ผลกระทบของข้อเสนอสิทธิผู้ป่วยในการแพทย์ข้ามเขตแดนของสหภาพยุโรป ต่อการท่องเที่ยวเชิงการแพทย์ในประเทศไทย

นาย ศักดา ฉันทนาวานิช

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาศิลปศาสตรมหาบัณฑิต
สาขาวิชายุโรปศึกษา (สหสาขาวิชา)
บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2552

THE EFFECT OF THE EUROPEAN UNION'S PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE INITIATIVE ON MEDICAL TOURISM IN THAILAND

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A Thesis Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Arts Program in European Studies
(Interdisciplinary Program)
Graduate School
Chulalongkorn University
Academic Year 2009

Thesis Title	THE EFFECT OF THE EUROPEAN UNION'S PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE INITIATIVE ON MEDICAL TOURISM IN THAILAND
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Field of Study	European Studies
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ศักดา ฉันทนาวานิช: ผลกระทบของข้อเสนอสิทธิผู้ป่วยในการแพทย์ข้ามเขตแดนของสหภาพยุโรปต่อการท่องเที่ยวเชิงการแพทย์ในประเทศไทย. (THE EFFECT OF THE EUROPEAN UNION'S PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE INITIATIVE ON MEDICAL TOURISM IN THAILAND) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: อ.ดร.ชันทาล แฮร์เบอร์โฮลสส์, 214 หน้า.

วิทยานิพนธ์ฉบับนี้มีเป้าหมายในการหาผลกระทบของข้อกำหนดว่าด้วยการบังคับใช้สิทธิผู้ป่วยในการแพทย์ข้ามเขตแดน ต่อการท่องเที่ยวเชิงการแพทย์ในประเทศไทย โดยการวิเคราะห์การเปลี่ยนแปลงของปัจจัยผลักดันผู้ป่วยจากสหภาพยุโรปให้ใช้บริการทางการแพทย์ภายนอกสหภาพ และ ปัจจัยดึงดูดผู้ป่วยจากสหภาพยุโรปเข้าสู่ประเทศไทย ในเดือนกรกฎาคม 2551 คณะกรรมธิการยุโรปได้เสนอข้อกำหนดดังกล่าว โดยมีเป้าหมายการดำเนินงานนโยบายในสามด้าน ซึ่งก็คือ คุณภาพและความปลอดภัย กระบวนการข้ามเขตแดน และความร่วมมือในระหว่างประเทศในระดับสหภาพยุโรป ถ้าข้อกำหนดนี้ ผ่านความเห็นชอบ และมีผลบังคับใช้ข้อกำหนดนี้จะส่งผลกระทบโดยตรงต่อปัจจัยผลักดันผู้ป่วยออกนอก สหภาพ โดยการแก้ไขปัญหาทางอ้อมให้ผู้ป่วยสามารถไปใช้บริการทางการแพทย์ในประเทศสมาชิกอื่นได้ ปัจจัยดึงดูด ในทางตรงกันข้าม จะไม่ได้รับผลกระทบ เพราะผลกระทบจะมาในรูปแบบของการเปลี่ยนแปลงการตอบสนองต่อปัจจัยดึงดูดของผู้ป่วย

วิทยานิพนธ์ฉบับนี้พบว่า ข้อกำหนดนี้มีผลกระทบที่แตกต่างกันไป ขึ้นอยู่กับกลุ่มผู้ป่วย และประเทศนั้นๆ โดยรวมแล้วผู้ป่วยสามารถใช้บริการการแพทย์ในประเทศสมาชิกอื่นได้ง่ายขึ้น แต่ว่าปัญหาของแต่ละประเทศที่เป็นเหตุทำให้ผู้ป่วยต้องใช้บริการทางการแพทย์ภายนอกสหภาพนั้นยังคงอยู่ และส่งผลให้ปัจจัยผลักยังคงมีผลกระทบอยู่ ปัจจัยดึงดูดจะได้ผลกระทบในส่วนของความพร้อมในการให้บริการ ซึ่งเป็นคู่กับปัจจัยผลักดันระยะเวลาการรอการรับบริการ กลุ่มผู้ป่วยจากประเทศมาที่ใช้บริการในประเทศไทย และมีปัญหานี้มาก คือ เยอรมนี สวีเดน และสหราชอาณาจักร ผู้ป่วยจากประเทศเหล่านี้อาจมาใช้บริการในประเทศไทยน้อยลง อย่างไรก็ตาม โดยรวมแล้วผู้ป่วยจากสหภาพยุโรป จะยังคงมาใช้บริการทางการแพทย์ในประเทศไทยต่อไป เพราะว่านักท่องเชิงการแพทย์ยุโรปนั้น มาประเทศไทย เพื่อที่จะท่องเที่ยว และรับบริการทางการแพทย์

สาขาวิชา ยุโรปศึกษา ..... ลายมือชื่อนิสิต .....

