Healthcare Export Developments in Europe

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The study was undertaken by within the Department of Social Policy and Social Work under the leadership of Dr Neil Lunt and Dr Dan Horsfall and funded by the Korea Health Industry Development Institute.

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Healthcare Export Developments in Europe

Executive Summary

Introduction

The export and import of health services has a long history, but the last 25 years has seen intensification of these processes and with this, greater attention. Globalisation has increased the potential for exports, whilst global economic competition has provided the incentive. It is unclear just how much is being exported, with many of the opportunities promised by the new global economy remaining under-exploited.

Whilst medical tourism is undoubtedly the dominant mode of patient mobility, it is not the only form. Furthermore, patient mobility is only one example of health service export. Trade in health services is often explored through the Global Agreement on Trade in Services (GATS) framework, which outlines four modes of trade in services:

Mode 1: Cross-border trade, where the trade takes place from one country into the other country. Here only the service itself crosses the border.

Mode 2: Consumption abroad, where the customer travels to the country where the service is supplied.

Mode 3: Commercial presence, where the supplier establishes a commercial presence abroad.

Mode 4: Movement of natural persons, where the provider of the service crosses the border.

Medical tourism represents the most active example of health service export. An increasingly popular form of consumer expenditure, medical tourism is a type of patient or 'consumer' mobility in which individuals travel outside their country of residence for the consumption of healthcare services. These journeys may be long distance and intercontinental, and cover a range of treatments including dental care, cosmetic surgery, bariatric surgery and fertility treatment.

In purely economic terms, however, health services exported through Modes 3 and 4 (in particular related to foreign companies situated in local healthcare markets) represent a much bigger slice of health service exports. In absolute terms trade through both Modes 1 and 2 is lower than through Mode 3.

The knowledge base for health service export

There are a set of interrelated questions regarding health service export including: what are the drivers; what is the nature, scope and scale of activities; how are health services export being facilitated; and who is involved in the export of health services?

Global economic pressures, in particular an increasingly open and competitive global economy, have exerted strain on domestic economies and in particular, health systems. One particular consequence of economic globalisation has been the increase in foreign direct investment (FDI). Moreover, services account for the majority of all FDI across the OECD.

The increasing pressures of globalisation have presented considerable economic challenges, which have been exacerbated by profound demographic change. In short, a greater number of people are living for longer, which in turn has created sometimes extreme pressure for health systems. Across the globe, many domestic health systems continue to undergo significant challenges and strain. The implications for health policy and delivery are wide-ranging: moves towards a global health agenda, greater professional mobility, corporate multinational health providers, e-health innovations, and increased patient mobility. The strain on health services has precipitated not only inward-facing reforms, but also attempts by healthcare providers, both public and private, to market their services beyond the domestic sphere in order to generate revenue.

Health developments have particular ramifications outside the OECD, including countries in the Middle East and Asia where spending on healthcare is currently at a low base.

The growing economic strength of formerly less economically developed countries combined with under-developed healthcare systems in such countries has provided the conditions for the export of services through modes other than medical tourism. Major healthcare expansion is underway in Saudi Arabia, Oman Kuwait, UAE and China with significant health restructuring, construction and Research & Development opportunities.

Those service providers seeking to export by locating a service in another country require not only the demand on the part of the consumer, but also the will or at least acceptance of the state or sub-state governance structures in order to operate in that country. Successful integration is likely to be aided or hindered by the existence or absence of extant or historic political relationships, cultural ties, or economic arrangements. Where such relationships are not deeply entrenched, a reputation as a market leader may compensate.

For those countries with previously and potentially profitable ties with other countries or regions, the export of services through Mode 3 is likely to represent a more lucrative avenue for investment and development. For those countries that are neither market leaders, nor tied politically, culturally or economically to receptive destinations that offer potential for health service export, direct-to-consumer marketing is likely to represent a more feasible approach.

Medical tourism offers opportunities as its services can be marketed in a range of ways. The normalisation of medical tourism is extremely important and where there is state recognition of or support for medical tourism this strengthens the hand of all those involved in exporting healthcare to foreign residents. State support can exist at various levels (local, national, supranational) and take a range of forms including legal, regulatory, financial and marketing.

Whether discussion centres on medical tourism or other health services, the notion of region is important and as such trading blocs such as the EU or ASEAN are the site of much intra-bloc trade in health services, but far less inter-bloc trade. Where relationships transcend region these are often bi-lateral

relationships, again often underpinned by historic cultural, political or economic relationships. Services traded through Mode 3 do lend themselves to an insider/outsider arrangement, far more than medical tourism, where reputations can be established quicker. However just as political and economic relationships shift with time, the development of more coherent national medical tourism strategies might develop to the extent that a national brand emerges that can compete with more established players in Mode 3 services.

The precarious economic environment experienced by most European countries post 2009 has increased the already considerable strain on health systems, especially those offering a universal service. An increasing attempt to market health services beyond domestic borders has formed part of a broader strategy to support domestic health systems in a range of countries.

Drawing on a series of studies that have attempted to capture the nature of medical tourism involving the UK, some key messages can be drawn:

- Medical tourism involving European countries as either the source or destination country is on the increase
- Intra-European medical tourism is clearly more evident than Europe-outside European medical tourism
- There are clear linkages between some source and destination countries that reflect historic relationships
- Certain countries have established reputations for excellence in particular clinical fields
- The biggest growth in export has involved Central and Eastern European countries
- Medical tourism flows tell us very little about the types of treatment being undertaken, whether it is low- or high-cost, or whether it represents an important revenue stream

It has been suggested that the EU Directive might pave the way for increased medical tourism activity. It certainly helps normalise the process. Uptake has however been slow.

It is clear then that whilst no form of health service is closed off to any country, different services are better suited to different approaches, providers, and even different countries. This informs the primary strategies, including marketing, pursued by public and private bodies seeking to export health services:

- Medical-tourism-led strategies often involve small-scale providers
- Medical-tourism-focused strategies may be formalised with public and private links. This may be a vehicle for the development of more formal relationships and even bi-lateral arrangements
- Strategies built upon establishing a commercial presence that primarily involves private companies make use of formal international relations. Whilst private enterprise provides the bulk of the delivery, it is often facilitated by state instruments
- System export involves high-levels of state involvement

The following country case studies draw out some of the approaches adopted by countries with different export focus and strategies.

UK healthcare export developments

Since the global recession there has been growing interest in how NHS organisations might better balance the demands on their resources, including identifying and seeking additional income from other sources.

NHS Trust models and approaches to delivering services to international patients include: 1) Foundation Trusts that partner private commercial interests 2) Overseas branches and overseas partnerships 3) Individual trusts' activities.
NHS facilities effectively compete with other NHS providers for such international patient activity, as well as with the independent sector. Treatment of overseas patients has become seemingly more competitive with the rise of Asian and Middle-Eastern providers, as well as competition within Europe, and amongst UK-based providers, both private and public.

A number of the specialist teaching hospitals have close clinical relationships with hospitals in Middle-Eastern countries, and offer clinical training, education and on-going support which may be more or less formalised (at hospital or national level).

There have been clear attempts since 2010 to support international activities of NHS Trusts and organisations. In 2012, the Healthcare UK scheme was launched, supported by the Department of Health and UK Trade and Investment. The aim of the scheme is to further promote and encourage overseas investment and activities from within the NHS, so providing profit streams for reinvestment in core NHS services. Healthcare UK also promotes the interests of private sector industry. The NHS is seen to offer the UK a unique advantage in being able to access a wide range of clinical trials and studies, and is also seen as a model of delivery that can be of value to emerging economies.

Healthcare UK seeks to use government-to-government agreements (Memorandums of Understanding), which shape bilateral agreements with countries in order to promote UK health providers (from across public and private sectors). Priority markets are identified as Turkey, Kuwait, Libya, Brazil, Saudi Arabia, Oman, UAE, India, Hong Kong and China. New markets are identified as those existing in Indonesia, Mexico, Columbia, Peru, Nigeria and the Middle East and North Africa.

French healthcare export developments

France, and in particular Paris, has been a historical provider of medical treatments for inward travelling elites, France is rarely, if ever, identified as a destination for contemporary medical tourism and does not appear in brokers' offers and is not referenced in the lists of destinations. There is said to be growing interest amongst Parisian hospitals in using medical tourism as a way to balance their debt. There are attempts to develop partnerships and to expand existing activities. Outside of Paris there has been some interest in the development of medical tourism, particularly Lyon, and also Marseille.

Medical tourism in France has to date had a lack of strategic orientation with little support from French Health or Industry ministers.

There are a range of international activities focussed on training programmes in Southern countries and the welcoming of foreign interns in French hospitals, technical and expert support missions on topics such as care techniques, clinical and medico-technical service management, management and infrastructures, maintenance and biomedical engineering. China and Russia are target market and typically activities to date have involved provider to provider developments.

German healthcare export developments

Germany has a tradition of treating international patients, typically focusing on more complex and specialist treatments. Medical and health tourism in Germany is only a niche market, however it is a very profitable one generating over €1bn p.a. for the German healthcare system. The biggest single source of patients is now from Russia.

One in ten German health clinics specialise in 'health tourism', and nearly nine in ten of those clinics reported rising numbers of patients. Many clinics have international offices, where they work on enquiries from abroad, arrange continuity of care for patients, provide translators and organise billing.

The task of dealing with health and medical tourism is delegated to the Ministry of Economics and Technology. There is also strong support for medical tourism from the federal states, independent of the government.

Health - Made in Germany', was initiated by the Federal Ministry for Economic Affairs and Energy, and provides key information and contact details related to German healthcare products and services. The initiative was developed together with the ministries of the 16 federal states of Germany. On behalf of the German federal government, the German National Tourist Board (GNTB) plays an important role in the promotion of Germany as a travel destination on the

international market. Strengthening the medical/health travel segment is a strategic action area for the GNTB.

The German Healthcare Export Group (GHE) brings together 51 innovative companies from across medical technology, which are strongly export-oriented. Overall the association represents around 80% by volume of all German exports in the medical technology sector.

There are examples of healthcare providers cooperating in the same region and also State level marketing. Apart from state-supported marketing of health tourism, several independent information portals have evolved.

In 2014 bi-lateral talks centred around the plan of action on German-Chinese public health cooperation. The plan lays down the political priorities and the fields for action for 2015 and 2016.

The German Medical Association sees its relations with the states of Central and Eastern Europe as being particularly important and has provided support for the establishment of systems of medical self-administration in this region.

Turkish healthcare export developments

Medical tourism in Turkey has increasingly become part of public policy developed by the state, and the Turkish Ministry of Health has sought to coordinate between different institutions working in this area. Health and medical tourism development is a 'Priority Transformation Program' in the 10th Development Plan (2014-2018) prepared by the Ministry of Development.

Within the Ministry of Health there is a dedicated Department of Health Tourism. Initiatives include: research activities; a 'Foreign Patient Tracking System'; 'International Patient Portal'; 'International Patient Assistance Unit'; and providing marketing events. A Board of Coordination for Health Tourism is currently being established, again under the Ministry of Health, to ensure the involvement of other relevant state institutions in the process.

For medical tourism, the top 3 countries from which international patients come to Turkey are Libya, Germany and Iraq. International patients also come to Turkey as part of bilateral agreements between Turkey and various countries, and agreements between social security institutions (Sudan, Afghanistan, Yemen, Albania, TRNC, Kosovo and Azerbaijan).

Aside from national-level developments, there are also some initiatives at the city level, mainly undertaken by Provincial Directorates of Health under the Ministry of Health, and city-based Associations of Public Hospitals which have brought together all public secondary and tertiary healthcare facilities under their authority with the recent restructuring of health services.

In addition, there is a sectoral business council which has been established with a view to promote Turkish health sector globally. DEIK/Health Tourism Business Council includes members from the Turkish Accredited Hospitals Association, Association of Turkish Travel Agencies, Turkish Airlines, Ministry of Health and Ministry of Culture and Tourism, as well as representatives from leading companies in health and tourism sectors. Private hospitals and some NGOs are also active in the area.

Initiatives are also being taken by the Turkish government and private sector for the provision of health services outside of Turkey. These mainly include the building and running of hospitals as well as the export of knowhow and medical technology. For the public sector, a specific unit has been established under the Turkish Public Hospitals Institution for the coordination of activities linked to hospitals abroad. The Turkish Cooperation and Coordination Agency (TIKA) under the Prime Ministry also play a key role in the spread of Turkish hospitals to different regions.

Hungarian healthcare export developments

Hungary has a long history of wellness tourism and has been a leader in the dental tourism industry for the past twenty years. It can be justifiably claimed

that Hungary is a market leader of both wellness and dental tourism within Europe. Large numbers of Germans, Austrians and UK nationals travel to Hungary, especially for dental treatment, which is aggressively marketed to foreign residents by Hungarian clinics.

The Hungarian government is an active agent 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 EU. Medical tourism is seen as a vehicle for economic growth as well as health system improvements. Despite the active involvement of the Hungarian government in promoting and developing the medical tourism industry, other health service exports remain underdeveloped.

Greek healthcare export developments

At the time of Europe's medical tourism 'take-off' (2004-2007) Greece could boast consistent and relatively promising numbers of visitors accessing medical or wellness treatments. At this stage the Greek market provision to international patients was based on medium and small medical private practices, rather than the public hospital system. Small practices, where one or two doctors work together use their facilities for most treatments, as well as private hospitals for treatments that require full anaesthesia were common. This activity did not build real momentum and government involvement remained superficial. The reasons for this can be traced to the onset of the global financial crisis, with which Greece suffered more than any other OECD country.

The financial crisis precipitated falling levels of healthcare expenditure both as a proportion of GDP and in per-capita terms. The implications of this has been rising costs (especially for dental treatment) as well as a plateauing of the hitherto rising proportions of doctors and healthcare professionals to service the population. This has severely reduced the capacity of the Greek healthcare industry to cater for international patients.

The last two years have however seen an increase in activity, not only from private providers, but also the government. Greece is still struggling with the ongoing financial crisis and this has clearly stifled what was an emerging medical tourism market. Recent efforts however suggest that such a market is thought to be of potential value and as such has attracted government support. Largely this has been for medical tourism activities, but there are some examples of other forms of health service export.

Swiss healthcare export developments

In 2008 the OSEC (Office Suisse d'Expansion Commerciale – Swiss Office for Commercial Expansion) and Suisse Tourisme founded 'Swiss Health' in order to support Swiss companies working in the health sector to develop their potential abroad.

According to the 2011 Euromonitor International report, the medical tourism sector in Switzerland should reach 1 billion francs in 2015, an increase of 20% in comparison to 2010. Potential clients are usually from Russia or China but also from the Middle East. There are examples of emerging dialogue between Swiss health professionals and Chinese counterparts.

Norwegian healthcare export developments

Seen as a high quality health care system with universal coverage, Norway also has a reputation for cutting edge fertility treatment and radiology services. Despite this, Norway has little presence in the emerging health export market, and there is little active marketing by either public or private bodies. For medical tourism, public hospitals and clinics have relatively no medical tourism marketing presence on the internet.

Beyond medical tourism Norway's export of health services is equally muted. There are no formal statements made by leading politicians, no pieces of legislation, no headline bi-lateral agreements and ultimately very little by the way of commercial presence. Rather, the Norwegian integration with the global health market is largely one of humanitarianism.

Swedish healthcare export developments

Sweden has high levels of public expenditure on health, both as a proportion of GDP and in per-capita terms. Sweden has a reputation for delivering a high-quality health service and has made some attempts to promote greater levels of health service exports including those beyond medical tourism, both through public and private activity and the public support of private activity.

SWECARE is 50% owned by the Swedish government and its primary objective is to market the Swedish healthcare system and Swedish healthcare companies internationally. SWECARE represents an association of private companies, public hospitals, government ministries and other stakeholders and underscores the national nature of Sweden's health export strategy.

The focus is on establishing Swedish commercial presence, of either state owned or private companies, in foreign healthcare markets rather than on medical tourism. In addition, especially where public entities are involved, an element of 'aid' is usually built into the commercial strategy.

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The export of health services

Introduction

The export and import of health services has a long history, but the last 25 years has seen intensification of these processes and with this, greater attention. Globalisation, in particular the increased connectivity of geographically dispersed locations alongside advances in information and communication technologies (ICTs), has increased the potential for exports, whilst global economic competition has provided the incentive.

Despite increased attention and no shortage of aspiration from both public and private providers, it is unclear just how much is being exported, with many of the opportunities promised by the new global economy remaining under-exploited.

It is important to establish what types of health services are (or could be) exported. Despite encompassing a wider range of activities, the term 'health service export' is often applied to or dominated by processes whereby people travel from their country of residence to obtain medical treatment in a different country (see OECD, 2011a: 53; AfDB, 2013; OECD, 2013: 166). A variety of labels have been attached to the process of patients seeking care in a different country and it is important to be aware of this debate, however 'medical tourism' is useful as it not only captures the essence of the process, it is also now recognisable in academic, commercial, and even governmental literature (Lunt and Carrera, 2010).

Whilst medical tourism is undoubtedly the dominant mode of patient mobility, it is not the only form. Furthermore, patient mobility is only one example of health service export. Table 1 presents a thorough, yet non-exhaustive selection of health services that are exported or could possibly exported.

Table 1: Examples of health services that can be exported.

Example of health service	Categorisation	Description	Relevant GATS mode
Medical tourism	Patient mobility/ export of direct healthcare	Patients who pay out of pocket for treatment in a different country	Mode 2
Cross-border care		Patients who cross borders to access treatment that may be funded or reimbursed by local healthcare providers	
Patient outsourcing		Patients whose treatment is provided in a different country as part of a formal arrangement between healthcare providers in two countries	
Remote diagnosis	Tele-health	Diagnosis carried out in a different country to the location of the patient	Mode 1
Remote consultations		Patient-clinician consultation carried out across international boundaries, facilitated by ICT	
Remote processing of samples		Processing of tests in a country other than that in which the samples or tests were taken	
Remote surveillance of health		Can be an extension of consultation or can involve the monitoring of patients, perhaps through technology, from distance. Enables 24/7 care from qualified professionals	
Accreditation programmes	Export of Regulation	Healthcare service offered in one country are occasionally accredited by organisations based in other countries or supranational organisations	Mode 1
Certification		Similar to accreditation but with a more formal link between the accrediting or certificating body and the certificated body	
Health insurance	Export of Regulation and financial services	Health insurance may be sourced from providers outside a person's home country. This might be used in the home country or others.	
Education programmes	Export of skills	Countries offering health education and training located within a different country	Mode 3
		Countries may provide health education to individuals (or networks) from other countries. In this example the service is delivered from within the country providing the service. Whether those accessing the service do so in the providing country or remotely determines the GATS mode	Mode 1 or Mode 2
Movement of HealthCare Professionals		The movement of HCPs in the labour market	Mode 4
Operation of facilities	Export of skills and/or FDI	Facilities in one country that are owned and/or operated by public or private bodies based in another	Mode 3
Management and oversight		Facilities based and owned in one country but managed or overseen by organisations based in another	
Facility building, establishment, or financing of facilities	Direct FDI	Facilities that are based in one country and operated wholly in that country but which were financed, established or built by organisations based in another country	
Consultations abroad	Temporary export of skills	HCPs whose service is primarily based in their own country but who travel to other countries to offer pre-op consultations prior to medical tourism	Mode 4

Trade in health services is often explored through the Global Agreement on Trade in Services (GATS) framework, which outlines four modes of trade in services (Chanda, 2001):

Mode 1: Cross-border trade, where the trade takes place from one country into the other country. Here only the service itself crosses the border.

Mode 2: Consumption abroad, where the customer travels to the country where the service is supplied.

Mode 3: Commercial presence, where the supplier establishes a commercial presence abroad.

