



International patients on operation vacation: medical refuge and health system crisis

Comment on “International patients on operation vacation – perspectives of patients travelling to Hungary for orthopaedic treatments”

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Abstract

An understanding of patient mobility, international patients and medical tourism includes supply and demand side considerations. As well as micro-level reports of motivation and satisfaction we must acknowledge broader system-level dynamics. Exploring these may unearth more complex geographies of patient travel.

Keywords: International Patients, Medical Tourism, Romania, Hungary

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Hungary has a long history of wellness tourism and has been a leader in the dental tourism industry for the past two decades. Large numbers of Germans, Austrians and UK nationals travel to Hungary for dental treatment, which is aggressively marketed to foreign residents by Hungarian clinics. UK research identifies Hungary as the fourth most popular destination for UK medical tourists, behind France, Poland and India (1).

The Hungarian government is proactive in promoting the Hungarian medical tourism industry and to this end has promoted medical tourism more widely, using influence within the Central and Eastern European region as well as the wider European Union (EU). Medical tourism is seen as a vehicle for economic growth as well as health system improvements. The Széchenyi plan (2011–20) (2,3), which promotes economic development, identifies the health industry as core to the overall strategy.

Discussion of patient mobility has generated much heat but frequently too little light regarding precise flows and drivers. Authoritative data on numbers and flows of patients who are mobile between countries and continents are difficult to identify. Although there is consensus that patient mobility has grown over the past decade, and that there are particular bilateral flows, capturing the activity with a level of accuracy remains problematic.

A key consideration when attempting to quantify such mobility, and therefore to understand its policy implications, is the precise definitions, their slipperiness, and overlapping usage. Taking for example the European context (and even here excluding temporary visitors, expatriates and long-term residents who may be treated abroad), potential patient flows include outsourced patients, patient directive, and international patients as outlined in below.

Outsourced patients

Within Europe, many countries sharing *common-borders* collaborate in providing *public funding* for health services from service providers across borders (4). Aside from sharing borders, some countries' health agencies contract overseas authorities to deliver services to patients who then travel overseas. In the early 2000s, UK supported some National Health Service (NHS) patients to travel to Brussels, France and Germany whilst guaranteeing safety and domestic liability (5,6). These developments are organisational purchasing initiatives, driven by waiting lists and a lack of available specialists rather than being targeted at saving money. They were best suited to patients based in particular geographical locations and a restricted range of treatments (given flights risks and recuperation).

Patient Directive

European citizens, under specific circumstances, have rights to receive medical care in other EU countries with their national purchaser reimbursing costs of treatment abroad. Clarifying legislation to codify such existing rights is gradually coming on-stream in member states. In many publicly-funded systems (such as the UK), the number of patients asserting EU rights is low and are likely to remain so given that patient financial incentives are weak. For EU states more widely, developing information and normalising flows will take time and such flows are likely to be localised or diaspora related.

International patients

The label *international patients* previously captured the travel of patients to overseas health facilities, sponsored by government or paying out-of-pocket. During the past decade

the term 'medical tourist' has also emerged, signifying new travel routes and market entrants. Much medical tourism debate focusses on intercontinental travel, out of pocket payments, and primarily more affluent western patients being treated in low- and middle-income countries.

Who pays (public taxation system, third party payers, or patients themselves), and the direction of flows, that is, from higher income countries to lower- and middle-income, or vice versa, or circulation among countries are ways of characterising the diversity of mobility.

Debate about appropriate terminology to describe the movement of individuals overseas for treatment is unlikely to subside soon. Across the social science and health services literature terms have included 'international medical travel', 'medical outsourcing', 'medical refugees' and 'medical exile' (7–9).

Alongside such definitional complexity, and acknowledging overlap between categories (for example international and outsourced patients), there are significant cross-country differences in what counts as health, wellness and medical treatment. Balneology, a widely accepted practice in Hungary and Ukraine, is considered non-mainstream healthcare in the UK, Germany and France. Similarly, setting the boundary of what is health and counts as medical tourism for the purposes of trade accounts is not straightforward. Cosmetic surgery for aesthetic rather than reconstructive reasons, for example, would be considered outside the health boundary (10).

The primary source of data relating to numbers and flows is the industry stakeholders themselves and commercial imperatives make establishing numbers problematic. However, there are separate political sensitivities – frequent opaqueness surrounding precise numbers being outsourced or patients supported under the European Directive are only partially explained by the technicalities of data collection. The integrity and political salience of national health systems is never too far from the surface when patient mobility is debated.

Beyond definitions, understanding the motivations of those who travel across borders is fundamental. Medical travel does not equate to untrammelled movement and activity, and flows are not from each and every point criss-crossing the globe. More typically there are bilateral flows or relations of a distinctly regional nature with specific patterns based on geo-political factors (such as colonialism, and existing trade patterns), or unique domestic circumstances within sender countries.

The sample of Kovacs and colleagues (11) consists of patients who are 87% of Romanian origin. Whilst Romania and Hungary share a common border, such mobility is not the result of country cooperation. A crucial task is explaining these flows and the push or pull factors underlying them. There is growing empirical evidence in the wider literature about differing motivations (1,12–15), and how word-of-mouth information and clinical networks shape travel patterns.

Considering the sample, why are patients predominantly Romanian? Patient mobility is paradoxical. Most patients prefer to be treated close to home and within jurisdiction. What then are the underlying drivers that set groups, such as those reported here, apart from populations that do not

travel?

Frequently medical travel has a focus on diaspora populations returning 'home' from a country of residence for medical treatment, or on countries which position themselves as destinations for patients from abroad. Whilst a study of Hungarian treatment, the wider explanatory frame is the nature of the Romanian healthcare system, with patients likely travelling because of domestic failings in safety and access. The pattern symbolises the nuanced geographies of medical travel that exist within the European region and beyond. Far from always being intercontinental and high-income to low-income exchanges, patients travel across borders in many regions of the world for reasons that are irreducible to consumerist notions of 'choice' (including for example within Africa and South East Asia) (16). Romanian patients' motivations may relate to cultural factors, including popular imagery and deeply engrained societal patterns, but also system level issues. On one level discussion is about international patients and Hungarian healthcare success; on another, it is also about a neighbour's failing healthcare system. With 2,140 Romanian-qualified doctors currently working in the UK (17), and the number of doctors in Romanian hospitals falling from 21,400 to 14,400 since 2011, there are endemic workforce shortages which are particularly acute in rural areas. Feraru (18) suggests that since 2007 over 10,000 doctors have chosen to practice in the West, adding to 10,000 that did so before 2007. Clinical risk, staff shortages and a wish to avoid a culture of 'informal payments' are plausibly concerns within the Romanian system motivating travellers. As a consequence, perhaps those travelling for operations may be seen as taking refuge rather than vacation (19,20).

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

NL is the single author of the manuscript.

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