ปีการศึกษา 2552 ..... ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก .....

5287575520: MAJOR EUROPEAN STUDIES
KEYWORDS : CROSS-BORDER HEALTHCARE / MEDICAL TOURISM / TRADE IN HEALTH SERVICE / THE EUROPEAN UNION / THAILAND

SAKDA CHANTANAVANICH: THE EFFECT OF THE EUROPEAN UNION'S PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE INITIATIVE ON MEDICAL TOURISM IN THAILAND. THESIS ADVISOR: CHANTAL HERBERHOLZ, Ph.D., 214 pp.

This thesis aims to investigate the possible effect of the European Commission proposed Directive on the Application of Patient's Rights in Cross-Border Healthcare on the medical tourism of Thailand through the push and pull factors. Issued in July 2008, the Directive has three working areas: safety and quality, cross-border scheme and European cooperation. If implemented, the Directive would have a direct effect on the push factors that drives EU patients to receive healthcare outside of the community by allowing indirectly solving the problem of the system through allowing patients to receive care in another Member States. The pull factors of medical tourists to come to receive treatment in Thailand, on the other hand, will be affected by change in the responsive of the European medical tourists to the pull factors. Through the analysis of the push and pull factors, the effect of the Directive on the Thai industry will be determined.

The findings of this thesis are that the Directive will have different impact on the push factors depended on the population group and the countries. Overall, the cross-border movement will be facilitated because of the scheme established and the European co-operation. Some patients will gain more confidence. However, the Directive does not solve the inherent problems of the system, which cause the push factors to be strong. The pull factors, on the other hand, remain largely unaffected. Only in the area of immediate availability that responds to the waiting time will be affected. Particularly, the number of patients from countries with this problem, which are Germany, Sweden and the UK, will partially decrease. The industry will remain overall strong as European medical tourists that come to Thailand come for both travel and treatment.

Field of Study : European Studies Student's Signature [signature]

Academic Year : 2009 Advisor's Signature [signature]

ACKNOWLEDGEMENTS

Throughout the Masters of Arts in European Studies (MAEUS) programme at Chulalongkorn University, academic year 2009, there have been ups and downs, time of merriment and time of predicament. Despite the hardship and sweat-lost, there is no obstacle unconquerable due to the helps and supports of beloved professors, friends and family:

To my thesis supervisor Dr. Chantal Herberholz, whose perspicacity has elucidated my thinking and evoked the hidden gems within the subjects. Most indebted gratitude to her trust and guidance.

To Assoc. Prof. Dr. Chayodom Sabhsari and Assoc. Prof. Dr. Sauwakon Ratanawijitrasin with sincere gratitude for their time, kindness and pinpoint recommendation.

To all the interviewees for their time and insight, which make this thesis complete. Special thanks to Dr. Ungoon Chantanavanich.

To all the venerated Professors at the MAEUS programme for their inspiring teaching, which motivated me to pursue this subject matter.

To all the MAEUS staffs for their constant support and their belief in me: Jiraporn Choorat and Vanpima Kounsuwan.

To all the friends at MAEUS programme for their trust, forgiveness and tolerance. To Pavaphon Supanantananont, who has been in the same boat with me through out the process pushing me not to be succumbed to all the dire elements and to accomplish this thesis in timely manners.

Last but not least, to all the members of the family who are always there with unrelenting encouragement, understanding and good food!

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CHAPTER I
INTRODUCTION

1.1 Background Issues

In searching for healthcare, specifically better healthcare and cheaper healthcare, patients may be required to go abroad. For European citizens, neighbours may be a good option. However, the process of cross-border healthcare should be clarified. As one of the attempt to facilitate and harmonize European cross-border healthcare, the European Commission proposed in July 2008 the Directive on the Application of Patients' Rights in Cross-Border Healthcare. Despite the intention of the Directive to facilitate the flow within the Community, the impact does not restrict itself within the Union. Thailand, as one of the major medical tourism hubs, could be affected by the change in European patients' behavior in choosing to receive healthcare outside of the Union as induced by the Directive. The question posed in this thesis is how would the directive change the push factors and could the pull factors of Thailand continue to attract the European patients.