Mode 4: Movement of natural persons, where the provider of the service crosses the border.

It is suggested that medical tourism represents the most active example of health service export (OECD, 2013: 167) with regards to the volume (number of cases) of imports and exports, the rate of growth, the potential for growth, the problems and risks associated with medical tourism and the 'profile' of medical tourism. An extensive body of literature exists[1] exploring issues associated with medical tourism including:

- Ethical issues
- Legal issues
- Regulatory issues
- Risk
- Impact on source and destination countries
- Marketing of medical tourism
- Facilitation of medical tourism
- Experiences of medical tourism
- Outcomes of medical tourism
- Continuation of care

[1] All are covered in the forthcoming 2015 *Elgar Handbook on Medical Tourism and Patient Mobility* (Lunt, Horsfall and Hanefeld).

Medical tourism can be considered as the process by which patients travel to another country to pay 'out-of-pocket' for medical treatment (Lunt et al., 2011). An increasingly popular form of consumer expenditure, medical tourism is a type of patient or 'consumer' mobility in which individuals travel outside their country of residence for the consumption of healthcare services. Medical tourism takes place when individuals opt to travel overseas with the primary intention of receiving medical (usually elective surgery) treatment. These journeys may be long distance and intercontinental, for example from Europe and North America to Asia, and cover a range of treatments including dental care, cosmetic surgery, bariatric surgery and fertility treatment. And whilst there is little agreement on the size of the medical tourism market, a conservative estimate suggests that at least five million people travel to another country and pay out-of-pocket for medical treatment each year (Horsfall and Lunt, 2015).

In purely economic terms, however, health services exported through Modes 3 and 4 (in particular related to foreign companies situated in local healthcare markets) represent a much bigger slice of health service exports. In absolute terms trade through both Modes 1 and 2 is lower than through Mode 3. Similarly the share of foreign companies within the healthcare service sector is much higher than ratios of trade to output through Modes 1 and 2 (See Herman, 2009).

The knowledge base for health-service export

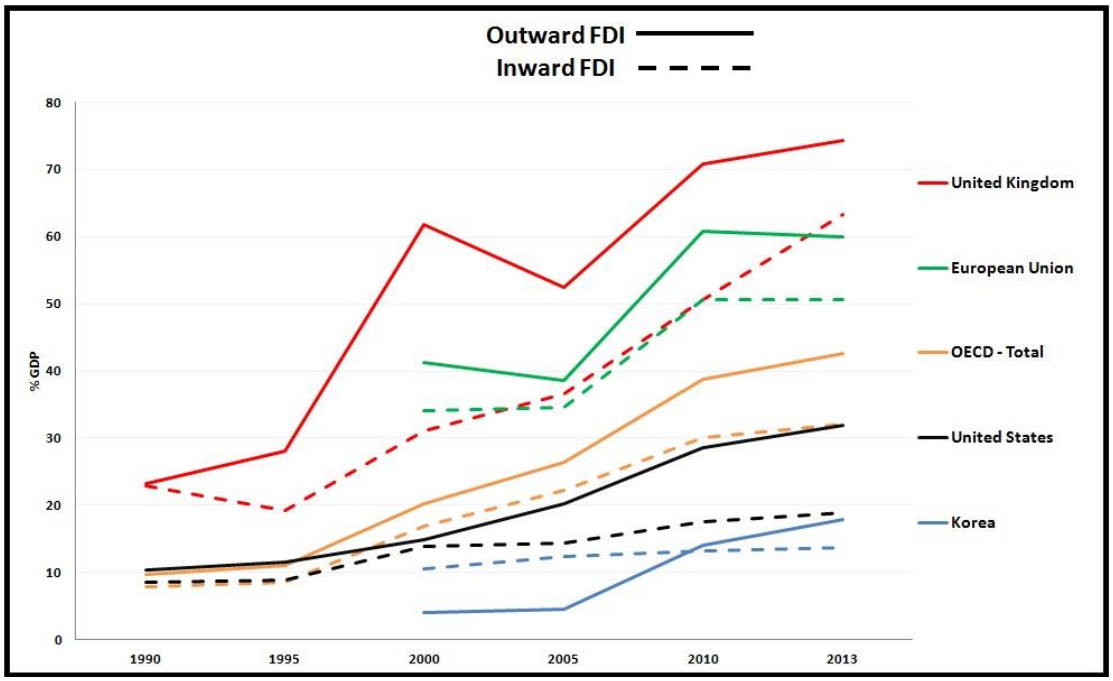
A range of questions present themselves at this juncture:

- Why is there an increased focus on the export of health services?
- What are the drivers of health service export?
- To what extent is health service export happening?
- Where is the activity?
- What services are being exported?
- How is the export of health services being facilitated?
- Who is involved in the export of health services?

To answer the first two questions it is necessary to outline the broader economic environment. Whilst globalisation has provided the means to facilitate health

service export through the rapid developments in ICTs, it has also provided the incentive. Global economic pressures such as an increasingly open and competitive global economy, have exerted strain on domestic economies and in particular, health systems. One particular consequence of economic globalisation has been the increase in foreign direct investment (FDI). Figure 1 depicts the upward trends in both inward and outward FDI since 1990. As can be seen, the selected countries and groups of countries have all experienced sharp increases in both inward and outward FDI.

Figure 1: Inward and outward FDI as a percentage of GDP 1990-2013.



Source: OECD, 2014a. FDI stocks (indicator).

Moreover, services account for the majority of all FDI (71% of all inward and 69% of outward in 2009) across the OECD (OECD, 2011b).

The increasing pressures of globalisation have presented considerable economic challenges, which have been exacerbated by profound demographic change. In short, a greater number of people are living for longer, which in turn has created sometimes extreme pressure for health systems.

Across the globe, many domestic health systems continue to undergo significant challenges and strain – tightened eligibility criteria, waiting lists, and shifting priorities for healthcare impact on consumer decision-making. There is also the emergence of patient choice and forms of consumer consciousness in healthcare, including within countries that traditionally have had public-funded services. The implications for health policy and delivery are wide-ranging: moves towards a global health agenda, greater professional mobility, corporate multinational health providers, e-health innovations, and increased patient mobility. All of these have implications for supply- and demand-side developments within medical tourism and patient mobility

Largely in response to economic and demographic changes, a number of OECD countries have introduced health reforms during the last 20 years, and in many cases this has involved marketisation and partial privatisation. Despite this, total expenditure on health has continued the steady increase that saw it rise from an OECD average of 3.8% GDP in 1960, to 7.5% in the mid 1990s before continuing its climb to 9.3% in 2011 (OECD, 2011a; OECD, 2013). Similarly, whilst many countries have introduced market-based reforms, public expenditure has increased as a proportion of GDP and also as a proportion of total expenditure throughout the 21st century. Whilst this may seem counter-intuitive, the past 20 years have witnessed a rapid increase in life expectancy, rising levels of cancer diagnoses, increased demands on palliative care and relatively new public health risks such as rising levels of obesity and related health problems. The real-terms increase in per-capita spending on health as a total, or when broken down into either in-patient or out-patient care in the period 2000-2009 stands at 4.1%, 3.2% and 3.4% respectively across the OECD (2011; 2013).

These health developments have particular ramifications outside the OECD, including countries in the Middle East where spending on healthcare is at a low base (Table 2).

Table 2: Health care spending of selected Middle East countries.

	Health spending, % of GDP	Government spending on health as % of all heath spending	Private spending on health as % of all health spending	Government spending on health as % of all spending
Oman	2.8	80.1	19.9	6.2
Qatar	1.8	77.5	22.5	5.5
UAE	3.7	74.4	25.6	8.8
Saudi Arabia	4.3	62.9	37.1	7
Kuwait	2.6	80.4	19.6	6.9
UK	**9.6**	**83.9**	**16.1**	**16**
Korea	**6.9**	**59**	**41**	**12.4**

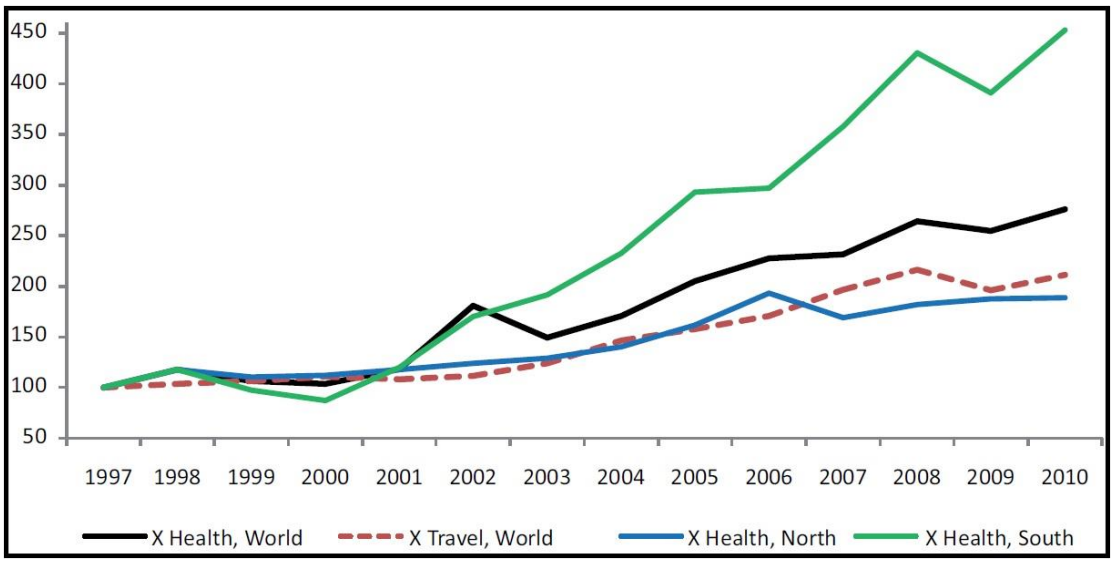
Source: World Health Organisation Statistics (2014)

Major healthcare expansion is underway in Saudi Arabia, where the Economist (2014) reports another 19 hospitals began construction during 2013 on top of 102 being built. This major infrastructure (including Health Cities) will see a doubling of capacity in four to five years. Investment is also evident around medical education and to increase the low levels of Research & Development. Similarly, in Iraq the expansion of oil output is supporting primary healthcare developments and the building of 20 hospitals (worth over US$2b). Further demand also exists around drugs and equipment, and Information Technology. Oman has a five-year plan for 2011-2015, and alongside the building of 30 hospitals and centres there is a focus on primary healthcare and integrated delivery. There is also major expansion of healthcare in China with significant health restructuring, construction and R&D opportunities, as well as those in primary healthcare and long-term care.

The strain on health services has precipitated not only inward-facing reforms, but also attempts by healthcare providers, both public and private, to market

their services beyond the domestic sphere in order to generate revenue. Whilst there are undoubtedly some organisations, or even countries, hoping to explore 'new' markets or to enter existing markets for the first time, in many cases it has been a deepening and formalising of existing approaches that has represented potential areas for growth and development (Figure 2).

Figure 2: Growth in health service exports (base 100:1997).



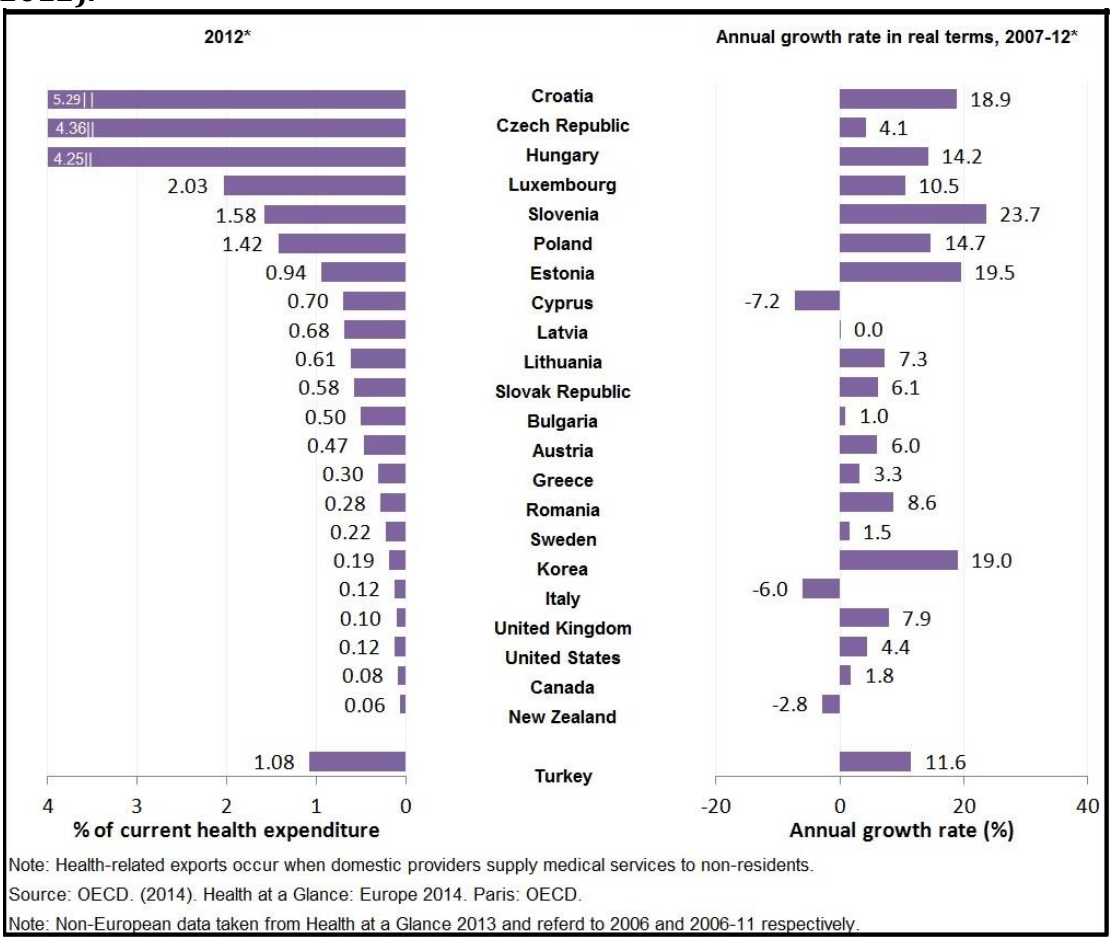
Source: AfDB, 2013.

At the individual level, lower transport and accommodation costs coupled with cross-country price differentials in part accounts for the growth of medical tourism. However it is the growing economic strength of formerly less economically developed countries combined with under-developed healthcare systems in such countries that has provided the conditions for the export of services through modes other than medical tourism.

Establishing the degree to which countries are exporting health services is not straightforward. A number of studies have pointed out the weakness in medical tourism statistics (see Lunt et al., 2014a; Connell, 2013), in particular the lack of reliability owing to the fact that they are often generated by industry sources, or others with a vested interest in inflating the estimates of the size of the market and its potential for growth. However, compared to other forms of health service exports, medical tourism statistics are relatively accessible and useful. Figure 3,

for example, ostensibly depicts the levels and growth rates of health service exports from OECD countries.

Figure 3: Export of health related travel or other services as a share of health expenditure (2012) and annual growth rates in real terms (2007-2012).



However, it is largely medical tourism that is represented here. The OECD make clear that the major example of health service report captured by this data is medical tourism (an earlier edition of *Health at a Glance* labels the chapter 'Trade in Health Services (Medical Tourism)' (OECD, 2011)) and an exploration of the 'System of Health Accounts' used to produce this data outlines reveals that health service exports covered by GATS Modes 3 and 4 are not included in the calculation of data such as that displayed in Figure 3. Figure 3 provides a useful illustration of the countries in which medical tourism and tele-health represent important dimensions of the overall health system, as well as which countries have experienced growth and contraction in health service exports. It does not,

however, tell us in absolute terms which countries are treating the greatest numbers of international patients and most importantly, which countries are engaged in the broader export of health services.

If as Herman (2009) contests, medical tourism and tele-health generate much lower levels of revenue than those services exported through Mode 3, why then is there so much focus on medical tourism? It is likely that this can be explained, at least in part, by the following:

- Negative implications associated with medical tourism
- Relatively lower boundaries to new entrants in the medical tourism market compared to other health-service markets
- The high growth rate in medical tourism
- Shifting regulatory and legal frameworks related to medical tourism
- Apparent potential in the medical tourism market

As discussed earlier there are a range of risks associated with medical tourism, especially with regards to patient safety and potentially for health provision in both source and destination countries. The potential implication of medical tourism has stimulated lively debate within academia and amongst public health providers.

For those wishing to increase their export of health services as a means of generating revenue, medical tourism is particularly appealing as it could be argued that medical tourism and some forms of tele-health exist in a more open market than other health services. Whilst Lunt et al. (2014a) demonstrate the importance of networks, existing trade relations and reputation, in successfully marketing medical tourism services, these potential barriers to new entrants are likely to be less entrenched and therefore weaker than those faced by bodies attempting to provide services in another country. In particular, those service providers seeking to export by locating a service in another country require not only the demand on the part of the consumer, but also the will or at least acceptance of the state or sub-state governance structures in order to operate in

that country. Successful integration is likely to be aided or hindered by the existence or absence of extant or historic political relationships, cultural ties, or economic arrangements. Where such relationships are not deeply entrenched, a reputation as a market leader may compensate.

For those countries with previously and potentially profitable ties with other countries or regions, the export of services through Mode 3 is likely to represent a more lucrative avenue for investment and development. For those countries that are neither market leaders, nor tied politically, culturally or economically to receptive destinations that offer potential for health service export, direct-to-consumer marketing is likely to represent a more feasible approach.

Medical tourism offers real opportunity here as services can be marketed in a range of ways. First, for new entrants to the medical tourism market it is likely that the cost of healthcare will be lower, especially with regards to labour costs. Whilst numerous studies have highlighted the fact that cost is rarely a sole and often not even a primary motivator for engaging in medical tourism, most patients do suggest that cost savings are extremely important. Moreover, the key players in medical tourism are almost always small, private providers with business models better suited towards consumer marketing rather than building relationships with state instruments. It is perhaps for this reason that the medical tourism industry consists of a wide range of small businesses often playing only a partial role in the overall medical tourism process. Whilst some 'one-stop' entities do exist, catering for the 'whole' medical tourism process, medical tourism is often packaged into combinations of the following:

- Pre-op consultations
- Facilitators
- Brokers
- Insurers
- Clinics/clinicians catering for single treatment areas
- Larger facilities offering a range of treatments

Even for those sceptical of the size of the medical tourism market, it is difficult to disregard the fact that whatever metric is used, be it industry sources, travel/passenger surveys, or data collected by bodies such as the OECD, growth appears healthy, especially in those countries that have combined private enterprise with government support. Given that the notion of travelling for care, perhaps rather alien to those whose country has a largely publically provided health system (such as the UK), is being increasingly normalised, alongside increasing demands on public health systems, it is understandable that there is optimism amongst those wishing to grow their medical tourism market.

The normalisation of medical tourism is extremely important and where there is state recognition of or support for medical tourism this strengthens the hand of all those involved in exporting healthcare to foreign residents. State support can take a range of forms such as:

- Legal
- Regulatory
- Financial
- Marketing

And exist at various levels:

- Local
- National
- Supranational

Lifting caps on the numbers of foreign patients public hospitals can treat, approving medical tourism visas, offering tax incentives to organisations that treat foreign patients and incorporating the medical tourism activities of public and private bodies into a national strategy are all examples of mechanisms for supporting a burgeoning medical tourism industry. European examples of such mechanisms are explored in the case studies within this report, but the use of visas, relaxing of temporary migration rules and regulations on healthcare providers are common beyond Europe.

