneo 2009, p.4).

Trade in health sector

The GATS distinguishes between four modes of supplying services: cross-border trade, consumption abroad, commercial presence, and presence of natural persons.

Medical tourism has received significant media coverage and attention. However, trade in health services is not limited to the cross-border movements of patients, which represents only one of the four possible modes of service delivery identified by the GATS – Mode 2. Other Key components include the temporary movement of health professionals to deliver services across borders (Mode 4), foreign establishment (Mode 3) and the cross-border provision of health services through technological means (Mode 1).

Trade in Health Services has an impact on "the availability of these services, the quality of the health system, and the population's health at a large in both the exporting and the importing countries. Effects of trade in health services also considerably vary from one mode to another, and imports often appear more important than exports to improve one country's domestic health system" (Cattaneo 2009, p.2).

Current commitments under the GATS

Agreements are harder to reach. The Doha round was initiated 10 years ago and little progress have been made on services. The level of commitments in the health sector remains particularly low between WTO's members, and is the lowest of all sectors. "Less than 50 members out of 153 have undertaken commitments in one of the four health services sub-sectors; most of the commitments concern hospital services" (WTO 2011).

It seems that many developing countries, including least developed countries, have made wide-ranging commitments for various health and medical services. A large majority of the Members with full commitments across Modes 1 to 3 are developing countries.

Mode 1: Cross-border supply of services is of growing importance with the development of telemedecine. Nevertheless, they are fewer commitments for Mode 1 than for any other mode. For example, of the 39 Members that have committed on hospital

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services, 11 have undertaken full bindings for Mode 1, while 27 have not undertaken any commitments. Of these, 13 Members felt, according to their schedules, that cross-border supply was not technically feasible.

Mode 2: There are opportunities for economic development when a country treats a foreign patient in its territory. Mode 2 commitments tend to be rather liberal as most governments have limited ability to prevent consumers from seeking medical treatment abroad.

Mode 3: By contrast, limitations on market access and national treatment are far more frequent under commercial presence. Over 40 members have made commitments, often subject to restrictions and limitations on the share of foreign capital. The limitations are intended to provide cover for economic needs tests, intended to contain health costs, nationality requirements, equity ceilings, joint venture requirements and not further specified licensing and approval procedures.

Mode 4: As in other areas, the level of commitments, governing the presence of national persons, trails far behind the commitments undertaken for the three other modes.

Health services have attracted very limited attention in the services negotiations. It is the only major sector where no negotiating proposal and no collective request have been tabled. Most of the countries are completely defensive instead of offensive in this sector, because of the important economical stakes.

Conclusion

Even if Members are engaged in Trade in Health Services through the GATS, it seems that any of them is ready to really move on with commitments and negotiations. Some proposals have been made through the years by a few members, trying to reach possible areas for future discussion and work, such as China or the USA, but without any results. China was asking for its doctors to have access to the European market, implying the same doctors recognition within countries. And the USA only proposed subjects to be discussed in order to try to move forward.

"The Structure and substance of GATS create a challenge for ministries of health to develop capabilities to manage the GATS 2000 process[1] effectively from a health policy perspective in two key areas: 1) Evaluating requests for, and offers of, specific commitments; and 2) Negotiations on GATS rules" (Drager and Fidler 2004, p.4).

Health policy analysis of GATS shows that requests for new market access commitments will pose the most difficulties for health policy-makers because measures that restrict market access may be used by health services objectives. ❑

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[1]The current round of liberalization process.

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