The European continent has long been a major point of destination as well as a point of departure of medical tourists. It was well known that American patients often fly to West Germany for cheaper and better operation. But what would the German doctors do once the Americans decide to change their destination to the closer South America? What if the Britons were to prefer to skip their long domestic waiting list and jump on a long-haul flight to Asia or to the newly admitted European Union (EU) member states such as Poland the Czech Republic for an instant operation, how would the system deal with that? Europe is known for its good healthcare insurance system. Some of which are cross-border allowing European citizen to reclaim the medical bill in foreign countries. But is the system good enough to compete with the emerging alternatives? How would the EU member states and the EU as a whole deal with this issue? Although there are so many interesting questions, not many have been explored and answers. The aims of this research will be to look the specific issues concerning the links between European cross-border healthcare and Thailand's medical tourism will be explored.

The unique and sensitive nature of the healthcare service industry, however, curbs the level of freedom. As the industry plays a leading role in maintaining welfare of

its citizen, state is thus obliged to wield its controls and regulate the industry.* The scarcity of health service could lead to a detriment of a nation during a pandemic breakout. On the other hand, the oversupply of health services could lead to excess competition resulting in malpractices and consumer's deception. The problem of information asymmetry intrinsic to the nature of healthcare service makes patients vulnerable to receiving extra treatments and purchasing excess services and medicines. These are some of the problems that must be considered in discussing healthcare service. Government must make a decision and direct the industry into the paths suitable for the country's ethos and long-run economic prosperity.

From the formation of the European Community to the present semblance of the European Union, the European continent has manifested itself as a more united and integrated region. The resulted common market of the EU as driven by the systematic legal spill over makes no exception of the relatively sensitive area that is traditionally governed by member states such as the healthcare sector. Due to the necessity to harmonize European social policies, the 2008 Renewed Social Agenda aims to combat the changing nature of European social welfare. As part of this agenda, the Directive on the Application of Patients' Rights to Cross-Border Healthcare was adopted as to provide a framework for safe, high quality and efficient cross-border healthcare.[1]

The proposal for the Directive on Application of Patients' Rights regarding cross-border healthcare was released on 2 July 2008. The proposal was to solidify and specifically legalize patient's rights as part of labour mobility in the four freedom of the production factors movement: goods, service, labour and capital. Once applied, the directive would eliminate future legal cases concerning rights to seek healthcare in other

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* Henderson, on the other hand, aptly implies both positive and negative ramifications of heath deregulation: "Deregulation has resulted in an explosion of facilities and practices previously considered unthinkable. The use of ambulatory surgery centres has risen, as has the construction of physician-owned clinics and hospitals. More physicians are advertising, more practices offer evening and weekend hours, and some physicians are even making house calls." While leading to the proliferation of services, which positively increases the level of access to healthcare and forms incentive to innovate and improve their services, deregulation negatively leads to the debate on ethics and business. In some culture, doctors play a role of a benevolent saint working for the sake of humanity. In reality, they are earthly human susceptible to daily consumption as well as greed and materialism. Some of them are shrewd businessmen being inventive in ways of moneymaking. The balance between the two is thus critical to the image and survival of health industry. Henderson, James W, Health Economics & Policy (Mason: South-Western Cengage Learning, 2009), 10.

[1] European Commission, Renew Social Agenda [online], 6 November 2009. Available from: http://ec.europa.eu/social/main.jsp?catId=547

member states. The directive on services in internal market in 2006 does not include health service as on of the sector. Nevertheless, with a number of legal cases requesting for rights of reimbursing healthcare cost in other member states. The European Court of Justice (ECJ) gives rulings confirming healthcare services as economic activity and thus requiring that the Community law is applicable to this activity.[2]

As a politically and nationally sensitive sector, the liberalization and integration of European healthcare sector is faced with fierce and rancorous debate along the process. A number of amendments have been made to seek compromise among Members of the European Parliament and Member States. On 23 April 2009, the European Parliament adopted the Rapporteur's report after over 80 amendments. The most recent update on the directive is on 2 December 2009. The Council could not reach a common position on the scope and the definition of the Directive. The countries that oppose the legislation are Spain, Portugal, Poland, Greece and Romania.[3] Some countries still have reservation regarding the burden of costs incurred on their national system as high as 2 Billion Euros.[4] On the other hand, some has called for the inclusion of public health protection into the proposal.