What is clear, however, is that whilst globalisation has provided a global audience for health services exporters to market towards, the market is not truly global. Whether discussion centres on medical tourism or other health services, the notion of region is important and as such trading blocs such as the EU or ASEAN are the site of much intra-bloc trade in health services, but far less inter-bloc trade. Where relationships transcend region these are often bi-lateral relationships, again often underpinned by historic cultural, political or economic relationships.

Where the service is being exported through Mode 3, the interplay between private and public bodies is extremely important. This gives rise to an extremely diverse range of actors involved in the process and a wholly different approach, especially with regards to marketing, from medical tourism. In particular, unlike the often simple business-to-consumer relationships typical of medical tourism, the export of skills and FDI may involve business-to-business, business-to-government, or government-to-government. Stakeholders might include:

- Single or multiple government ministries or departments
- Local governments
- Public bodies
- Primary healthcare facilities
- Research institutions
- NGOs
- Individual private enterprises
- Associations of private enterprises
- Representatives of special economic zones

Quality is central to such exports and whilst brand can be extremely marketable within the medical tourism industry, the reputation of companies and often more pertinently, countries, is perhaps the most valuable commodity. Regardless of whether the majority of the exporting activity is conducted by or through private companies, the role of international cooperation between countries, through formal trade pacts or slightly less formal memoranda of understandings is

central. As such it is to be expected that such forms of export represent not only private enterprise, but also part of a wider national strategy.

Services traded through Mode 3 do lend themselves to an insider/outsider arrangement, far more than medical tourism, where reputations can be established quicker. However this dualism is not fixed. Just as political and economic relationships shift with time, the development of more coherent national medical tourism strategies might develop to the extent that a national brand emerges that can compete with more established players in Mode 3 services. For example, with national support it may be possible for private companies based in one country to secure contracts to provide healthcare through formal insurance schemes, either to large companies based in different countries, or perhaps even to the public sector of a foreign government. It is unlikely that private companies acting alone would be able to secure such contracts, or at least sufficient business so as to negate the need to market towards individual consumers. However, as part of a national strategy, perhaps even as part of an association of providers, private companies given the right circumstances might be able to transcend the relatively small world of out-of-pocket medical tourism towards something more complex, entrenched and potentially more lucrative. Whether this in turn could lead to involvement in the export of higher quality services involving more permanent arrangements through Mode 3 is unclear, yet cannot be dismissed.

Countries that formally support a burgeoning medical tourism industry, regulate it and oversee quality assurance may, given the right circumstances, build a reputation, which if developed alongside investment in other aspects of health service provision may become marketable, especially in regions without strong historic ties to countries such as the US, Germany, the UK and other perceived global healthcare leaders. Both Turkey and the UAE for example are well located and can demonstrate cultural sensitivity to many neighbouring countries with less developed healthcare systems and, in some instances, weakened ties with the West.

A focus on Europe

It is instructive that the WHO's 2002 publication *Trade in Health Services: Global, Regional and Country Perspectives* includes no chapter from a European perspective, nor any single country case study from Europe. Even the chapter focused on the East Mediterranean region references only one European country (Cyprus).

The advent of the 21st century represented a time of potential and possibility for European countries, but little activity. This is not to say that health services were not being exported, but where this was occurring it was largely through long-established trading and sometimes paternalistic or colonial relationships. The established health systems in Europe were only just beginning to be subjected to market-style liberalisation policies and the deeply entrenched nature of many public health systems in Europe did not lend themselves to dynamism.

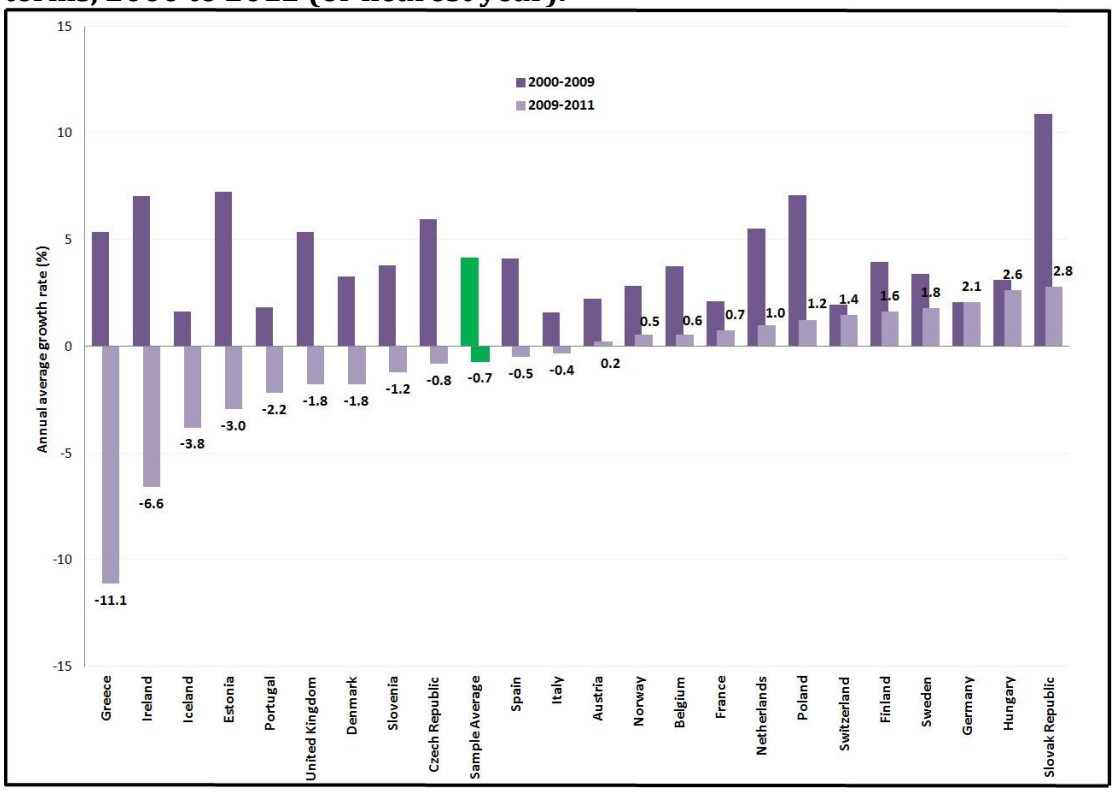
Whilst Europe is home to different types of healthcare system, the two dominant models, sometimes labelled the 'enhanced command and control health care state' and the 'corporatist health care state' (Moran, 1999; Burau and Blank, 2006), both have the principle of universality enshrined within them (Smith et al., 2012).

Whether the dominance of universal health systems and the increased burden such systems have faced as a consequence of demographic changes and emerging health risks such as obesity and diabetes has acted as a barrier to health services export is unclear. It is important to note that whilst the principle of universality prevails, European health systems are far from homogenous. Even those that are loosely categorised as sharing important features with others are the product of complex and often country-specific contexts, which extend far beyond the arena of health and as such the degree to which European health systems can be grouped is to some extent limited (Burau and Blank, 2006).

The prevalence of universal health systems with high levels of public expenditure has certainly added to the strain of the recent economic crisis as

experienced by European countries. Throughout the period 2000-2009 social expenditure and health expenditure continued to climb (OECD, 2012; OECD, 2014b), but post-2009 health expenditure as a proportion of GDP has fallen across the EU. With regards to per-capita expenditure, Figure 4 illustrates the impact of the financial crisis on per-capita health expenditure growth rates.

Figure 4: Annual average growth rate in per-capita health expenditure, real terms, 2000 to 2012 (or nearest year).



Source: Adapted from OECD, 2014b, with authors' own calculations.

As can be seen, in this sample of European countries (not all are EU member countries and not all EU countries are present), since 2009 growth has been on average, negative and even positive growth rates demonstrated within this selection of countries are somewhat muted compared to the period 2000-2009. High levels of negative per-capita health expenditure growth rates are particularly evident in countries such as Greece, Ireland and Portugal, all of which experienced sovereign debt crises post 2009, however other countries such as the UK and Denmark have also witnessed negative growth.

It is worth noting that with the exception of Hungary, every country reported by the OECD (2012) to have below average GDP growth or below average public social spending growth (in some cases both) when comparing the periods 2007/8 with 2011/12, demonstrates negative growth in per-capita expenditure on health in Figure 4.

Only Denmark, which had average GDP and public expenditure growth, demonstrates negative per-capita health expenditure growth without below average GDP or public expenditure growth.

Hungary bucked the trend amongst the countries with low levels of GDP or public expenditure growth by maintaining a positive growth in per-capita health expenditure. All other countries to maintain positive growth rates in per-capita healthcare spending throughout the countries were those that had either GDP or public expenditure growth that was average or better. Sweden, Switzerland, Norway and Poland all enjoyed above-average growth of GDP whilst demonstrating positive growth in per-capita health expenditure.

The precarious economic environment experienced by most European countries post 2009 has increased the already considerable strain on health systems, especially those offering a universal service. An increasing attempt to market health services beyond domestic borders has formed part of a broader strategy to support domestic health systems in a range of countries.

Most European countries have seen increasing activity in the field of medical tourism, with countries such as Poland, Hungary, the Czech Republic and Turkey witnessing a rapid expansion of their medical tourism industry. It is no coincidence that these countries have been extremely active in marketing not just at the level of individual businesses, but also as part of a broader national strategy.

As discussed at length in the literature, establishing firm figures pertaining to medical tourism is difficult. However, drawing on a series of studies that have

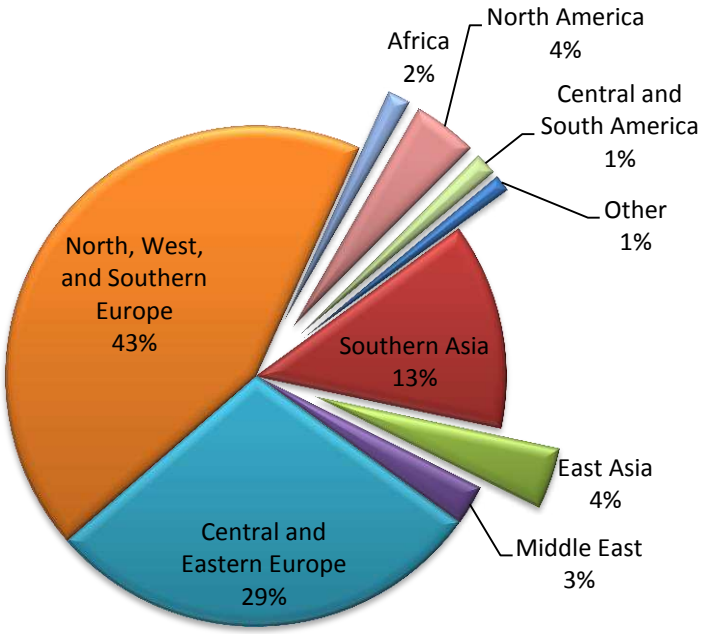
attempted to capture the nature of medical tourism involving the UK, some key messages can be drawn:

- Medical tourism involving European countries as either the source or destination country is on the increase
- Intra-European medical tourism is clearly more evident than Europe-outside European medical tourism
- There are clear linkages between some source and destination countries that reflect historic relationships
- Certain countries have established reputations for excellence in particular clinical fields
- The biggest growth in export has involved Central and Eastern European countries
- Medical tourism flows tell us very little about the types of treatment being undertaken, whether it is low- or high-cost, or whether it represents an important revenue stream

Exploring data pertaining to the UK, it is evident not only that inbound and outbound medical tourism to and from the UK has been on the increase, but also that proximity seems to be an important factor in determining where a medical tourist will travel to. Figure 5 depicts the destinations of UK medical tourists broken down by region across the time period 2000-2010.

As Figure 5 shows, most UK medical tourists are not travelling beyond Europe and there is much to suggest that a large proportion of those travelling to Africa, the Middle East and South East Asia are diaspora or have strong cultural or familial ties to the country to which they travel.

Figure 5: Total outward medical travel by UK residents by destination region over the time-period 2000-2010.



Source: Lunt et al., 2014b.

Broken down by country, France, Poland, and India are the most popular destinations for UK medical tourists, with France holding relatively steady, India demonstrating a gradual increase, and Poland experiencing a rapid increase as of 2007. The French case may be explained as an historical and geographical option with its proximity to the UK proving convenient alongside a familiarity of British holiday makers with France. Similarly both Belgium and Spain can be found in the top ten destinations across the decade (fifth and eight respectively), perhaps for similar reasons.

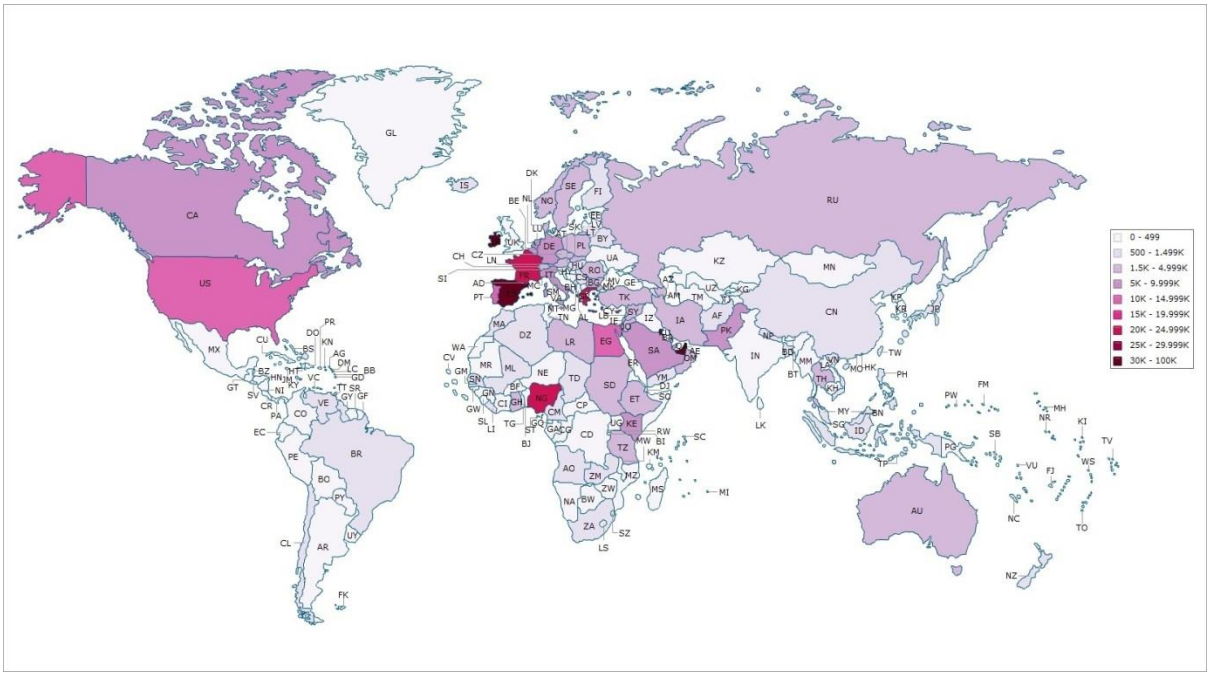
India has proven a popular and increasingly visited destination during the time-period, which might reflect the fact that the UK has a large population with historic ties to India and that travel to this region has become much more accessible in recent years. Indeed, it may even be that those travelling retain Indian citizenship. Similarly Pakistan was the tenth most popular destination for UK medical travellers, once again, possibly a reflection of a large population of people in the UK with historic ties to Pakistan.

Poland has demonstrated the largest surge in popularity and by 2009 was the most visited destination for medical travellers from the UK. Again, as with India and Pakistan, this may reflect the fact that the UK is home to a large population of people with historic and familial ties to Poland, a population that has burgeoned considerably during the second half of the last decade. While this is likely to be the case, the importance of both proximity and accessibility to Central and Eastern Europe and the emergence of a reputation for high-quality cosmetic care (whether this is accurate or not) are also undoubtedly factors. Hungary, with a reputation as a leader in dental care is, like Poland, easily accessible by low-cost airlines operating from the UK and is the fourth most visited destination by UK travellers. Similarly the Czech Republic is the twelfth most visited destination and like both Hungary and Poland has developed a reputation for particular types of treatment and is well served by budget airlines.

Figure 6 illustrates the countries from which medical tourists have travelled to the UK over the period 2000-2010. The largest number of inbound medical travellers are from North, West and Southern Europe. The greatest numbers of patients travelling into the UK for treatment were from Ireland and Spain, and these two countries also show a growing trend of patients coming to the UK. The number of Greeks and Cypriots travelling into the UK to access treatment rose rapidly in 2009 and 2010. These figures may reflect a change as a result of the economic crisis, which in turn has meant severe public sector cuts including in health. In the case of Spanish (and perhaps French) residents, it is highly likely that a substantial number will be UK expats and it is unclear whether these engage in out-of-pocket medical treatment or whether they use NHS services.

A further significant number of patients travel from the Middle East countries (specifically from the United Arab Emirates and Kuwait) although visitor numbers from both countries dropped sharply in 2008 and 2009 respectively.

Figure 6: Source countries of medical travellers to the UK (2000-2010).



Source: Lunt et al., 2014b.

Despite some variation between years, a stable inward flow of medical travellers from Nigeria is also evident over the past decade. It is likely that this speaks to a burgeoning of the middle class in Nigeria (and perhaps other African countries) and it is presumed that flows from countries such as Algeria, Morocco, and Tunisia to France and Italy are likely to be significant.

Whilst the data presented in Figures 5 and 6 is centred on the UK experience, it illuminates a wider European perspective. Medical tourism is occurring throughout Europe and is on the increase. It also points to the high levels of activity in Central and Eastern Europe.

It is worth noting that in Central and Eastern Europe there are a range of national government agencies and policy initiatives that have sought to stimulate and promote medical tourism in their countries. Many countries see significant economic development potential in the emergent field of medical tourism. Hungarian, Polish and Czech governments have all sought to promote their comparative advantage as medical tourism destinations at large international trade fairs, via advertising within the overseas press, and official support for

activities as part of their economic development and tourism policy. For example, in Poland many of the clinics supplying services to medical tourists are state owned, serving Polish citizens alongside medical tourists. The Polish government is actively attempting to harness the potential of recent EU ascension to compete with more far-flung destinations for the custom of European medical tourists. To encourage market growth and development there was also the creation of the Polish Medical Tourism Chamber of Commerce and networking with the Polish Association of Medical Tourism (Smith et al., 2012).

Hungary has also sought to utilise the opportunities presented by EU ascension and develop a medical tourism industry. Whilst many of the clinics offering treatment are undoubtedly private, the role of the Hungarian government is worth noting. For example, the Hungarian government has promoted free spa days to tourists and designated 2003 as the Year of Health Tourism. This increased activity has seen Hungary labelled as the 'dental capital of the world'.

The confluence of increased system pressure and apparent normalisation and rising popularity of medical tourism underpin the proposal of an EU-wide directive on cross-border care. This Directive (European Parliament, 2011) enshrines in law the rights of EU citizens to seek treatment in a country other than their usual place of residence. Crucially patients may only receive treatment in another EU country under the Directive for treatments to which they are entitled in their state/country of affiliation. In addition, the treatment must be unavailable within a reasonable timeframe in the country of affiliation. In short, the Directive explicitly aims to address undue delay for treatment found to be offered elsewhere in the EU in a shorter time period. The country of affiliation (country of patient's residence) and not the country of treatment determines whether at a local or national level the patient is entitled to the health care.

There are a number of restrictions on who can seek treatment and for what under the Directive. Notably, patients must in many cases acquire prior authorisation before choosing to cross a border for healthcare. This is especially the case when the treatment involves overnight hospital accommodation of the

patient for at least one night; requires use of highly specialised cost-intensive medical infrastructure or equipment; involves treatment which has potential for particular risk to patient (or population); or where there could be serious concerns about quality and safety of care. The patient's country of residence may object if the healthcare offered by a provider raises serious and specific concerns relating to quality of care and patient safety. Authorisation can also be rejected if the healthcare can be provided within the patient's country of residence within a time limit which is medically justifiable, taking into account the current state of health and the probable course of illness of each patient concerned.

Ultimately a patient can only access treatment abroad under the Directive if:

- The treatment they seek has been deemed clinically necessary
- The treatment is provided within the patient's country of residence
- For reasons of access (temporal or spatial) the patient cannot feasible undergo treatment in their country of residence
- The risks associated with undergoing the treatment abroad are deemed acceptable
- The patient satisfies the eligibility criteria of the country of treatment
- The country of treatment raises no objections

Furthermore it is worth noting:

- Patients are only reimbursed costs equivalent to those set in their country of residence
- Treating countries are not allowed to apply a different tariff for patients covered by the Directive from domestic patients

It has been suggested that the EU Directive might pave the way for increased medical tourism activity (OECD, 2013). It certainly helps normalise the process. Uptake has however been slow, largely as a consequence of the fact that in a number of countries dental and cosmetic treatments are not provided, at least fully, through the public health system. As such, medical tourists who travel for most cosmetic or dental treatments would not be entitled to reimbursement under the Directive.

There are examples of countries outsourcing primary care to reduce the strain on the domestic health system (Lowson et al., 2002) and as such it may be that there is genuine potential in utilising the Directive to reduce the strain on domestic health systems. This is however likely to be better facilitated where the public sector of the treating country plays a central role in the provision of treatment, at least in an oversight capacity.

Consequently a major barrier to the growth of medical tourism as a response to the Directive is that at present, medical tourism is driven by commercial interests lying outside of organised and state-run health policy-making and delivery. There are possibilities to bring it more within the remit of domestic policy arena, involving for example third-party payers sending patients abroad.

National strategies that have been adopted in some countries such as Poland, Turkey and Hungary have the potential to enable healthcare providers focused on medical tourism to transcend the direct-to-consumer market in which they currently operate, though they are as yet some way off this.

More formal outsourcing relationships, which may be stimulated by the Directive, clearly offer more lucrative and sustainable revenue streams than the piecemeal and often low-value costs involved in medical tourism. However, in its current form, it is unlikely that medical tourism would provide sufficient revenue in the long-term to justify substantial levels of state input or support.

As noted earlier, it is the export of services through GATS Mode 3 that represents the most lucrative revenue streams. Figures suggest that across Europe as of 2009 the share of foreign companies in the healthcare sector stood at just over 16% (Herman, 2009).

Whilst the rewards are greater, delivering or managing primary care or providing formal education in foreign countries requires access to, if not 'closed' markets, then heavily 'gated' or restricted markets. Data from 2009 suggests that

the US, the UK and Canada dominate in terms of services exported through commercial presence (Mode 3) (Herman, 2009).

It is clear then that whilst no form of health service is closed off to any country, different services are better suited to different approaches, providers, and even different countries. This informs the primary strategies, including marketing, pursued by public and private bodies seeking to export health services:

- Medical-tourism-led strategies often involve small-scale providers
- Medical-tourism-focused strategies may be formalised with public and private links. This may be a vehicle for the development of more formal relationships and even bi-lateral arrangements
- Strategies built upon establishing a commercial presence that primarily involves private companies make use of formal international relations. Whilst private enterprise provides the bulk of the delivery, it is often facilitated by state instruments
- System export involves high-levels of state involvement

The following case studies draw out some of the approaches adopted by countries with different export focus and strategies. We focus on a number of European countries and overview their developments and recent activities (UK, France, Germany, Turkey, Greece, Hungary, Switzerland, Norway, Sweden).

We focus on a number of developments including strategies of individual companies, government-to-government activities, government-to-business developments, and activities of private sector associations.

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Section 2
UK healthcare export developments

NHS policy background: hospital trust freedoms

A key element of UK health service reform was the establishment of NHS Foundation Trusts (hospital providers of healthcare services) as public benefit corporations in 2003 (Health and Social Care Act 2003). This status gave them additional freedoms including the ability to sell land, to receive loans from public and private sectors, to enter into joint ventures with the independent sector (profit and non-profit sectors), and to make surpluses and losses. A limit on the amount of income hospitals can raise from private activities was introduced by the Labour Government in 2003, as part of the legislation to establish NHS Foundation Trusts. The cap for Foundation Trusts was fixed at that existing in the 2002-03 base financial year and so varied from hospital to hospital. As well as private patient income, the percentage could include income from external business ventures such as commercialisation of Research & Development, training and consultancy. Surpluses must benefit NHS patients who remain the core responsibility of the hospital board.

In the early 2000s, government departments, agencies and public bodies were encouraged to make better use of their physical and non-physical assets by engaging in commercial services based on them, if appropriate (HM Treasury, 2002). Making better use of commercial potential may include selling existing goods and services, developing new goods and services from existing assets, licensing and leasing arrangements and sponsorship activities.

Since the global recession there has been a growing debate about the extent to which NHS organisations can become more innovative, entrepreneurial and deliver more for less in challenging strategic and operational environments (White Paper, 2011). This financial impetus has led to a growing interest in how NHS organisations might better balance the demands on their resources, including identifying and seeking additional income from other sources (see Gregory et al., 2012; Lyons, 2014). The coalition government took office in 2010

and their policy statement 'Innovation, health and wealth' (Coalition Government, 2011: 7) sought to accelerate innovation in the NHS as one way of supporting 'growth in the life sciences industry' and so contribute towards economic growth.

Under the 2012 Health and Social Care Act the cap for Foundation Trusts was increased, and allowed 49% of income to be earned from non-NHS work. However the core legal duty of Foundation Trusts remains unchanged – that of caring for NHS patients and delivering authorised services. Any major increase in private sector income (increases by 5% or more of its total income) requires governance approval at board level.

NHS international commercial activities

There are a range of models and approaches that NHS Trusts adopt in delivering services to international patients and when developing international partnerships. These include:

Foundation Trusts that partner private commercial interests

For example, the Health Corporation of America (HCA) NHS Ventures has a number of partnership arrangements with NHS Trusts, whereby patients are treated exclusively in private settings. HCA's first such venture was the 2006 partnership arrangement to develop Harley Street at University College Hospitals, a complex cancer centre facility. The HCA runs the hospital's private patient wing, leasing space and paying for services, and profits from private patients are shared with the hospital. In 2010 HCA formed a partnership with Christie NHS Foundation Trust in Manchester to establish the Christie Clinic.

Overseas branches and overseas partnerships

A small number of Trusts have opened branches overseas or partnered with commercial interests and healthcare developments in the Middle East. Great Ormond Street Hospital (GOSH) established a regional office at Dubai Health Care City in 2006 and Moorfields in 2007 opened a facility there. Imperial

College London Diabetes Centre opened its Abu Dhabi facility in 2006 (and later Al Ain), specialising in diabetes treatments, research and training.

GOSH's Gulf Office averages 300 patient contacts annually. It offers support to patients and families travelling from the region to London that parallel those undertaken by facilitators within the wider medical travel industry: advice on investigations and pre-treatment, information and assistance with accommodation and transport to the hospital and information on services and London, and assistance obtaining visas. Upon return to the Gulf the Office claims to provide medical records and adequate information for the referring hospital/doctor, continuity of care with equipment or medication, and on-going contact with families and communication with clinicians at GOSH.

In 2007 Moorfields opened a facility in Dubai Health Care City (Moorfields Eye Hospital Dubai – MEHD), that operates as an overseas arm of the hospital. MEHD has 10 consultants permanently based in Duba, across all major ophthalmic sub-specialties, and its doctors have typically undergone training at Moorfields. Since 2007, MEHD has treated more than 33,000 patients from across 90 countries at its purpose-built campus, with around 70% coming from the Emirati and expat Arab communities. The hospital has established 18 insurance affiliations and many of the patients are covered by insurance – the number of insured patients is rising strongly as a proportion of the total patient base. During 2013/14 income rose 10% to £6.3 million, however the operating cash surplus was a modest accounting (non-cash) loss overall of £200,000 due to exchange-rate fluctuations.

During 2013-14, MEHD and United Eastern Medical Services (UEMS) developed plans for a clinical facility in Abu Dhabi. Under this partnership arrangement, UEMS physical and administrative infrastructure is provided by UEMS, and Moorfields provide the clinical expertise. There is also a strong historical relationship with Imperial College London Diabetes Centres in Abu Dhabi and Al Ain, to provide eye clinical services to diabetes patients. During the year, MEHD signed an MoU with Dubai Healthcare City focused on supporting specialised eye

healthcare within the UAE, including education and research. This has included the MEHD providing regular teaching sessions and participation in scientific meetings (Moorfields Eye Hospital NHS Foundation Trust, 2014).

Individual trusts' activities

Patients travel from overseas for health treatments, for which reimbursement is expected (whether pre-paid or through an Embassy or insurer 'Letter of Guarantee'). It is particularly specialist NHS facilities where these private services are offered to patients. Services are delivered in integrated facilities which use shared theatres and treatments for reasons of intensive care units and specialist supports, and there are also dedicated facilities with private operating theatre space and ward facilities. Types of treatment centre on complex tertiary procedures (including paediatrics and heart surgery), and also include maternity services and ophthalmic surgery. These NHS facilities effectively compete with other NHS providers for such international patient activity, as well as with the independent sector.

There was significant expansion of international patients within the NHS during the 1970s, fuelled by growing oil wealth (with important flows from Kuwait and Qatar). During the 1980s there was significant competition among Britain, France and Germany for Arabic patients (Roberts, 1991). Attempts to attract international patients were evident during economic downturns of the 1980s and early 1990s, with private activity squeezed within domestic health markets and public sector retrenchment. Treatment of overseas patients has become seemingly more competitive with the rise of Asian and Middle-Eastern providers, as well as competition within Europe, and amongst UK-based providers, both private and public.

A number of the specialist teaching hospitals have close clinical relationships with hospitals in Middle-Eastern countries, and offer clinical training, education and on-going support which may be more or less formalised (at hospital or national level). GOSH activity, for example, is undertaken through partnerships with the Dubai Health Authority. This provides a visiting consultant programme

to the main government hospitals. Similarly, a programme of education and training for paediatric services is run in partnership with the Kuwaiti Ministry of Health to enhance delivery of its government hospitals. In 2013, Leeds Teaching Hospitals developed a partnership with the King Hussein Cancer Center in Jordan to allow sharing of expertise and innovation in the Middle East. This includes offering specialist training to visiting delegations. King Hussein Cancer Center is the sole specialised cancer centre in the Middle East that treats both adult and paediatric patients, and has a new wing due to open in 2015.

Academic Health Science Centres

Academic Health Science Centres (AHSCs) are networks that seek to bring together providers of training and education, clinical research, primary, secondary and specialist delivery and informatics. They focus on translational research processes and sharing knowledge with internal and external partners. The first round of AHSCs operated from 2009 to 2013. From 2014 there are six such networks of excellence: Cambridge, Imperial, Kings, Manchester, Oxford and UCL.

Some networks have explicitly emphasised their role in facilitating relationships abroad. For example, Imperial College Health Partners argue that 'despite significant demand for NHS-related services, the NHS has not exported its model systematically abroad', and so has been working with UK Trade and Investment and commercial partners to ensure it offers a comprehensive and systematic range of commercial services to clients abroad. Whilst across its network many providers have undertaken international work in the form of treating international patients or through forms of philanthropy, there has been little that is systematic and the ventures have been comparatively small. Similarly, King's Health Partners is a group that includes three London hospital trusts, and has signed contracts to open clinics in Abu Dhabi and Dubai. The partners also emphasise global health including education and training, delivery and capability enhancement and research and policy advice.

The NHS 'brand' and establishment of UK Healthcare

There have been clear attempts since 2010 to support international activities of NHS Trusts and organisations. NHS Global was launched in 2010 by NHS Chief Executive, David Nicholson, who argued that 'It is now more important than ever to maximise the international potential of the NHS'. The 2011 White Paper also highlighted the potential of the NHS to exploit the power of its international reputation and financially gain from the NHS 'brand' when marketing NHS services to overseas patients.

In early August 2012, the Healthcare UK scheme was launched, supported by the Department of Health and UK Trade and Investment. The aim of the scheme is to further promote and encourage overseas investment and activities from within the NHS, so providing profit streams for reinvestment in core NHS services. Healthcare UK also promotes the interests of private sector industry. The Treasury (2011) has expressed interest in these developments and its Plan for Growth outlined:

> *The Government will work with the NHS and industry to design and establish a proactive entrepreneurial NHS Global to make the most of the brand internationally and to offer support and advice to NHS Trusts*.

The NHS is seen to offer the UK a unique advantage in being able to access a wide range of clinical trials and studies, and is also seen as a model of delivery that can be of value to emerging economies (BIS, 2012). Health-related goods for export include: pharmaceuticals/biopharmaceuticals, and related technologies; regenerative medicine and advanced therapies; medical devices and technology**;** research services; healthcare systems and hospital services**.** UK healthcare and life sciences industries (pharmaceuticals; medical biotechnology and medical technology) hold a 14.9% share of world exports, and a 5.0% share of world FDI.

Healthcare UK is a vehicle that:

- Supports both public (NHS) and private sector healthcare interests
- Seeks to leverage benefits by emphasising the national system of healthcare

- Identifies public policy as a potential asset (particularly the NHS model and brand and UK Universities for education and research)
- Explores trade and partnership options with private and public interests overseas
- Pursues both hard export opportunities (infrastructure; investment; devices) and softer export opportunities (education and training; advice; regulation)
- Identifies both health and social care export opportunities
- Pursues traditional export markets and opens emerging export opportunities.

Recent activities and developments

Healthcare UK seeks to use government-to-government agreements (MoUs, which shape bilateral agreements) with countries in order to promote UK health providers (from across public and private sectors). It aims to engage UK health interests, raise the profile of UK healthcare sector and to identify international opportunities. There are campaigns in priority markets and the promotion of UK strengths and partnerships. It seeks to offer a single gateway for overseas buyers.

Healthcare UK identifies a range of strengths within the UK health system:

- Clinical skills development
- Clinical services provision
- Design, build, and operate facilities (planning; finance; design; engineering; project management; construction; procurement; operation)
- Informatics and performance management
- Primary healthcare and public health
- Regulation of healthcare (including accredition and NICE International)
- Social care
- Strategic planning
- Telehealth/ e-health
- Training and education

Healthcare UK is strategically targeting commercial opportunities in China, India, Brazil and the Arabian Gulf. It has held launch events and agreed MoUs in each of these regions (during 2013-14 there were six missions led by ministers or business ambassadors). Such national agreements aim to facilitate more local-level business interactions, especially in countries such as China where central control is strong but initiatives are also devolved to cities and provinces.

Priority markets are identified as Turkey, Kuwait, Libya, Brazil, Saudi Arabia, Oman, UAE, India, Hong Kong and China. New markets are identified as those existing in Indonesia, Mexico, Columbia, Peru, Nigeria and the Middle East and North Africa (Healthcare UK, 2014).

In its own assessment it identifies £556 million of business agreed during 2013-14 (Healthcare UK, 2014). Of this £556 million:

- £281 million was for private business
- £218 million was public sector business
- £35 million was NHS business
- £22 million was business and NHS/public

It also reports identifying £10.8 billion of qualified leads (including infrastructure £6.5 billion; health system development £2.1 billion; education and training £1.5 billion and primary care £367 million). The country spread of these qualified business leads is:

Saudi Arabia	£1.9b
Libya	£5.3b
Kuwait	£307m
UAE	£222m
Brazil	£133m
Hong Kong	£203m
India	£3m

Healthcare UK reports being ahead of its initial targets for securing actual business and qualified leads. Wider questions relating to its activities include whether such opprotunities will benefit NHS/public services or be skewed toward the private sector, and do all Trusts have the capacity to benefit or will public-sector activities be concentrated within a small number of organisations.

Targeting markets in China

Healthcare UK identifies China as a major strategic market where health restructuring creates opportunities around construction, Research & Development and primary healthcare. The Prime Minister and Health Secretary have visited China, and major business deals include:

- Sinophi Healthcare winning contracts for hospital management and hospital investment totalling £120 million. These contracts include a joint venture with Huai'an First People's Hospital, in Jiangsu Province in East China, and also an agreement to build a 1,000-bed oncology hospital.
- Sinophi Healthcare also signed an MoU with UK-based accreditation company, QHA Trent, in November 2013. The aim is for QHA Trent to work on projects in Sinophi's and partners'-managed and owned hospitals in China (inaugural accreditation projects will be in Jiangsu province).
- Heythorp Healthcare is a London-based healthcare management group who work with property developers and owners. They have established a Memorandum of Understanding with Jiangsu Far East (Yadong) around a joint venture, mixed-use healthcare facility which includes elderly nursing, specialist dementia services and care training.
- Healthcare UK agreed a MoU with the CITIC Trust and Circle Partnership to explore commercial opportunities for UK business in primary care services, integrated care and education and training.
- IXICO agreed a MoU with the Beijing Union Medical and Pharmaceutical General Corporation. They will collaborate to support dementia diagnosis and evaluate new treatments (10 Downing Street Press Release, 2013).

- Consultant engineers Arup have been responsible for the Pingtan Union Hospital, Fujian. Arup reviewed architectural and MEP layout designs[2].
- With expertise in planning and programme delivery, EC Harris was a strategic advisor for a new health and senior care facilities (Altac Hospital in Dalian, late 2012). This included providing strategic healthcare planning, capacity modelling and development of the overall long term business plan. There is also ongoing support for Dalian Altac to source investment partners and international operators for both new and existing health operations. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271480/Healthcare_UK_China_and_the_UK.pdf

Targeting opportunities in India

India is another strategic healthcare market that has been identified. In a recent piece Howard Lyons (2014), Head of UK Healthcare, identifies that a large proportion of NHS staff have been trained or were born overseas and have extended networks with overseas healthcare professionals, which create opportunities. For example, 25,000 doctors of Indian origin are registered with the GMC and currently work in the UK[3].

During 2013-14 there was a Prime Minister's Delegation and Trade Envoy to India, and in 2013 an India-UK MoU was agreed. Chair of the UK India Business Council and former health secretary, Patricia Hewitt, suggested that between 10 and 20 NHS trusts were talking with local healthcare providers about opening branches in India[4]. There are examples of such clinicians developing links with home countries: the MIOT Hospital in Chennai has opened an antenatal screening programme for thalassaemia following links developed with the Whittington Hospital in North London. The intention is for the MIOT model to be a template which can be adopted in Chennai and across other states. Other NHS

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/271480/Healthcare_UK_China_and_the_UK.pdf)
[3] https://healthcareuk.blog.gov.uk/2014/05/02/nhs-in-world-wide-demand/
[4] http://www.independent.co.uk/life-style/health-and-families/health-news/up-to-20-nhs-trusts-seeking-healthcare-deals-in-india-8781104.html

organisations identified include the Royal Free and King's College hospitals, and the London Ambulance Trust.