Three main objectives of this draft Directive are as follows:

- To outline common principles of how healthcare should be delivered in EU member states to ensure safety and quality of the care;
- To set a specific framework for patients' rights to seek healthcare in another member state; and
- To provide a framework for cooperation between healthcare systems of the Member States. Included areas are such as e-health and health technology assessment.[5] [6]

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[2] Further information on pertinent ECJ cases can be found in detail: Hatzopoulos, Vassilis, The ECJ Case Law on Cross-Border Aspects of Health Services [online], 20 January 2010. Available from: http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_ecj_en.pdf

[3] European Cancer Patient Coalition, Cross-Border Healthcare: Failure to reach political agreement on draft directive [online], 5 January 2010. Available from: http://www.ecpc-online.org/newsletter/member-updates/252-122009-crossborder.html

[4] Assembly of European Regions, Cross-border healthcare services [online], 5 January 2010. Available from: http://www.aer.eu/main-issues/health/cross-border-healthcare-services.html

[5] Vassiliou, Androulla, Proposal for a Directive on the application of Patients' rights in cross-border healthcare - Press Conference on Patient's Rights in Cross-Border Healthcare [online], 6 November 2009. Available from: http://ec.europa.eu/healtheu/doc/crossborder_vassiliou_.pdf

[6] NHS European Office, Consultation, A European health service?: The European Commission's Proposals on cross-border healthcare [online], 20 January 2010. Available from: http://www.nhsconfed.org/Publications/Documents/european_health_service.pdf

The proposal clearly aims at creating equal opportunity to all patients in the EU. However, in reality it remains doubtful whether this Directive can achieve that. According to the original draft proposal, patients can receive reimbursement toward the costs of treatment in another EU Member States that the patient is entitled in the home country. The reimbursement is limited to the cost of the same treatment in the home system. The home system will be responsible for such treatment cost. However, the reimbursement does not cover travel, accommodation and other expenses that would not incurred if patients are treated in the home country. The Directive clearly aims at supplementing freedom labour mobility in that they are entitled to costs of home treatment abroad. Whether this is fair for patients abroad depends on the amount of the reimbursement. If treatment cost in the home system is little compared to that of the host country, patients would have to pay the difference in costs themselves while their co-workers who are citizens of the host country are entitled to full reimbursement. However, not all services are available for reimbursement, only the home system has the rights to declare if such services are available for their citizens or not. Therefore, the home system can restrict the reimbursement and reduce the impact of the over-utilization of the service abroad. This will be done through prior authorization system. Under such scheme, patients have to make a request for treatment abroad before they can receive such treatment. Two criteria governing the prior authorization system are that the treatment must require an overnight stay in a hospital and the outflow of patients does not pose serious risk of undermining the planning or financial balance of the system. It must be noted that this Directive does not have an effect on the European Health Insurance Card (EHIC) scheme, which allows EU citizens who travel to another EU state to receive emergency or immediately required treatment under the same conditions as patients of the host countries. This scheme, introduced in 2004, remain side by side with the newly established scheme, as it is give access of healthcare for the unplanned care. While the Directive covers planned care, the EHIC covers the unplanned.[7]

What would this means to the medical tourism industry is that some of the money going into this industry would be from the public sector not the medical tourist themselves. More people would look for medical treatment in another Member States creating the possibility of over-crowdedness in countries where the standard of the care

[7] Ibid.

is higher, such as Germany, France, and Scandinavian countries.[8] However, what kind of procedures are being cover remains in debate at this stage of the legislative process, the final stage of the proposal would determine the level of integration.

This community framework will lead Europe into a more integrated environment whereby the EU citizens could utilize healthcare in member states that is not of their own nations in a fair and regulated way such that it would an integrated European healthcare network slowly replacing individual national system. Inequalities in European healthcare both within and between Member States should be rectified as to prevent the worsening of the inequalities.