Targeting opportunities in the Middle East

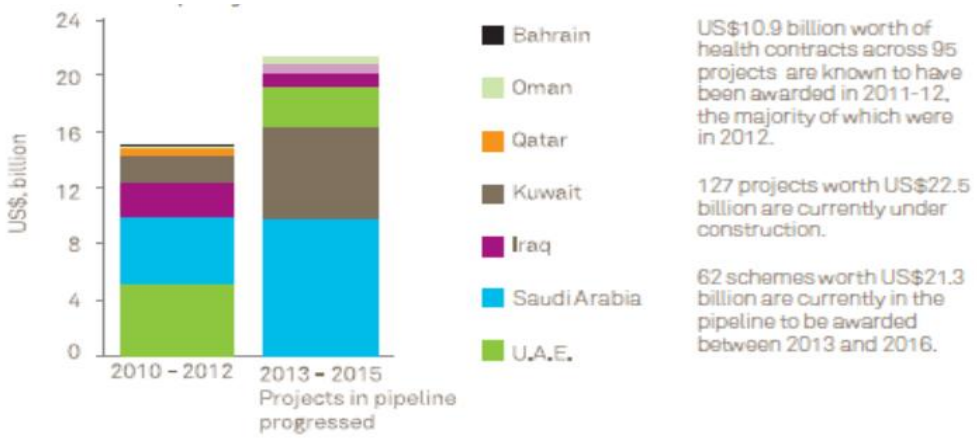
The Gulf region is a significant growth area and has strong trade and historical links with the UK. The long-running Arab Health tradeshow has had a major presence from UK providers of health services, both public and private sector. Countries in the Gulf region are seeking to improve domestic healthcare provision in order to stem the flow of publicly funded treatment abroad for patients who require specialist care and complex surgery

The UK and Kuwait have established an MoU, and Kuwait is the UK's third largest trading partner in the Gulf. The establishement of seven new hospitals are identified as opportunities for UK business interests. Similarly, Saudi Arabia has major infrastructure and education developments, as well as major developments underway in Oman, UAE, Kuwait and Qatar (Bambridge, 2013). These include:

- King Abdullah Bin Abdulaziz – Security Forces Medical Complexes Development Project
- Sidra Medical & Research Centre
- International Medical City (IMC), Salalah
- Cleveland Clinic; Al-Maryah, Abu Dhabi
- Sultan Qaboos Medical City Complex, Barka
- King Abdullah Medical City, Makkah
- Jaber Al-Ahmed Al-Jaber Al-Sabah Hospital
- Al-Jahra Hospital
- Mafraq Hospital, Abu Dhabi
- Al-Ain Hospital, Abu Dhabi
- King Faisal Medical City, Assir
- Sheikh Khalifa Medical City
- Kuwait Children's Hospital (KCH), Sabah
- Ajyad General Hospital, Makkah
- Kuwait Cancer Control Center

Figure 7 below illustrates recent and planned opportunities within healthcare and the Middle East (AECOM, 2013).

Figure 7: Healthcare project awards.



Source: Meed (As of February 2013), cited in AECOM, 2013.

Kuwait Scotland eHealth Innovation Network (KSeHIN)

KSeHIN is a collaboration between the Kuwait Ministry of Health (MoH) and Dasman Diabetes Institute and a Scottish consortium consisting of academic (University of Dundee), public sector health (NHS Tayside) and private sector health interests (Aridhia – informatics). It seeks to leverage educational, research and informatics resources in Kuwait and Scotland to advance clinical care, research and training in diabetes and other chronic diseases. To date, Aridhia has developed and implemented the Kuwait Health Network (KHN) informatics portal which provides real-time connection across all primary health centres in Kuwait and the Dasman Diabetes Institute. It is also being rolled out across all state-owned hospitals. A disease registry and electronic shared clinical care record is also being developed, which will support integrated care of diabetes and its complications across Kuwait[5].

UK Biocentre

[5] https://www.gov.uk/government/publications/digital-health-working-in-partnership/digital-health-working-in-partnerships

UK Biocentre support clinical, disease and population-based studies. It has recently established a collaboration with the National Guard Health Affairs to develop a biobank in the Kingdom of Saudi Arabia to enable population-based medical research[6].

PA Consulting and the Executive Council of Dubai

The Executive Council of Dubai has responsibility for the implementation of the Dubai Strategic Plan. The Council appointed PA Consulting from the UK to define the blueprint for health and social development. PA drew up the detailed strategies and implementation plans agreed during the blueprinting[7].

Targeting opportunities in Turkey

UK Trade & Investment has identified opportunities for British companies in the following key areas of the Turkey Healthcare Campuses project:

- planning and master planning
- project management and advisory services
- laboratory design
- hospital design and architecture
- clinical support and cooperation
- ICT / hospital information systems
- niche construction skills
- hospital operation and commissioning
- facilities management
- education and training
- financial structuring and insurance
- security

Opportunities are said to be large: private finance initiatives (PFIs) and public-private partnerships (PPP) will allow around £8 billion to be spent on building and upgrading up to 40 hospital sites over the next decade. Turkey's Ministry of Health anticipates a total of around 95,000 new hospital beds being needed by

[6] https://www.gov.uk/government/publications/overview-working-in-partnership/healthcare-uk-working-in-partnership--2#taking-uk-expertise-to-the-world
[7] https://www.gov.uk/government/publications/overview-working-in-partnership/healthcare-uk-working-in-partnership--2#taking-uk-expertise-to-the-world

2023. During September 2014 there was the first UK-Turkey Health Week with the UK Business Ambassador for Healthcare and Life Sciences, Lord Kakkar, hosting a high-level delegation[8].

Strengthening health systems in developing countries

The UK has a long tradition of supporting healthcare development in developing countries. DfID utilises NHS expertise through the Health Partnership Scheme (HPS) and its funding of NICE International. HPS, operated by the Tropical Health and Education Trust (THET), arranges over 80 institutional health partnerships between UK-based health organisations and those in low and middle-income countries. The partnerships allow skills transfer and the exchange of ideas and the building of support for broader UK development priorities. Organisations that have received grants include NICE International and a number of the Royal Colleges. DfID has increased support for the scheme with an additional £10m funding running to 2017 (House of Commons International Development Committee, 2014).

Education and training

- UK Medical Schools are able to offer places to international students to a limit of 7.5% of total entry. During a visit to India (August 2014) Nick Clegg called for a relaxation in the cap and a lifting of visa restrictions for this particular group. The British Medical Association responded by urging caution around the matter. An earlier 2012 review recommended that there should be no increase in the cap (DH/HEFCE, 2012).

- Imperial College jointly created and subsequently managed the Singapore Medical School ('LKC Medicine') with Nanyang Technological University (NTU). The collaboration admitted its first students in 2013. http://www.lkcmedicine.ntu.edu.sg/Pages/Home.aspx

[8] https://www.gov.uk/government/news/uk-turkey-health-week-to-promote-british-expertise-in-8-billion-turkish-healthcare-market-announced

- The Royal College of Surgeons of England (RCS) has recently accredited four education and training centres in China (Beijing, Shanghai, Chengdu, Guangzhou) in collaboration with Johnson & Johnson Medical Education Centres. These centres now operate full RCS QA and monitoring processes in line with RCS standards and with the support of online faculty participant evaluation being run in Chinese and English[9].

- From 2006, BMJ has offered Masterclasses as a series of interactive and case-based educational courses. In June 2011, its first Masterclass for GPs in India attracted 1,500 doctors in a video-conference meeting (across 40 centres around India). Masterclass sessions focused on cardiology, respiratory medicine and paediatrics. The speakers were all leading UK clinicians. Another Masterclass held jointly with Indian Medical Association (Maharashtra Chapter) in April 2013 focused on diagnosis and management of chest pain and was attended by approximately 500 doctors[10].

- Healthcare UK has also widened its team to members with specialist health training and education skills and experience to support the UK's training and education sector in winning business opportunities abroad[11].

Regulation

NICE International (established in 2008) undertook a number of workshops and research development activities. They included workshops in India; development of Hospital Management of Acute Stroke guidance in Vietnam (Rockefeller funded); working in Cyprus; a workshop in the Philippines; a Ghana study tour to the UK (funded by Rockefeller); and a research collaboration with China (funded by DfID).

[9] www.gov.uk/government/uploads/system/uploads/attachment_data/file/271480/Healthcare_UK_China_and_the_UK.pdf

[10] www.gov.uk/government/uploads/system/uploads/attachment_data/file/311349/Healthcare_UK_India_and_the_UK_LOW.pdf

[11] https://healthcareuk.blog.gov.uk/2014/11/06/why-its-so-important-to-promote-uk-excellence-in-healthcare-training-and-education/

Other

- During September 2013, two construction sectors contracts were signed with Sweden to the value of £30 million. Facilitated by UKTI, Astins and Measom, were awarded contracts for the New Karolinska Solna (NKS) University Hospital in Stockholm. It is said to be the world's largest PPP hospital and Sweden's first PPP building.
- Expatriates who live all or part of the year in Spain are being offered new products by Bupa in partnership with its sister company Sanitas. The plan gives access to healthcare in Spain and another European country of choice.

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Section 3
French healthcare export developments

Introduction

France, and in particular Paris, has been a historical provider of medical treatments for inward travelling elites, including from the Middle East during the 1960s and 1970s (Kronfol, 2012: 1235), and also former colonial countries of North Africa and elsewhere in Europe (Khelifa, n.d). The 1980s saw competition between Britain, France and Germany for Arabic patients (Roberts, 1991). With the recent increase in global medical travel and the rise of East Asian and Eastern and Central European providers, France is rarely, if ever, identified as a destination for medical tourism and does not appear in brokers' offers and is not referenced in the lists of destinations (Khelifa, n.d.).

Khelifa states that France benefits from many advantages which would make it competitive on the market of medical tourism:

- It is the premier touristic destination in the world with 83 million visitors annually
- It has a wide range of hotel accommodation, infrastructure and hospitals
- Prices for medical services are particularly low compared to other developed health systems and even emerging countries
- The high quality of French hospitals and French medical training and profession

Developments: medical tourism

There is said to be growing interest amongst Parisian hospitals in using medical tourism as a way to balance their debt. In 2012, l'Assistance-Publique Hopitaux de Paris (AP-HP or Public assistance Hospitals of Paris – 37 hospitals in Ile de France) signed a contract with Globemed, based in Lebanon, which will be liaising between Parisian hospitals and concerned states. The development manager of the AP, Stephane Feriaut, however, commented that the hospitals of Paris do not aim to become private and that foreign patients would only represent 1% of the total number of patients (Francetvinfo, 2012). This initiative

was solely meant to be open to Middle Eastern countries but there was an aspiration to extend these services to Asia, Russia and East Europe (Barret, 2012; Francetvinfo, 2012). At the time, the AP-HP already received 7,500 foreign patients every year who were particularly attracted by hospitals such as Pitie-Salpetiere or Necker (Barret, 2012), of which 2,300 were from the Middle East (Cadu, 2012).

In the same year AP-HP developed a scientific and medical partnership with Beijing (Lorriaux, 2012) which involves exporting AP-HP's scientific, management, and organisational skills. For example, the agreement involves supporting Chinese practitioners and researchers with expertise around clinical research methodologies. The AP-HP will also share its knowledge in order to improve the Chinese healthcare system. This cooperation is between Parisian hospitals and China and it is notable that Chen Zhu, the Chinese Minister of Health, trained in France for five years at the Saint Louis Hospital, which is part of the AP-HP network. Similar kinds of partnerships were formed with Vietnamese practitioners in the past.

However, one doctor at the AP-HP underlines the weaknesses of Parisian hospitals: 'the problem is that our institution doesn't know how to value a personal service. We could make clients pay a lot more and invest in research or a foundation, but technically we don't know how to charge those services!' (Le Figaro, 2008). When the AP-HP receives a foreign patient, whether the patient is paying with private funds or through a private insurance, or regardless of how wealthy the patients is, it charges the same price as the one charged to the French public insurance (Le Figaro, 2008).

Outside of Paris there has been some interest in the development of medical tourism. François Gaillard, director of the Lyon Tourism Office and congresses, was considering medical tourism for Lyon since 2005, and it is something that has also attracted interested from the city council as well. It is suggested that more recently, citizens from the European Union Area come between the Rhone and Saone, mainly for artificial inseminations, and knee and cancer surgery

which are specialities of hospitals in Lyon. Lamy (2012) argues that French and foreign professional athletes also regularly use the services of Dr Bertrand Sonnery-Cottet (Mermoz private hospital) and Prof Bertrand Moyen (Centre hospitalier Lyon Sud – South Lyon Hospital centre). Additionally, François Niforos, located in Boulevard des Belges in Lyon, is a world-famous cosmetic surgeon and one of the Allergan's (Californian laboratory which produces Botox) ten key opinion leaders. Niforos suggests that 25% of his clientele are foreign, mainly from Greece, Switzerland, Italy, East Europe, Ukraine, and Russia. Lyon is also a leader in organising and hosting medical conferences (Lamy, 2012).

Burhin (n.d.) suggests that France is mainly well-known for its well-being and spa tourism. He also adds that there is an increase in medi-spas and centres for nutritional medicine which have a high potential for a complementary development to medical tourism. Menvielle and Menvielle (2010) confirm the popularity of thermal therapy in France, specifically on la Cote D'Azur.

Plotard (2013) suggests that there is more enthusiasm in Marseille, especially from the Chamber of Commerce & Industry which has created a 'Pole Sante mediterranee' (Mediterranean health unit) in charge of organising medical touristic trips. Ypsee (the company being based in Marseille) is considered as a candidate to manage this platform. In fact, in 2012, AP-HM (Hospitals of Marseille) announced that they would be welcoming 1,000 foreign patients every year and would promote the 'ultraquality' of Mediterranean medicine specifically in hand surgery, radiosurgery, and ophthalmology (Barret, 2012). The Pole Sante mediterannee (Mediterranean health unit) which gathers health professionals in the public and private sector wishes to develop medical tourism in France. The health department has chosen Stratis to be in charge of their marketing strategy and international communication (Stratis, n.d.).

A study undertaken between September and October 2013 using an online questionnaire received responses from 29 licensed surgeons actively in practice (Estheticon.fr, 2013). The main findings were that:

- 38% of French plastic surgeons practised surgery on foreign patients who travelled specifically for the operation.
- These patients represent on average 2.3% of these plastic surgeons' clientele.
- The average length of stay in France following a surgery under anaesthesia is generally from 5 to 13 days.
- The most popular operations are breast augmentation, breast reduction and rhinoplasty.
- Foreign patients came mostly from Africa, Middle East, Great Britain and Switzerland.

Health export strategy

Khelifa (n.d.) argues that a major weakness of France in terms of medical tourism is its lack of strategic orientation. The subject receives relatively little support from French Health or Industry ministers. The only significant public action was the Social Security Finances Law in 2012, which allows hospitals and clinics to freely charge foreign patients who do not benefit from the AME (Aide Medicale de l'Etat – Medical support from the state), nor from bi-lateral agreements of social security. Khelifa comments that despite the AP-HP and AP-HM initiatives, the lack of strategic orientation at a national level is reflected by a strong lack of social consensus on this topic.

The report suggests that the implementation of a strategic plan for the development of a medical tourism offer in France should encompass three axis:

- Strategic orientation: seriously evaluating the benefits that France could get from medical tourism.
- Construction: building and developing the French offer (regional clusters with groups of private or public infrastructures according to their medical specialities).
- Communication: promoting French services to international buyers.

Plotard (2013) underlines that French law prevents mixing tourism and medical services as the code du Toursime (Tourism code) is the framework for the selling

of touristic services and the Code de la sante (Health code) prohibits medicine being practised as commerce. The ethics of medical tourism are also raised by Catherine Fisch who created 'SAM', a company that would provide touristic and medical services in Paris. She suggests that medical tourism is still taboo, as 'in France people don't like to mix money and healthcare' (Le Figaro, 2008). This seems to be reflected in the institutional attitudes towards medical tourism as she suggests that there is no public recognition of the activity, loans are difficult to obtain, the ministry of health is not responsive, and clients do not know who to trust (ibid.). Similarly, in 2012 the General Confederation of Labour (CGT) reacted to the AP-HP announcement: 'the selection of patients according to their bank account is inacceptable' (Khelifa, n.d.).

Language is mentioned as a problem on several occasions since the majority of medical tourists are English speakers (L'Hostis, n.d.). However, L'Hostis suggests that there could be a demand from French-speaking countries such as Canada, where waiting lists are long and prices are more expensive. She suggests that the coastal location of some French regions should be reflected upon. Burhin (n.d.) lists Medsolution (www.medsolution.com) as a French retailer for packages targeted at Canadian clients.

International cooperation and development

In 2012, the Hospital Federation of France (FHF) and the French Agency for Development (AFD) signed a €2 million subvention. The objective was to develop hospital networks and partnerships in order to improve the quality of hospital care and management in developing countries. In 2009 the project launched by the Ministry of Foreign Affairs 'hospital networks and partnerships' (with €320,000) enabled support for several partnerships abroad, for example, the partnership between the Hospital centre of Puy-en-Velay and the one in Dédougou in Burkina Fasso or the AP-HP – Ambroise Paré and the National Institute of gerontology in Vietnam. Four years later, the FHF and AFD wish to reinforce this project and develop new partnerships and networks between 'North and South' hospitals. The aim is to financially support five different partnerships for a length of four years between French hospitals and foreign

hospitals (public or private), to organise exchanges around hospital cooperation and based on French expertise. In addition, the project should contribute to the improvement of human resources in the health sector. It is part of the French strategy of cooperation and support through the development of the health sector which notably aims at decreasing maternal and child mortality in the South.

The FHF and AFD called for candidates in 2013 and were specifically looking for proposals from 28 target countries in which the AFD already intervenes, namely:

- Eight countries in the Mediterranean and Middle East region for which projects relate to non-transmissible diseases, mental health, and pathologies linked to accident (Tunisia, Morocco, Egypt, Autonomous Palestinian territories, Jordan, Turkey, Yemen)
- 20 other countries for which the focus is on projects on decreasing child mortality and improvement of maternal health (Afghanistan, Benin, Burundi, Burkina Faso, Cameroun, Comores, Congo Brazzaville, Côte d'Ivoire, Djibouti, Ghana, Guinea, Haiti, Madagascar, Mali, Mauritania, Niger, Democratic Republic of Congo, Senegal, Chad, Togo)

Reports made by the FHF and AP-HP count about 700 cooperative actions put in place by French public hospitals in the past. These international activities mainly focus on training programmes in Southern countries and the welcoming of foreign interns in French hospitals, technical and expert support missions on topics such as care techniques, clinical and medico-technical service management, management and infrastructures, maintenance and biomedical engineering. However, the organisations note that French hospitals are rarely part of greater international programmes in terms of hospital expertise which are funded by bilateral (AFD) or multilateral (EU and the World Bank) funds.

China and Russia as target markets

The HP-AP (Parisian hospitals) will be participating in France-China Meetings (rencontres France-Chine) in Beijing from August 15th to 17th 2015. The HP-AP has already signed two cooperation agreements with China. The first of these is

with the leading Beijing Union Medical Centre. The second with the Beijing Municipal Health Bureau where the HP-AP will play a role within the training centre, especially for emergency medicine and other projects such as geriatric homecare. The HP-AP will sign two more agreements at the 2015 France-China meetings. The first agreement will focus on the cooperation with Xinhua hospital in Shanghai. The second agreement will be signed with a private partner that wishes to refer Chinese patients to Parisian hospitals[12].

The Hopitaux Universitaires de Strasbourg (University hospitals of Strasbourg) has a 'solid and high level' partnership with Omsk Medical Academy (Occidental Siberia). The academic/medical agreement was signed in 2006 and allows doctors to regularly operate in the partner city. The University hospitals of Strasbourg also welcome Russian interns on permanent contracts. The University hospitals of Strasbourg also support the Vologda hospitals by sharing their expertise, with the financial support of the French Embassy in Russia[13].