The pattern of patients' movement would, as a result, shift in response to the services available in other member states. If costs incurred are less and benefits received are more than those in home country, logically, patients would travel for foreign health services whether inside or outside the EU. Nevertheless, logical economic thinking does not solely influence the decision-making process of choosing medical services. As illustrated in a number of literatures, there are other factors in the equation as well: the nature of the illness or the treatment, the need for close observation, the distance from home, etc. If the services take the form of medical tourism, the tourism factors would be counted. Irrational behaviour and personal preference will complicate the equation further. While the Directive neither specifically nor directly induce the change in such behaviour when it comes to choosing tourism and travelling, the Directive could influence their selection of destinations via the medical part to remain within the Union as they have rights to cross-border healthcare and reimbursement for the utilisation of care within the Union. Therefore, the Directive could represent a form of regional discrimination as the scheme induces more trade within the Union, but not outside.*

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[8] European Public Health Alliance, Directive on Patients' Rights in Cross-border Healthcare [online], 3 January 2010. Available from: http://www.epha.org/a/2878

* On a worldwide scale, the general framework for healthcare service is governed by the World Trade Organization (WTO) rules: General Agreement on Trade in Services (GATS). In analyzing the GATS and health service, David Luff characterized the GATS as "total flexibility." The preamble of the GATS explicitly states that nations still retain the rights to regulate services as to preserve national interest and conform to national policy. Despite the intended raison d'être of the WTO as a trade liberator, trade in services remains mostly nationally regulated. Therefore, not only has the EU the rights to their autonomy through the provided flexibility, it also has the rights to form its own bubble leaving the rest of world outside if it chooses to do so. Penetration, thus, becomes the keyword to success in medical tourism and trade in health service in the EU single market. Luff, David, World Bank and Oxford University Press, Domestic Regulation & Service Trade Liberalization: Regulation of Health Services and International Trade Law (2003), 191.

Thailand, whose medical tourism industry benefits from the inflow of European patients, might be suffered by this discrimination. With its relative novelty and its extensive linkages with tourism, the medical tourism is a niche industry that only certain privileged countries with certain and sufficient pull factors could possess. While any countries can have the internationally recognized level of medical care and accredited title, they do not have the excellence of Thai hospitality inherent to the Thai people nor the tourists' attractions unique only to Thailand. The cooperative synergy between the tourism and the healthcare sides is the key to the vividly vibrant potency of the medical tourism industry. Some of them include direct pluses such as the financial gains, the importation of foreign technology and the rapid development of medical community as a response to the transformation of the industry. Other implicit benefits are the overall awareness to this industry as well as to the importance of health in general.

Thailand, as one of the major medical tourism hub, cannot rely solely on its competitive advantages as many other countries are trying to catch up and become a leader of the flock. Everyone is looking outward in search for possibility to draw more medical tourists to their countries. Nearby competitors such as India, Malaysia and Singapore constantly reinvents themselves to rise over the others. Coupled with the possible effect of the Directive, the Thai medical tourism industry could suffer tremendously as Europeans constitutes a significant portion of foreign patients in Thailand.

With the prospect of the Directive on the Application of Patients' Rights to Cross-Border Healthcare Patients' Rights coming into force, uncertainty abounds. Whether the Directive would encapsulate the European Healthcare industry remains debatable. The proposal of the Directive still undergoes an amendment process subjecting to compromise. It may or may not come into force. How should the Thai medical tourism industry react if the Thai industry would like to tap into the European Union? Does the Thai industry want to react?

1.2 Research Questions

Based on the framework of the European Commission's proposed Cross-Border Healthcare Directive and its possible effect, the general research question of this thesis would be:

- What are the effects of the European Union's Cross-Border Healthcare Initiative on the Thai medical tourism industry?

However, to narrow down the scope of this research and explore the related aspects as guided by the general question above, the following questions should be considered:

- How would the Directive induce or detract European Union public healthcare service receivers from selecting healthcare service outside of the community i.e. the push factors?
- Are the Thai pull factors of medical tourism susceptible to such effects?
- Should the Thai industry react to the Directive? If so, on which area should the Thai medical tourism industry focus in order to attract more medical tourists from the European Union?

1.3 Research Objectives

- To assess the effects of the European Union's Cross-Border Healthcare Initiative based on the existing European healthcare system and the cross-border healthcare schemes on the push factors.
- To make a link between European medical tourists through the push factors with the Thai medical tourism industry through the pull factors.

1.4 Motivation

The medical tourism industry, despite its novelty, has generated a substantial amount of revenue for Thailand. The industry has an inherent intertwined linkage with the tourism industry, which is one of the major industries in Thailand. If the medical tourism industry prospers, the tourism industry will prosper as well. Thailand as a well-established travel destination should perceive the medical tourism as an opportunity to boost the tourism industry.

In 2005, approximately 1.3 million of foreign patients utilized the Thai medical industry. The revenue created was over 30 billion baht. Of all patients from around the world, European constitutes for a significant portion of 16% of all foreign patients, which is tantamount to over 200,000 patients.[10] Of all European patients, half is estimated to be medical tourists, who had the intention before travelling to utilize healthcare services in Thailand. These medical tourists form an interesting group why do they choose to do so. Some decides to remain in their home countries, while some decides to go abroad.

The proposal of the Directive on the Application of Patients' Rights to Cross-Border Healthcare by the Commission, if adopted and implemented, will create a change in European healthcare system. Citizens of the European Union will have legitimate rights under a specific framework to go to another Member States for medical treatment. Uncertainty abounds as to how the Directive would affect the decision-making and the movement of the European medical tourists. This Directive could become a threat to medical tourism in other regions. Since European medical tourists constitute a significant portion of all medical tourists to Thailand, it is therefore worthwhile to investigate the implications of this Directive.

1.5 Benefits

This study will be beneficial to the understanding of medical patients from the EU. Why do they go abroad? Are the attempts of the European Union and its Member States a failure that their citizens have to go outside of the Community for healthcare? This thesis will provide an up-to-date situation of the European healthcare system and the prospective change in EU cross-border healthcare after the implementation of the Directive on the Application of Patients' Rights in Cross-Border Healthcare.

This understanding can be used to form a medical tourism link between Thailand and Europe. By identifying the change in the European push factors, the Thai industry could create or alter responsive pull factors.

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[10] Suraphong Amphanwong, Thai Government Policy and Support still lacking to truly support Thailand's position as Asia's Medical Hub (interview report, translated by Dephi Health Services) [online], 10 January 2010. Available from: http://www.business-in-asia.com/medical_tour/medical_interview.html

Through its emphasis on the European side, this research would serve as an example for the study of regional medical integration's effect on third party. Such studies are, for example, the impact on the decision making process of the patients within a region where medical integration happens and the change in competitiveness of the region after the integration.

1.6 Hypotheses

The European Union's Directive on the Application of Patients' Rights in Cross-Border Healthcare, after its implementation, will detract some citizens of European Union from using medical tourism services in Thailand as more European citizens will be able to use their rights through the cross-border scheme established by the Directive. However, the degree of effect will depend both on the extent of the scheme and the efficiency of the system as at both the national and European levels. The nexus of Thai medical tourism industry will be an influential determinant in the decision making process in choosing Thailand as their destination for medical tourism.

1.7 Scope of the Study

The Directive on the Application of Patients' Rights in Cross-Border Healthcare is designed to facilitate cross-border healthcare within the European Union. Despite the inward looking aspect of the Directive, its effects are not limited within the Community. This study aims at investigating its effect on medical tourism in Thailand. In doing so, it is important to cover and analyse a number of elements of the European healthcare system and its cross-border healthcare scheme, while on the Thai side the coverage is much smaller. Due to the lack of information on the European side, this thesis prioritises the European side in an attempt to demystify the push factors and connecting them to the Thai pull factors.

In the first part of this thesis will provide the overall picture of European Healthcare system with an emphasis on the cross border healthcare scheme in order to derive the push factors. The scope of the study in this section includes the following elements: authority over healthcare, reasoning for cross-border in the EU, European healthcare structure as well as the Directive and its impact. The analysis framework will be based on the original draft Directive proposed in 2008. Nevertheless, the progresses and the amendments are provided and taken into consideration. However, their effects

would not alter the effect of the original proposal on the push factors much. While there are many cross-border healthcare schemes in the EU, only the formal European-wide cross-border healthcare scheme will be of focus. This means that the focus will be on the public sector. European private sector as well as private insurance will not be discussed in detail.

Vice versa, the second part, which is on the Thai medical tourism industry, will be focussed on the private sector. The public sector will be of less importance. Only when the policies or the effect of public sector is on the pull factor would the public sector or the government be discussed.