[12] http://presse.aphp.fr/lassistance-publique-hopitaux-de-paris-participera-aux-rencontres-france-chine-a-pekin-du-15-au-17-aout
[13] http://www.strasbourg.eu/developpement-rayonnement/europe-international/ville-partenaire-solidaire/cooperations-partenariats/vologda-russie

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Media coverage

Le Parisien
http://www.leparisien.fr/laparisienne/sante/le-tourisme-medical-attise-l-appetit-de-plus-en-plus-de-pays-30-04-2012-1979277.php#xtref=https%3A%2F%2Fwww.google.co.uk%2F

Le Figaro
http://www.lefigaro.fr/assurance/2013/04/16/05005-20130416ARTFIG00367-sante-tourisme-medical-et-prise-en-charge.php

Section 4
German healthcare export developments

Introduction

Germany has a tradition of treating international patients, typically focusing on more complex and specialist treatments. Approximately 224,000 foreign patients were treated in Germany in 2012, an increase of 8.6% to the previous year and numbers are expected to have grown since. The estimated proportion of foreign patients in German hospitals is about 0.5%. That means medical and health tourism in Germany is only a niche market, however it is a very profitable one generating over €1bn p.a. for the German healthcare system. The biggest single source of patients now come from outside the EU (Russia); in 2012, 8,300 Russians were treated in hospitals and another 12,400 were ambulant patients.

One in ten German health clinics specialise in medical tourism, and nearly nine in ten of those clinics reported rising numbers of patients. Many clinics have international offices, where they work on enquiries from abroad, arrange continuity of care for patients, provide translators and organise billing. The task of dealing with health and medical tourism is delegated to the Ministry of Economics and Technology, and the government aims to strengthen Germany's position by targeting international medical tourism and cross-border medical tourism, and also by giving advice on how to improve competiveness. There is strong support for medical tourism from the federal states, independent of the government. For example, with the support of the federal state government of North Rhine-Westphalia there is an initiative to strengthen the position of the Cologne-Bonn-Düsseldorf area in the field of medical tourism (especially targeting Russia). For most international guests a valid visa is required to enter Germany for medical treatment and organisations typically offer support with the formalities (such as providing the necessary invitation letter for the embassy). Russian patients favour the federal state of North Rhine-Westphalia,

with the cities Cologne, Bonn and Düsseldorf and Bochum. In southern Germany, Munich, Regensburg and Freiburg are popular. [14]

Export initiatives and activities

'Health - Made in Germany', was initiated by the Federal Ministry for Economic Affairs and Energy, and provides key information and contact details related to German healthcare products and services. The initiative was developed together with the ministries of the 16 federal states of Germany. These states provide contacts for questions regarding export and trade in the health care industry. Industries represented were:

- Medical biotechnology industry
- Pharmaceutical industry
- Telemedicine and health-related services (Germany's companies in the field of telemedicine and health-related services are able to deliver 'turn-key' solutions and train local staff in the use of technical equipment)
- Medical technology industry

Germany's federal government is pursuing a 'High-Tech-Strategy' to promote innovation in the areas of biotechnology, pharmaceuticals and medical technology. From 2006 to 2009, the government provided €1.23 billion to support this initiative.

On behalf of the German federal government, the German National Tourist Board (GNTB) has been working internationally to promote Germany as a travel destination for more than 60 years. The GNTB plays an important role in the promotion of Germany as a travel destination on the international market. In this respect, the GNTB relies on its close collaboration with the German travel

[14] http://www.aerztezeitung.de/panorama/medizintourismus/article/854054/medizintourismus-na-sdarowje.html?sh=1&h=-145943621
http://www.innovativergesundheitstourismus.de/fileadmin/user_upload/pdf/BMWI_Branchenreport_Kliniken_web.pdf
http://de.rbth.com/gesellschaft/2014/07/16/medizintourismus_deutschland_ein_magnet_fuer_russen_30315.html
http://de.rbth.com/gesellschaft/2014/07/16/medizintourismus_deutschland_ein_magnet_fuer_russen_30315.html

industry, partners from commerce and trade associations. Strengthening the medical/ health travel segment is a strategic action area for the GNTB.

The German Healthcare Export Group (GHE) brings together 51 innovative companies from across medical technology, which are strongly export-oriented. The GHE offers potential customers a wide variety of products and services, from equipment to hospital IT, and covers almost the entire medical technology product range. GHE provides member companies with a platform for exchanging their export business experiences. Overall the association represents around 80% by volume of all German exports in the medical technology sector. GHE is present at important national and international trade fairs, including a large joint stand and adjacent lounge at MEDICA. GHE has also appearing at the Arab Health in Dubai since its establishment. GHE was also represented (booth and lounge) at the SE Asian Healthcare Show, Kuala Lumpur Convention Centre from 4-6 March 2014.[15]

The German National Tourist Board (DZT) advertises the country's healthcare system in a brochure called Medical Journeys. The brochure, with a circulation of 50,000, is published in German, English, Russian and Arabic. Many hospitals concentrate most of their marketing resources on the CIS region (Russia and the Ukraine). There is currently double the amount of patients from the CIS in comparison to the Middle East. One example that focuses on Russia (and the Ukraine) is the campaign 'Healthdestination Rhineland', which was sponsored by the European Union and the federal state of North Rhine-Westphalia**,** primarily to market the Bonn-Cologne-Dusseldorf area as a medical destination. The initiators of the campaign focus on information material in Russian as well as visiting trade-shows in Russia, Kazakhstan and the Ukraine and having a high media-presence in the target countries.[16]

[15] http://www.gheg.de/en/about/profil.html
http://www.hospitalar.german-pavilion.com/content/en/general_information/contacts.php?contact_id=9881
http://www.health-made-in-germany.de/EIG/Navigation/EN/institutions,did=458622.html

[16] http://www.spiegel.de/international/germany/german-health-care-system-cashes-in-on-foreign-patients-a-933517-2.html
http://www.expat-news.com/14973/life-style/medizintourismus-in-deutschland-vor-allem-russen-nutzen-angebot/

The main subject of the Foreign Trade Congress 2014 was the need for on-going dialogue between business and policy makers for providing stronger local support to medium-sized companies in the field of medical engineering. The final policy recommendation from policy makers at the 5th Congress was that companies should feature abroad under a Germany PLC umbrella, cooperate with one another and help each other gain entry to local networks. Stephen Steinlein, State Secretary of the Federal Foreign Office, highlighted that the Federal Foreign Office with its 227 embassies and consular offices, was the service partner across the world for German industry.[17]

The geography of Germany has encouraged the collaboration of hospitals close to borders, including 'Euroregionaler Medizinisher Verein (EmV)'; The EmV hospitals are positioned at the border to the Netherlands and allow patients to use hospitals in both countries (especially when they have been put on the waiting list for complicated surgery). The demand for medical treatment is highest in areas like orthopaedics, eye treatments and special surgery and the treatment costs are met by the medical insurance companies of each country. Surgery for Danish patients with life-threatening adiposis: The clinic Tönningen provides Danish patients with surgery and medical treatments (adipositas-chirurgie).[18]

There are examples of healthcare providers cooperating in the same region. For example 'Gesundheitsregion Köln-Bonn' (Region Cologne-Bonn) is an organisation that offers a marketing platform for a variety of healthcare providers (from clinics to private practices). Many other cities and federal states market themselves as providing the best healthcare for foreigners, including Hamburg and Berlin-Brandenburg, both of which have detailed websites with informational material. Bad Godesberg (near Bonn) is said to attract more than 73,000 foreign patients each year; most of them from France,

[17] http://www.gheg.de/media/file/160/Press_Release_GHE_Foreign_Trade_Congress_09.2014.pdf
[18] http://www.innovativer-gesundheitstourismus.de/fileadmin/user_upload/pdf/BMWI_Branchenreport_Kliniken_web.pdf
www.adipositas-nord.de

the Netherlands and other European countries. Those patients come to Germany for treatments ranging from from kidney transplants to difficult cancer and heart surgeries. The biggest demand for German health services is in 'high end' practices like orthopaedics, internal medicine, cardiology, oncology and trauma and reconstructive surgery[19].

State-level marketing is evident: the City of Hamburg's tourism authority published a 60-page supplement to the Moskauer Deutsche Zeitung, a German-language newspaper in the Russian capital, in which it advertised Hamburg as an 'ideal health care city'. Both the federal government and the German parliament gave their seal of approval to the PR document. Network for Better Medical Care, Berlin, provides international patients with links to clinics, travel agents and other useful information[20][21].

In addition to state-supported marketing of medical tourism, several independent information portals have evolved. One of them is called Zentra, and is specifically aimed at Russian customers and aims to help them find information about clinics and medical centres all over Germany. The portal allows for specified searches, including preferred region, diagnostic and international rankings of the institutions.[22]

Figure 8 shows that the demand for services from specialists in internal medicine has steadily been increasing from 2011 to 2013 (by 12.2%).

[19] http://www.general-anzeiger-bonn.de/lokales/bonn/Patienten-aus-der-ganzen-Welt-kommen-nach-Bad-Godesberg-article280878.html#plx122460493

http://de.rbth.com/gesellschaft/2014/07/16/medizintourismus_deutschland_ein_magnet_fuer_russen_30315.html

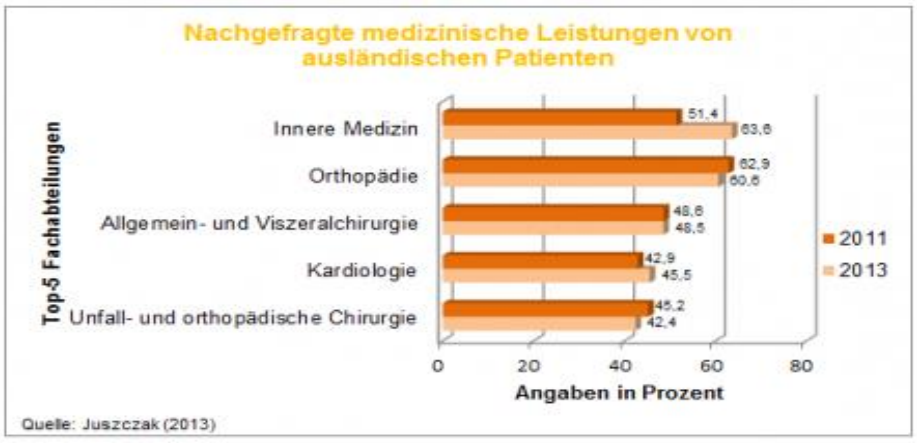
http://www.innovativer-gesundheitstourismus.de/fileadmin/user_upload/pdf/BMWI_Branchenreport_Kliniken_web.pdf

[20] http://www.spiegel.de/international/germany/german-health-care-system-cashes-in-on-foreign-patients-a-933517-2.html

[21] www.nbmc-berlin.de

[22] http://www.aerzteblatt.de/nachrichten/37490/Auslaendische_Patienten_bescheren_Kliniken_Millionenerloese.htm

Figure 8: Demand for medical services by foreign patients.



Source: http://www.leading-medicine-guide.de/Gesundheitstourismus

Innere Medizin = Internal medicine
Orthopädie = Orthopaedics
Allgemein Chirurgie = General surgery
Kardiologie = Cardiology
Unfall Chirurgie = Reconstructive surgery

A number of clinics in Germany emphasise the comprehensive services for foreign/international patients. For example:

- In the City Clinic Munich the international department takes care of international patients of five other clinics, providing services including Arabic, English and Russian coordinators, visa organisation and airport shuttles[23].
- The Carl Gustav Clarus University Hospital in Dresden has an international patient service, offering special cultural and religious services to accommodate demands of a variety of patients[24].
- Helios clinics advertise having a staff who speaks multiple languages for international patients[25].
- Johann-Wolfgang-Goethe University Hospital offers cost calculations for all different treatments and translations to English and Russian[26].

[23] www.klinikum-muenchen.de
[24] www.uniklinikum-dresden.de/patienten-und-besucher/international-patients
[25] www.helios-healthcare.com
[26] www.klinik.uni-frankfurt.de

Many hospitals put a lot of effort into accommodating the needs of foreign patients and their families. Many hospitals have multilingual internet portals with information on accommodation, translators, culture programmes and prayer rooms. Doctors and nurses are offered the opportunity to take language courses to build up a basic vocabulary in languages such as Arabic and Russian. Representatives of clinics often travel to Arabic tourism exhibitions to present their services to potential clients.[27]

China-Germany collaboration

At the invitation of the Federal Chancellor Angela Merkel, the Third German-Chinese Government Consultations were held in Berlin from 9-10th October 2014. The Federal Minister Hermann Gröhe outlined that: 'The German-Chinese Plan of Action for Public Health Co-operation contains an ambitious framework for action over the coming two years. Our common objective is to make medical progress accessible to patients as soon as possible'. The bi-lateral talks were centred around the plan of action on German-Chinese public health cooperation. The plan lays down the political priorities and the fields for action for 2015 and 2016. In the course of the talks, both parties agreed on the following topics:

Communicable Diseases and Hygiene: Both Germany and China have a key role to play regionally and are stepping up cooperation. A comprehensive strategy to combat multidrug-resistent (MDR) pathogens and other pathogens requires complex hygiene standards to be drawn up by German and Chinese university clinics.

Oncology: Germany will oversee the setting up of a breast cancer centre in China and will continue efforts in both training and equipment in the area of oncology.

Hospital Management and Quality Assurance: China aims to improve the provision of care, especially in the primary care sector, and is looking to the

[27] http://www.aerzteblatt.de/nachrichten/37490/Auslaendische_Patienten_bescheren_Kliniken_Millionenerloese.htm

German model of hospital care. Germany provides support for this reform process by contributing its experience and expertise in the DRG system.

Rescue Services and Emergency Medicine: Both countries will continue to supervise the pilot projects in two Chinese cities. There is an agreement to carry out such activities as joint communicating, training and drilling and build an integrated emergency rescue system in China. There are also plans to exchange information on emergent occurrence of acute infectious diseases, and strengthen cooperation in prevention, control and treatment, including sharing of scientific research achievements.

Health Care Industry

Germany has emphasised non-discriminatory market access for German enterprises and particularly for Chinese firms with German parent companies. Germany advocates transparent marketing authorisation procedures to facilitate innovation and to speed up the recognition of products and procedures.[28]

Russia

In 2008 the Martin-Luther-Krankenhaus (hospital) in Berlin signed an exclusive contract with the Russian health insurance company Sogaz, from Gazprom. Those insured by Sogaz can now be treated in the hospital in Berlin and this development is mainly for managers and higher ranked employees[29].

One problem reported with Russian patients has been the rise of 'patients facilitators' in Russia, rather than direct hospital contacts. Those agencies are small and unregistered and may not always forward patient fees to hospitals. The German government and the federal state governments do not interfere and

[28] http://www.fmprc.gov.cn/mfa_eng/topics_665678/lkqzlfwdgelsydllhglnzzzbbcxdsjyosnhy/t1200147.shtml

http://www.auswaertiges-amt.de/EN/Aussenpolitik/RegionaleSchwerpunkte/AfghanistanZentralasien/AktuelleArtikel/131004_Krankenhäuser_fuer_NordenAFGs.html
http://www.bmg.bund.de/ministerium/presse/english-version/ministry/news/germany-and-china-agree-on-an-action-plan.html

[29] http://www.monitor-versorgungsforschung.de/news/der-russische-patient

have been failing to tackle these practices. In a few cases the hospitals had to be reimbursed for failed payments by using tax money, or the patients were involved in long court proceedings as a result of unpaid bills.[30]

Other developments

Germany is funding the construction of hospitals in the northern Afghan towns of Mazar e Sharif, Feyzabad, Taloqan, Kunduz, Khanabad, Keshem, Warduj and Baharak to for €55 million. German support for the Afghan healthcare sector has so far helped give some five million people access to better medical care. The regional hospital in Mazar e Sharif was handed over to its Afghan operators in May 2012. The German government's priorities are now advising the hospital management and training hospital staff. This is particularly important, as the institution is designed to function as both a model hospital and teaching hospital. [31]

Freiburg Medical Laboratory Middle East LLC is a joint venture between the University of Freiburg, Synlab Laboratories (Germany) and the Al Abbas Group (UAE). FML was the first medical laboratory to receive the coveted ISO 15189 accreditation certificate in the Middle East. The goal of this independent laboratory is to provide patients, doctors, clinics, polyclinics and hospitals with sophisticated lab-analysis and routine medical tests that meet predefined quality parameters. Currently, FML performs more than 400 general and specific investigations. German equipment being sought for Middle Eastern hospitals is another emerging theme.[32]

Training and education initiatives by German professionals

There are examples of a German University Hospital advising the Yemeni government in the building and operation of a new, 400-bed facility. There are

[30] http://www.spiegel.de/international/germany/german-health-care-system-cashes-in-on-foreign-patients-a-933517-2.html

[31] http://www.auswaertiges-amt.de/EN/Aussenpolitik/RegionaleSchwerpunkte/AfghanistanZentralasien/AktuelleArtikel/131004_Krankenhäuser_fuer_NordenAFGs.html

[32] http://www.fml-dubai.com/AboutFML.aspx
http://www.medizin-und-technik.de/naher-und-mittlerer-osten

also examples of German companies exporting surgical and diagnostic clinic and a laboratory - including medical technology to Nigeria and also training staff on site. The German Medical Association sees its relations with the states of Central and Eastern Europe as being particularly important and has provided support for the establishment of systems of medical self-administration in this region. In the majority of German states medical chambers have now established themselves to the extent that this support has developed into a partnership, enabling positive cooperation on common areas of interest. This is exemplified by the annual ZEVA symposium which promotes cooperation in the region by providing a platform for exchange between representatives of physicians' chambers from Central and Eastern European countries.[33]

[33] http://www.health-made-in-germany.de/EIG/Navigation/EN/telemedicine-health-related-services.html?themaIdx=3
http://www.bundesaerztekammer.de/page.asp?his=4.3572

Section 5

Healthcare export developments in Turkey, Hungary, Greece

Turkey

Medical tourism in Turkey has increasingly become part of public policy developed by the state, and the Turkish Ministry of Health has sought to coordinate between different institutions working in this area. Alongside significant efforts at the state level to regulate and promote medical tourism, non-state actors including hospitals and NGOs also play a role. Below we detail recent developments.

First, health and medical tourism development is a 'Priority Transformation Program' in the 10th Development Plan (2014-2018) prepared by the Ministry of Development. This programme consists of four elements focusing on institutional and legal infrastructure, physical and technical infrastructure and service quality and marketing, and it is to be coordinated by the Ministry of Health and Ministry of Culture and Tourism (TC Kalkınma Bakanlığı, 2013). In 2010, a specific unit for the coordination of health tourism was established under the Ministry of Health and it has now become the Department of Health Tourism. Therefore, the Ministry looks both to regulate and improve the provision of health services to foreign patients, and promote Turkey as a major destination for medical tourism. Its initiatives in this regard include:

- Research activities to give healthcare providers up-to-date information about the sector: annual evaluation reports[34], detailed studies on specific themes such as international patient care processes and the role of intermediary agencies[35].

[34] For example, 2013 Evaluation Report can be accessed at http://www.saglik.gov.tr/SaglikTurizmi/dosya/1-91774/h/evaluaton-report-on-medical-tourism-in-turkey-2013.pdf

[35] For an example, see the Research Report on Processes and Intermediary Agencies in Medical Tourism (2012) at http://ilegra.com.tr/saglikturizmi/dokumanlar/saglik-turizminde-surecler-ve-araci-kuruluslar-raporu.pdf

- A 'Foreign Patient Tracking System[36]' to develop an evidence-base for future policies: a web-based registration system for international patients.
- An 'International Patient Portal[37]' to provide guidance to those who consider treatment options in Turkey: central website containing information about healthcare services in Turkey and travel arrangements as well as a hospital search tool which includes both public and private providers. The site can be accessed in four languages.
- An 'International Patient Assistance Unit[38]' to provide consultation and interpreting services over the phone: 24-hour call centre in six different languages.
- Events to bring major international actors in the sector together and develop links such as the Istanbul Health Expo: the most recent exhibition and congress (10-13 December 2014) included health and medical tourism as well as medical technologies and expertise[39].

Meanwhile, a Board of Coordination for Health Tourism is currently being established, again under the Ministry of Health, to ensure the involvement of other relevant state institutions in the process. This board is to include, among others, representatives from the Social Security Institution, Ministry of Culture and Tourism, Ministry of Economy and Ministry of Foreign Affairs[40]. These institutions are already involved in medical tourism related activities to different extents. For example, the Ministry of Economy provides substantive economic incentives to organisations which engage in promotional activities abroad by giving them financial support to cover up to 50% of their expenses[41]. Moreover, starting from 2013, 50% of revenues obtained from medical tourism have been exempt from tax (Republic of Turkey Ministry of Health, 2013a). The

[36] http://sbu.saglik.gov.tr/sbyabanci/
[37] http://www.saglikturizmi.gov.tr
[38] http://saglik.gov.tr/SaglikTurizmi/resim/1-42578/en.png
[39] Details of the event can be accessed from the Ministry of Health webpage at http://saglik.gov.tr/SaglikTurizmi/belge/1-38579/health-expo---saglik-turizmi-medikal-teknolojiler-tibbi-.html
[40] http://www.saglikaktuel.com/haber/saglik-turizmi-icin-koordinasyon-kurulu-olusturulacak-42833.htm
[41] Relevant regulations can be accessed from the Ministry of Health website at http://saglik.gov.tr/SaglikTurizmi/dosya/1-76035/h/ekonomi-bakanliginin-saglik-turizmi-ile-ilgili-tesvikle-.pdf

establishment of the Board is aimed at building on this multidimensional approach and creating an institutional structure for the coordinated management of medical tourism as a state policy.

Regarding visa arrangements, there is no specific scheme for people who are visiting Turkey for medical purposes in place. Although Turkey has recently been liberalising its visa regime with an increasing number of countries, visa requirements might be an issue in some cases and the participation of the Ministry of Foreign Affairs in the coordination of the process is important in this sense. Currently, citizens of 62 countries are able to travel to Turkey without a visa[42] and obtaining a tourist visa is usually a quick and straightforward process for others, who are now able to make an application online[43].

For medical tourism, the top three countries from which international patients come to Turkey are Libya, Germany and Iraq, according to 2012 data (Republic of Turkey Ministry of Health, 2013b: 35). In the case of Libya, free treatment of Libyan citizens during the civil war in the country and the following undertaking of the newly formed Libyan government to bear the expenses of patients sent to Turkey increased the number of medical tourists coming from this country. In Germany, the existence of a large Turkish community residing there is thought to play an advertising role and the high number of German tourists visiting Turkey for other purposes contributes to its popularity as a medical tourism destination (Republic of Turkey Ministry of Health, 2013b: 36). The citizens of these two countries are exempt from visa for their travels up to 90 days[44].

International patients also come to Turkey as part of bi-lateral agreements between Turkey and various countries, and agreements between social security institutions. The countries with which Turkey has International Bilateral Agreements on Health are Sudan, Afghanistan, Yemen, Albania, TRNC, Kosovo and Azerbaijan (Republic of Turkey Ministry of Health, 2013b: 12). A number of

[42] According to the information given in the International Patient Portal at http://www.saglikturizmi.gov.tr/
[43] The online visa application portal can be accessed at https://www.evisa.gov.tr/en/
[44] Country specific information about visa requirements is available from the Ministry of Foreign Affairs website at http://www.mfa.gov.tr/visa-information-for-foreigners.en.mfa

patients from these countries are treated in public and university hospitals in Turkey under the relevant protocol. At the same time, hospitals in Turkey offer healthcare services to citizens of other countries and to Turkish citizens residing abroad within the scope of Social Security Agreements. The expenses of these patients are primarily paid by their respective social security institution and Turkey has agreements in place with the following countries: Germany, Austria, Holland, Belgium, France, Turkish Republic of Northern Cyprus, Macedonia, Romania, Albania, Bosnia Herzegovina, Czech Republic, Azerbaijan, Luxembourg and Croatia (Republic of Turkey Ministry of Health, 2013b: 12).

Aside from national-level developments, there are also some initiatives at the city level, mainly undertaken by Provincial Directorates of Health under the Ministry of Health, and city-based Associations of Public Hospitals which have brought together all public secondary and tertiary healthcare facilities under their authority with the recent restructuring of health services. In this sense, cities which are already popular tourist destinations seem to promote themselves as major medical tourism destinations as well. The following examples can be given for recent activities at this level:

- Market research and feasibility studies by Antalya Association of Public Hospitals established Russia as one of the main target markets, and followed up by the building of special links with some municipalities and health organisations in this country[45]
- Link-building activities by Muğla Provincial Directorate of Health engaged in correspondence with procurement committees and investors from various Middle Eastern and European countries[46]
- Cooperation between foreign companies, Turkish travel agencies, hotels and hospitals organised by Muğla Provincial Directorate of Health resulted in the first patients from the Netherlands arriving in Bodrum in September-October 2014[47]

[45] For details see http://saglik.gov.tr/SaglikTurizmi/dosya/1-93688/h/drcenker-ates.pdf
[46] For details see http://saglik.gov.tr/SaglikTurizmi/dosya/1-93689/h/drcihan-tekin.pdf
[47] Details of the cooperation can be accessed from the Ministry of Health webpage at http://saglik.gov.tr/SaglikTurizmi/belge/1-38138/mugla-il-saglik-mudurlugu-organizasyonu-ile-saglik-turi-.html

- The Medical Tourism Guide prepared by Antalya Provincial Directorate of Health[48] covered information on public and private hospitals in Antalya as well as the city's natural and cultural landmarks
- Antalya Association of Public Hospitals began to use social media for the purposes of promotion[49]

In addition, there is a sectoral business council which has been established with a view to promote the Turkish health sector globally. DEIK/Health Tourism Business Council includes members from the Turkish Accredited Hospitals Association, Association of Turkish Travel Agencies, Turkish Airlines, and the Ministry of Health and Ministry of Culture and Tourism, as well as representatives from leading companies in the health and tourism sectors[50]. Detailed information on healthcare in Turkey including group statistics, patient testimonials and price comparisons with other countries which are popular destinations for medical tourists is available from their website[51].

Private hospitals and some NGOs are also active in the area. Private hospitals, and especially major hospital groups, have international patient centres which offer foreign patients a comprehensive range of services from assistance with visa procedures to airport transports and accommodation arrangements. Some examples include the Acibadem Hospitals Group, Group Florence Nightingale Hospitals and the Medical Park Hospitals Group[52]. Similarly, Dunyagoz Hospitals Group, which is an eye-care specialist, has comprehensive health packages for international patients and attracts more than 30,000 foreign patients per year from more than 100 countries[53]. Ophthalmic treatment is the specialty which brings the highest number of patients to Turkey as medical tourists (Republic of Turkey Ministry of Health, 2013b: 26). Regarding NGOs, training programmes,

[48] Available for download at http://en.antalyasm.gov.tr/
[49] Facebook page of the association can be accessed at https://www.facebook.com/pages/Antalya-Public-Hospital-Association-Medical-Tourism/313776912166906?sk=timeline
[50] http://www.healthinturkey.org/en-EN/about/78.aspx
[51] http://www.healthinturkey.org/en-EN/home-page/1.aspx
[52] The details about the services provided to international patients in these hospitals can be found at
http://www.acibademinternational.com/international-patient-center/
http://www.groupflorence.com/international-patient-center.html
http://www.medicalparkinternational.com/internationalpatient-center
[53] http://en.dunyagoz.com/about-us/medical-tourism.html

promotional activities and meetings organised by the Health Tourism Association of Turkey, and the active role of the Health Travel Development, Support and Organization Services Association in the organisation of the aforementioned Health Expo can be mentioned[54].

Finally, the developments in medical tourism in Turkey are not only concerned with the promotion of the country as a major destination for international patients. At the same time, initiative is taken by the Turkish government and private sector for the provision of health services outside of Turkey. These mainly include the building and running of hospitals as well as the export of know-how and medical technology.

As to the public sector, a specific unit has been established under the Turkish Public Hospitals Institution for the coordination of activities linked to hospitals abroad. The Turkish Cooperation and Coordination Agency (TIKA) under the Prime Ministry also plays a key role in the spread of Turkish hospitals to different regions[55]. The following are recent examples of government-led projects and partnerships in this area:

- Nyala Sudan Turkish Training and Research Hospital opened in February 2014: will be jointly managed by Turkey and Sudan for five years, then be transferred to Sudan at no charge[56]. The cooperation protocol between the two countries, on which the Nyala Hospital was established, also includes provisions for the treatment of some Sudanese patients in Turkey and the training of Sudanese healthcare personnel.

[54] Webpages of these associations can be accessed from the following links respectively: http://www.saglikturizmi.org.tr/en and http://satud.org/

[55] Although TIKA was initially engaging in developmental collaboration with Turkish speaking countries in Central Asia, its activities have recently been expanded to various regions including the Middle East, Pacific, Africa and the Balkans among others. A detailed description of the agency can be found at http://www.tika.gov.tr/en/about-us/1

[56] Details of the cooperation can be found at http://www.nyalasudanturkhastanesi.saglik.gov.tr/AboutUs.aspx

- Somalia Mogadishu Turkish Training and Research Hospital: Turkish doctors from various specialities are sent to the hospital by the Ministry of Health[57].
- Pakistan Recep Tayyip Erdoğan Hospital started to receive patients in June 2014: cooperation between countries to be continued through doctor- and nurse-exchange schemes[58].
- Afghanistan Kabul Ataturk Children's Hospital: founded in cooperation with the Turkish government and recently renovated by TIKA[59].
- Turkish Trauma and Rehabilitation Hospital in Lebanon: completed in 2010 by TIKA but not in operation yet, as it was to be run by Lebanon and there are unresolved funding issues[60].

Turkish private healthcare providers have also been extending their activities to foreign markets in recent years, mostly as profit-oriented investments but sometimes also proclaiming charitable motivations. In addition, there are commercial contractors which take part in the construction and equipment of hospitals abroad. Some examples are as follows:

- Acibadem Health Group: started a knowledge-transfer scheme with the private Sistina hospital in Macedonia, which is now affiliated to the group. It became part of a global network (International Healthcare Holdings) which operates hospitals and clinics in Malaysia, Singapore, India, China and Brunei, and took over the management of Faruk Medical City in Iraq for 10 years[61].
- Medical Park Hospitals Group established and equipped the Al Shifa Hospital in Mogadishu, Somalia[62].

[57] Details about personnel arrangements can be found at http://www.saglik.gov.tr/TR/belge/1-37951/somali-mogadisu-egitim-ve-arastirma-hastanesinde-gorevl-.html
[58] http://www.tika.gov.tr/haber/pakistanda-recep-tayyip-erdogan-hastanesi-faaliyete-gecti/1368
[59] http://www.milliyet.com.tr/kabil-ataturk-cocuk-hastanesi-hizmete-ankara-yerelhaber-409568/
[60] http://www.dailystar.com.lb/News/Lebanon-News/2014/Oct-04/272944-sidons-mayor-apologizes-for-failure-to-open-turkish-hospital.ashx
[61] Details of these initiatives are available from the following websites:
http://www.saglikaktuel.com/haber/acibadem-saglik-grubundan-yurtdisinda-iki-hastane-16284.htm
http://www.acibademinternational.com/about-acibadem/
http://www.acibadem.com.tr/AcibademKurumsal/tanitim
[62] http://www.medicalpark.com.tr/web/5-26959-1-1/medical_park_-_tr/medical_park/haberler/medical_parktan_somaliye_shifa_

- Medicine Hospital opened its first hospital abroad (Medicine Hospital International Kosovo) in Pristina, specialising in cardiology and cardiovascular surgery[63].
- Dunyagoz Hospitals Group, an eye-care specialist providing healthcare services in six clinics abroad (the Netherlands, Germany, United Kingdom, Georgia and Belgium[64]).
- Batigoz (West Eye Hospitals), again an eye-care specialist with three branches abroad (Bucharest in Romania, Arbil and Sulaymaniyah in Iraq[65]).
- Nigerian Turkish Nizamiye Hospital was built with the support of Turkish entrepreneurs and First Surat Group which is an active education company in the country[66].
- Delta Trade Company-Acendis is a commercial agency undertaking turnkey hospital projects abroad and also selling maintenance services to hospitals[67].

[63] http://www.medicinehospital.com.tr/kosova-medicine-hospital-hakkinda-oku.html
[64] http://www.dunyagoz.com/hakkimizda/hakkimizda.html
[65] http://www.batigoz.com/en/branches.html
[66] http://www.aksiyon.com.tr/karakutu-dunya/nijerya-bati-afrika-da-bir-turk-hastanesi-nizamiye_537902
[67] http://www.medikalplus.com/sektor/455-acendis-dtc-yurt-disinda-sekiz-hastane-projesi-tamamladi.html

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Hungary

Health services have been a central and controversial issue for a succession of Hungarian governments since the advent of the twenty-first century. Substantial restructuring of healthcare provision has occurred, often concentrating a series of once regional powers into central administration. Whilst per capita healthcare expenditure is comparatively low when considered alongside other European countries, healthcare expenditure as a proportion of GDP, at 8%, is close to the average for the region (OECD, 2014). Perhaps more noteworthy is the fact that despite the difficult economic climate post 2007, Hungarian healthcare expenditure has continued to grow. Indeed Hungary was the only OECD country with below average GDP or expenditure growth through the financial crisis to maintain healthcare expenditure growth (OECD, 2012; 2014). Such investment manifests itself in reasonably high concentrations of medical personnel as a proportion of the population (OECD, 2009; 2013; 2014). Despite this, there is evidence to suggest that the investment in and importance of healthcare services has not entirely benefitted Hungarian citizens. Hungary has one of the highest rates of out-of-pocket healthcare expenditure (as a proportion of household expenditure) within the OECD, a stark divide in terms of access to doctors when comparing rural and urban regions, and the second highest levels of unmet medical needs (behind Poland) amongst OECD countries (OECD, 2013).

With regards to the export of health services Hungary can justifiably position itself as a health and medical tourism market leader in both the historic and more contemporary sense. A long history of wellness tourism, particularly to spa and bath regions of Hungary, has increasingly formed part of a national strategy to brand Hungary as a health and medical tourism centre. As illustrated in figure 3, Hungary, along with other countries in Central and Eastern Europe has extremely high levels of health service exports as a share of health expenditure alongside an annual growth rate in such exports of 14.5%.

There is scant evidence of any export activity of note that would be categorised under GATS Modes 1 and 3 and whilst there has been some evidence of a ‘brain drain’ of Hungarian healthcare professionals (which can be considered as Mode

4), Hungarian exports almost wholly fall within Mode 2. Whilst out-of-pocket medical tourism is the dominant form of export, there are other forms of mobility evident. In particular the Hungarian government have been particularly active in supporting the ratification of the EU Cross—border Directive and attempting to increase knowledge, understanding and use of the provisions therein.

The Hungarian government has been particularly active in supporting the development of patient mobility-based health service exports especially related to dental and wellness tourism, placing medical tourism and patient mobility at the heart of a number of government initiatives and in turn creating or further endowing a range of agencies or ministries:

- Széchenyi plans – The first Plan (2001-2004) established the importance of medical and wellness tourism to the Hungarian economy. This was further entrenched by the 'New Plan' (2011-2020), which placed health tourism at the heart of its strategy for 'Healing Hungary'.
- National Tourism Development Strategy (2005-2013) – Identified health tourism to be a potential area for product development.
- New Hungary Development Plan (NHDP) (2007-2013) – This plan highlighted the importance of health and medical tourism, in particularly wellness tourism, to regions such as the South Great Plain region and the Central Tansdanubia region.
- Ministry of National Resources – Oversaw issues ranging from health to social security. Identified health tourism as a central revenue generator.
- Magyar Turizmus Zrt (Hungarian Tourism Association) – places wellness tourism at the heart of its marketing.
- Nemzeti Fejlesztési Ügynökség (National Development Agency) – Oversees the NHDP as well as the 'Healing Regions' programme
- Orvosi Turizmus Iroda Zrt (Medical Tourism Bureau) – Established in 2010 to provide support for the disparate medical tourism activities and promote Hungary as a medical tourism 'brand'.

- Magyar Fogaszati Turizmus Fejlesztesi Programiroda (Hungarian Dental Tourism Development Bureau) – instituted to support and promote dental tourism in Hungary.

Of particular note is the recent Széchenyi plan (2011-2020) (MNEH, 2010; Kiss, 2012), which builds economic development around seven 'break-out points'. The first of these relates to the health industry, advancing a 'Healing Hungary' programme, at the heart of which can be found health and wellness tourism. It is posited that "this programme intends to provide the Hungarian economy with cutting-edge developments across diverse fields, emphasizing the uniqueness of the country. It will lay the foundation for job creation, higher incomes and an increase in the gross domestic product" (MNEH, 2010).

To facilitate this, the newly established Medical Tourism Bureau has been tasked with facilitating public and private bodies in a range of endeavours:

- In three years to double, in five years to triple, the number of tourists being assisted in travelling to the country and being treated by Hungarian dental care.
- Create 3000 new jobs in five years.
- To stop the outflow of the medical community abroad, and manage to keep 1000 dentists in the country in the next five years.
- To support the country in retaining its leading market share in Europe.
- Help Hungary become this sector's global market leader by the end of 2015

State activity has not been solely inward facing, bi-lateral arrangements exist with a number of countries in order to provide emergency health cover and many of these arrangements reflect deeper cultural, economic and political relationships, which might pave the way for arrangements covering other forms of medical care.

Through the Switzerland-Hungary cooperation a 'Healing Regions' programme has been developed. In some ways this represents Mode 3 export from

Switzerland, but in reality the Swiss presence amounts to little more than initial funding. The programme seeks to promote medical tourism in the North and North West of Hungary (FDFA, 2014) and does not establish any partnership between Swiss and Hungarian business.

Hungary has also sought to utilise political alliances and roles to champion the cause of patient mobility as well as promote the Hungarian 'brand'. During Hungary's Presidency of the Council of the European Union the issue of patient mobility was placed firmly on the agenda, with strong Hungarian support provided for the EU Cross-border Directive. Hungary actively sought to highlight the importance of patient mobility and health tourism as an economic growth strategy (Réthelyi, 2010), in particularly for those countries in the Central and Eastern European region.

Similarly, during Hungary's Presidency of the Visegrad (V4) Group (2013-14) cooperation and support for patient mobility initiatives was advanced. During the Hungarian Presidency, the Visegrad Group (Hungary, Czech Republic, Slovakia and Poland) was being actively marketed, largely through trade shows, as the main health and medical tourist destination in the region, rich in natural thermal and healing waters (Visegrad Group, 2014).

Whilst there is strong government support for medical tourism across the whole of Hungary, it is the fields of wellness tourism and dental tourism, especially in Budapest and the North of Hungary in which the most concerted effort can be found. Hungary has for some time commanded a reputation as the dental tourism leader, though it is facing serious commercial pressure from neighbouring countries. It is estimated that between one in two and one in three of all Austrians travel to Hungary to meet their dentistry needs (Liedig, 2002; O'Neil, 2006) , but whilst Germany, Austria and other countries in the immediate vicinity are the source of many dental tourists seeking treatment in Hungary, patients are also travelling from more distant European locations.

Hungary is the fourth most popular destination for UK medical tourists, behind France, Poland and India (Lunt et al., 2014), and a review of web sites marketing dental services to English-speaking medical tourists found that Hungarian clinics dominated online dental tourism marketing (Horsfall et al., 2013).

Hungary is then a leader in terms of medical tourism in Europe with scope to expand, however other health service exports are undeveloped and there appears to be no obvious strategy to address this. Given the strength and extent of the Hungarian government's support of the medical tourism industry as a prop for wider economic growth, this lack of development of other exports possibly suggest that it is not felt that such exports are likely to have substantial impact on the domestic economy.

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Greece

With the exception of a small number of countries, the modern phenomenon of medical tourism as opposed to the more historic patterns of travelling for healing and convalescence, gathered pace in the first few years of the twenty-first century. In many countries these 'early years' largely involved small, individual enterprises marketing directly to consumers, or in some instances, diaspora communities. The development of national medical tourism associations, often allied to supranational bodies gathered pace after 2005. Trade fairs became more common and many national medical tourism markets, as well as the global medical tourism industry began to take shape. Greece's experience was in many ways not dissimilar; with a reputation as a wellness location already established without any concerted efforts at marketing health tourism, a location at the heart of Europe but also close to North Africa and the Middle East, comparatively lower costs in relation to other EU countries, and a tacit implication of some degree of quality assurance vicariously extending from EU membership, Greece was seemingly well placed to take advantage of the rising popularity of medical tourism.

At the time of Europe's medical tourism 'take-off' (2004-2007) Greece could boast consistent and relatively promising numbers of visitors accessing medical or wellness treatments. At this stage the Greek market provision to international patients was based on medium and small medical private practices, rather than the public hospital system. Small practices, where one or two doctors work together use their facilities for most treatments, as well as private hospitals for treatments that require full anaesthesia were common. To comply with regulatory frameworks surgeons used private hospitals' facilities for surgeries with limited scope to 'rent' space in public hospitals as happens elsewhere.

At this time Greece was considered a destination for travellers from all across Europe seeking a diverse range of treatments including general wellness, dialysis services, fertility treatment, dental treatment and cosmetic surgery.

As with many countries, these independent businesses began to form loose associations and through these and along with external activity, prompted government engagement with the issue. In January 2007, the Greek Government outlined a programme for 'The National Strategy for Health and Social Solidarity' with the plan to obtain the following targets for the period of 2007-2013:

- Improve some specific kinds of tourism (by supporting investment projects for the development of the medical tourism).
- Create medical centres in hotel facilities or near to hotels for patients, especially diabetic and kidney patients.
- Create tourist resorts for the care of disabled people.
- Develop physical rehabilitation centers for the care of Greek and foreign patients, by utilizing the weather conditions of Greece.
- Promote the expertise in specific fields of the health services in order to establish Greece as an expert in these fields by the South-Western European countries or even the whole world. (IKNI, 2012).

Unlike many other countries however this activity did not build real momentum and government involvement remained superficial. The reasons for this can be traced to the onset of the global financial crisis, with which Greece suffered more than any other OECD country.

Whilst social expenditure as a proportion of GDP has remained steady throughout the crisis, this masks a fall in Greece's real spending and real GDP (OECD, 2012). Greece has witnessed the highest levels of negative growth in per-capita health expenditure during the crisis (an average annual growth rate of -11% between 2009 and 2011) whilst also seeing health expenditure as a proportion of GDP also fall (OECD, 2014). This has manifested in rising costs (especially for dental treatment) as well as a plateauing of the hitherto rising proportions of doctors and healthcare professionals to service the population. Greece is one of the only OECD countries to experience this, which set against rising demands placed on all OECD countries' health systems, has severely reduced the capacity of the Greek healthcare industry to cater for international patients.

This is not to say that Greece ceased to be a destination for medical tourists, rather the impetus remained with smaller, private enterprises. Unlike other countries, Greece did not build on the momentum apparent in 2007. That said, Greece has levels of health service exports (as a share of health expenditure) in excess of countries such as the UK, US and Canada, as well as a growth rate 3.3% (OECD, 2014).

The last two years have however seen an increase in activity, not only from private providers, but also the government. In December 2013, the ministers of Tourism and Health services spoke about their cooperation at the 'Medical Tourism in Practice' event held at the Hellenic Chamber of Hotels. Here an institutional framework for the development of medical tourism in Greece was introduced, involving close cooperation between the ministries of Tourism and Health (GTP, 2013a).

Despite the recent state involvement, the government's objectives remain modest and there is an acknowledgement of specific barriers and limitatations to a burgeoning medical tourism industry in Greece and Greece's establishment as a medical tourism leader. In particular there is acceptance that Greece faces a substantial amount of work to ensure that the country's medical and tourism sectors meet international standards. It is felt that to achieve this legislation, synergies, agreements and exchange of expertise and scientific staff of Greece with other countries is essential. As such, the Greek government seeks only to combine leisure travel to Greece with medical care, mainly for mild medical incidents (GTP, 2013b). This is reflected in the way medical tourism is marketed on official government platforms, with the only obvious mention being a section about wellness tourism on the national tourism website for Greece.

Despite these relatively modest aims, the Greek government has extended support for the medical tourism industry to public providers, organising seminars that seek to highlight possible strategies for recruiting foreign patients and taking care of them (Tovima, 2014). Whilst public hospital involvement in medical tourism is in its infancy, there are examples of big public and university

hospitals such as The University General Hospital of AHEPA in Thessaloniki providing services for and marketing them to, international patients (HR-MoH, N.D).

Bi-lateral arrangements are gradually being developed with government support in order to not only increase trade but also establish Greece as a centre of excellence for certain services.

One such arrangement has emerged from The Greek Society for Reproductive Medicine, which in collaboration with the respective Romanian company organised the 'Human Reproduction-New Technologies' conference in Romania during the September of 2014. Ministers of Health from both countries were present and the Romanian Health Minister committed to the formalization of a partnership. Under this arrangement the Romanian government undertakes from 2015 to support financially (for the first IVF cycle) Romanian couples in order to travel to Greece so as to access fertility treatment (OnMed, 2014).

The conference also saw the establishment of partnerships between Greek and Romanian universities, with arrangements put in place facilitate knowledge transfer between universities in Athens and the University of Bucharest, involving e-learning opportunities for Romanian healthcare professionals and medical students (OnMed, 2014).

Greece is still struggling with the ongoing financial crisis and this has clearly stifled what was an emerging medical tourism market. Recent efforts however suggest that such a market is thought to be of potential value and as such has attracted government support. Largely this has been for medical tourism activities, but there are some examples of other forms of health service export.

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Section 6
Healthcare export developments in Switzerland, Norway and Sweden

Switzerland

In 2008 the OSEC (Office Suisse d'Expansion Commerciale – Swiss Office for Commercial Expansion) and Suisse Tourisme founded 'Swiss Health'[68] in order to support Swiss companies working in the health sector to develop their potential abroad. This potential is based on perceived high-quality treatment, political security, tourism experience and infrastructure, and high-quality communication and transport. The OSEC and Suisse Tourisme have charged SWIXMED AG[69] to run the association. The company has expertise in the organisation of Swiss medical treatments for foreign patients. Every year the company oversees patients from more than 30 different countries (Communiqué de presse 2008).

According to the 2011 Euromonitor International report, the medical tourism sector in Switzerland should reach one billion Swiss francs in 2015, an increase of 20% in comparison to 2010. Potential clients are usually from Russia or China, but also include the Middle East. Kosmina comments that Chinese clients are particularly interested in animal-cell treatments practices by health and wellbeing centres such as the Clinique La Prairie in Montreux. Medical tourism in Switzerland generally concerns wealthy clientele attracted by the political stability of the country, its 'legendary discretion' and high quality technology and training of Swiss doctors (Paillard et al., 2013). This reputation seems to be increasingly important for cosmetic treatments and surgery (Douez, 2012). George Frei, Head of Swiss Health, asserts that there is an increase in demand for plastic surgery and reconstructive surgery, especially following breast cancer treatments or after accidents. Anna Kosmina, Head of the Rayan Partners Agency, suggests that potential patients are attracted by the Swiss approach to cosmetic care as Swiss surgeons attempt to 'hide' the interventions by making

[68] http://www.swisshealth.ch/en/index.php
[69] http://www.swixmed.com

them look natural as opposed to North American surgeons, and it is easier to ensure the quality of services (Douez, 2012). Private hospitals such as the ones in Lausanne, Berne and Geneva attract patients for procedures such as medical spa treatments, cosmetic surgery, IVF treatments, neurosurgery, obesity surgery and orthopaedic surgery (Voyage Médical, 2014). Switzerland is popular for its thermal tourism, notably thanks to its numerous thermal sources such as Loèche-les-bains, Ovronnaz or Saillon (Paillard et al., 2013).

In 2013, a group of health professionals from the CHUV (Vaudois University Hospital Centre) and some representatives of the Department of Health and Social Action (DSAS) met medical professionals and authorities from the University Hospitals of Nanjing and Zhenjiang in China. This meeting allowed the professionals to define some potential partnerships, especially around paediatrics and the organisation of hospital care for patients. The doctors will visit partner hospitals. Moreover, the CHUV is interested in Nanjing hospital expertise in traditional Chinese medicine, which represents an opportunity for the training of Swiss doctors (Arcinfo 2013; Canton de Vaud 2013).

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Norway

Norway has the highest per-capita public health expenditure across the OECD and is second only to the US in terms of total per-capita health expenditure (OECD, 2013). Similarly it has one of the highest ratios of doctors to population and nurses to population, both significantly higher than the OECD average. Since 2008, Norway has had one of the highest growth rates in public expenditure on health (OECD, 2014b). Seen as a high-quality healthcare system with universal coverage provided through taxation and a modest insurance scheme, Norway has undoubtedly got a strong product to be marketed. In particular Norway has a reputation for cutting-edge fertility treatment and radiology services.

Despite this, Norway has little presence in the emerging health export market, which is perhaps a reflection of the lack of active marketing by either public or private bodies. Focusing first on medical tourism, public hospitals and clinics have no medical tourism marketing presence on the internet. This may reflect the fact that those who do travel to Norway do so to access 'high-end' procedures. It may be that typical forms of marketing are less useful here than networks and even word-of-mouth. However, it is telling that none of the four regional health authorities make any reference to international patients on their websites. Nor do any of the trusts for which the authorities act as an administrative umbrella. Many of the individual hospitals do not even provide web content in any foreign language, and those that do carry only basic information. At the provider level, then, there appears to be little marketing of services to international patients from within the public health providers. This lack of public sector marketing of health services reflects a broader silence from within national and sub-national public bodies. No legislation, policy reports, or even public speeches by politicians have made direct reference to medical tourism in the past three years. There is not even passing reference to wellness activities on the government-maintained tourism portal. The state is simply not advertising itself as open for business.

Beyond the public sector, a range of private facilities exist. Here there is some activity but again, even private facilities are not actively marketing services to

international patients, especially when compared to similar clinics based in Central and Eastern European countries. There was some media coverage of private facilities attempting to market themselves to an international – largely UK – audience (Leafe, 2008; Simpson, 2009; The Scotsman, 2009). The suggestion at the time was that many of the private clinics had previously held government contracts for the delivery of health services, however the election of a left-of-centre government in 2009 saw many of these contracts not renewed or even revoked. As such private clinics had the capacity to market to an international audience. The UK, especially Scotland, was identified as offering potential owing to the waiting times in public hospitals, public concern about MRSA, and high costs in private clinics, as well as the increased provision of low-cost air travel between the UK and Norway.

The tentative expansion of services for international patients coincided however with the deepening of the European economic crisis and medical tourism slowed. One of the pioneers, SCANHEALTH Scandinavia, which was actively marketing itself to UK patients in 2008, scaled back its international patient portfolio and is only now considering actively pursuing the market. No obvious marketing appears on the website, rather visitors are informed that the clinic is only 90 minutes from UK airports.

Beyond medical tourism Norway's export of health services is equally muted. We found no formal statements made by leading politicians, no pieces of legislation, no headline bi-lateral agreements and ultimately very little by the way of commercial presence. Rather, the Norwegian integration with the global health market is largely one of humanitarianism. A range of hospitals as well as the 'peace corps' (Fredskorpset) engage in a range of export form non-commercial purposes, providing oversight, financing and management of facilities through Africa. Similarly, formal relationships with Russia and Moldova involve Norwegian support in improving primary health, notably in tackling HIV and tuberculosis.

2013 saw Oslo host the 38th World Hospital Congress and the issue of health service export, most prominently medical tourism, was widely debated (IHF, 2013). As yet this does not seem to have catalysed any direct activity.

Norway has the reputation, infrastructure and diplomatic relationships to potentially support greater export of services through all GATS Modes. As yet it has done little more than dip its toe in the waters of medical tourism.

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Sweden

As with its Scandinavian neighbour Norway, Sweden has high levels of public expenditure on health, both as a proportion of GDP and in per-capita terms. There are a relatively high number of both doctors and nurses per 1,000 of the population and as with Norway, the majority of Swedish health expenditure is financed through public sources (OECD, 2014b).

The similarities between Norway and Sweden do not end there; Sweden does not demonstrate high levels of health exports in OECD statistics, though these do not take into account commercial presence abroad and the services exported to out-of-pocket medical tourists are high-end, with the purchasers motivated as much by quality as by cost. Sweden has a reputation for delivering a high-quality health service and this is potentially very marketable. In terms of medical tourism, fertility treatment in particular is popular, whilst prosthetics is an emerging specialism.

Unlike Norway, Sweden has made some attempts to promote greater levels of health service exports including those beyond medical tourism, both through public and private activity and the public support of private activity. Perhaps the most obvious manifestation of this is SWECARE:

> *a unique platform where academia, public and private sector join forces toward enhanced export and internationalization of Swedish health care and life science. SWECARE acts as a door opener for companies and organizations looking to access ministerial speaking partners, business contacts or collaborators* (SWECARE, n.d.).

SWECARE is 50% owned by the Swedish government and its primary objective is to market the Swedish healthcare system and Swedish healthcare companies internationally.

It is important to note that whilst there are similarities between this and other national strategies employed elsewhere (Turkey in particular), the focus is on establishing Swedish commercial presence, of either state-owned or private

companies, in foreign healthcare markets rather than on medical tourism. In addition, especially where public entities are involved, an element of 'aid' is usually built into the commercial strategy.

SWECARE represents an association of private companies, public hospitals, government ministries and other stakeholders and underscores the national nature of Sweden's health-export strategy. It is difficult to assess the success of this strategy in terms of revenue; however Swedish healthcare has been exported far and wide, from Ghana to Poland and Eastern Europe, to the UAE. Examples of this diffusion include:

- The Sweden Ghana Medical Centre, primarily a cancer care and treatment centre based in Ghana and overseen by Swedish management (SGMC, n.d.)
- The Medicover centre. Based in Warsaw, this large clinic offers a range of treatments to domestic and international patients, but reflecting its Swedish part-ownership and the high proportion of company executives from Sweden, actively targets Swedish medical tourists. With facilities in Poland, Romania, Germany, Ukraine, Belarus, Moldova, Bulgaria, Turkey, Serbia and Georgia, Medicover boasts that it is the largest private sector employer of medical professionals. It is not, however, solely medical-tourism focused, also delivering occupational health services, diagnostic services and charitable, aid services (Brignall, 2014; Medicover, n.d.).

This strategy is not confined to supporting private businesses abroad. In Sweden it is the county councils that deliver the medical care to the citizens in the county and the domestic dominance of the public sector is reflected in its centrality to Sweden's health service exports. Many examples of Swedish diffusion into foreign markets involve solely or primarily public entities. Examples include:

- SymbioCare: founded by the Swedish Government it purports to do 'health by Sweden' beyond the borders of Sweden. Directly marketed to foreign healthcare providers, often national governments, its objective is 'to make your healthcare system meet the medical needs of tomorrow'.

The primary export of Symbiocare is expertise and management (Symbiocare, n.d.).

- Sahlgrenska I.C.: This county council-owned company, besides offering health care, has an agreement with the Icelandic Health Insurance Authority (Sjúkratryggingar Íslands) on performing all organ transplants (Sahlgrenska I.C., ND).
- Skåne Care AB.: This county council-owned company offers heathcare to international patients. It also markets itself as a leading centre for diabetes research and care, as well as a world leader in terms of nurse training and education. One particular partnership with a range of universities saw Skåne Care carry out a diabetes education programme at the Fatima College of Health Sciences, UAE (Skåne Care AB, n.d.).

Sweden clearly aspires to build upon an already entrenched strategy of exporting health services. Whilst this is likely to continue its path of packaging Sweden as a world class health system to be exported en masse, there has also been increased interest in medical tourism to the extent that May 2015 will see Stockholm host the Scandinavian Medical Tourism Conference.

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Afterword

The nature of health service exports in Europe is complex, with a wide range of processes evident. Whilst medical tourism dominates much of the discussion, research, and in many countries, activity, it represents only one form of health service export. In financial terms it is less significant than other forms of export, especially those involving the export of management structures, expertise, and often a 'brand' or reputation.

As outlined in this report and elsewhere, medical travel of international patients to developed health systems (including UK, Germany, United States and France as well as regional hubs in the Middle East and Africa) focussed on innovation, reputation and quality has long been evident. In what marked a transition from this Phase I to Phase II of medical travel, there emerged between 2004 and 2007 a global debate concerning opportunities and risks of new forms of medical travel. Focussed on cost and emphasising the possibilities of long-distance travel and new market entrants, this Phase II development was labelled as medical tourism. Healthcare providers and health-related services targeting such markets were frequently supported by their national governments through formal strategies and marketing plans. Phase I and Phase II activities began to co-exist within regional and global settings – and whilst competition for travelling patients is increasingly intense, the regional nature of medical tourism means that providers do not necessarily compete for the same pool of patients.

Given the continued development of medical tourism throughout the financial crisis that has pervaded Europe, it seems inappropriate to label medical tourism as a transient or passing phenomenon; Phase II medical tourism is happening to ever increasing degrees supported by an ever evolving industry. Medical tourism is appealing to many countries, most of which have a rationale for believing that their unique selling points would enable their medical tourism market to prosper, as there are no insurmountable barriers to recruiting medical tourists. However countries seeking to expand their medical tourism activity in Phase II experienced opportunities being all too frequently oversold. In addition, Phase I countries that had previously offered services to international patients

increasingly sought to distinguish their longstanding activities and reputations from the encroachment of new market entrants. For such developed health systems it was also apparent that despite healthcare investment and economic expansion in countries such as China and regions including Middle-East, the traditional international patient treatment model was stymied by modest scope for mobility from such regions.

As a result in Phase III there is a re-strategizing and greater realism around patient flows on the one hand, and attempts to explore the opportunities such countries and regions potentially offer for wider system exports on the other. These latter activities focus on the wider health system expertise that underpins treatment: facilities, clinical services, equipment, system knowledge and expertise, Research & Development, training and education.

It is the deeper trade patterns often driven by a shared history and culture that are home to the extremely high value market in health service exports. That is not to say that such a process is straightforward. However the complex relationships and the intricacies of regulatory and legal frameworks needed to support the export of other health services is a much more difficult barrier to overcome. As some countries had begun to experience in Phase II, no amount of investment will counterbalance a lack of historical, political, or cultural relationships, or the lack of an international reputation for quality.

There are then different models of health service export marketing, which often represent strategies aimed at capturing different forms of health service export. Not only do those wishing to increase their health service exports need to identify an appropriate marketing strategy for the type of service they wish to export, they must also establish themselves as an 'insider', largely through reputation or relationships. This can be extremely difficult.

Analysing the export of health systems also moves beyond the confines of social and public policy analysis. Whilst many European countries identified here engage in collaboration with overseas countries for humanitarian reasons there

are also strong trade or diplomatic agendas. Health diplomacy and mechanisms of soft power are clearly evident across the range of country activities reported within this review.