In discussing cross-border healthcare and medical tourism, there are multiple possibilities of services coverage. The scope of health services entails a high range of possibilities through organic development of profit making process. From outsourcing of CT-scan reading to traditional spa offered as part of Ayurvedic Therapy, its synergies and linkages seem limitless. Despite the extensive linkages of the medical tourism industry, to limit the scope of study as to pertain to direct effect generated by the Union's legislations concerned, only the links and factors affecting the medical tourists' decision-making in choosing medical tourism in Thailand. Therefore, only the factors affected will be analysed on the basis of the effect on Thai industry to answer the following question: Are the pull factors of Thai medical industry susceptible to the change in push factors as transformed by the Commission's legislations?

This research, therefore, focuses mainly on the Mode II of international trade in service as devised by the World Trade Organization in the GATS. Mode II, which is generally referred to as consumption abroad, in this context of medical tourism basically refers to the use of service whereby the service recipients travel to receive such services in other countries.[11] The general sense of the terminology "medical tourism" should be redefined. Foreign tourists who happen to utilize medical service during their stay in a foreign country without former intention to utilize such service before leaving their home country are neither counted nor considered in this research. Expatriates are also not considered, as they nevertheless need medical attention on usual basis. The holistic coverage of the term "health tourism," which covers all health-related activities, will not be used and considered in this research. The example of the non-related areas is the

[11] Janjaroen, Wattana S., Siripen Supakankunti, Health Services Systems and the Consequences from the General Agreement on Trade in Services (GATS) (Faculty of Economics, Chulalongkorn University, 1999)

wellness sector, which includes sports and spa industry. On the other hand, the following sectors, which directly involve doctors, hospitals and medical treatment, will be covered: elective treatment such as physical and dental check-up, LASIK; cosmetic treatment such as plastic surgery, orthodontics; and curative Treatment such as cancer treatment, hip replacement and heart surgery.

1.8 Limitations

Limitations, however, abound. Firstly, there is no direct academic literature available. For example, there is no comprehensive analysis of the European Healthcare system. It was only in 2007 that the European Union has 27 Members States. 27 nations account for the difficulty to summarize and predict the future trend; this is not only because merely the number accounts for 27 different individual systems, the constant changes and dynamic transformation of the systems also make it merely wasteful to freeze the time and analyze the system at a time without keeping up with the changes and looking forward. Due to the contemporariness of the Directive, there are very few literatures available. The Directive is designed to improve the internal movement of cross-border healthcare. Therefore, there is no impact analysis and literature on to external parties.

Generally, literature on medical tourism suffers a lack of academic and trustable data due to the newness of the subject of the data. The High level Group on Health Care Services of the European Commission also stated that there is a need for comparable data on patient mobility.[12] In a number of sources, many authors on the subject have to resort to the use of data from newspapers, magazines and the Internet articles as basis of their analysis. Their validity should always be questioned and scrutinized. Data on mode II patients also do not exist as a separate category. Furthermore, direct data concerning medical tourism and medical tourist are not available or sometimes not publicly available, whether the reason is the sensitivity, the privacy or trade secret. Surveys and questionnaires are also very limited. The data is also not categorised with a specific goal of understanding planned medical tourism. In fact, there is no harmonised system of data

[12] High Level Group on Health Services and Medical Care, Health and Consumer Protection Directorate-General, European Commission, Summary paper on Common principles of Care, from the Mapping Exercise of the High level Group on Health Care Services 2006 [online], 26 December 2009. Available from: http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/high_level_wg_003_en.pdf. 2.

collection in healthcare. Even the number in the EU-wide cross-border healthcare scheme is not comparable. As part of the concerned Directive, one specific proposal is the establishment of data collection method, so that the data can be used and analysed to form policy and make decision.

CHAPTER II
LITERATURE REVIEW

In considering the subject of cross-border healthcare within the European Union, the proposed Directive on the Application of Patients' Rights in Cross-Border Healthcare epitomizes the upcoming trend of medical integration, medical tourism and trade in health services. However, before approaching the Directive and cross-border healthcare, it is important to understand the concept of healthcare as services, the context in which healthcare should be provided as well as its current situation.

This research, in connecting the European cross-border healthcare and the Directive with the medical tourism industry of Thailand, attempts tackle both the European and the Thai sides. However, priority must be given to the European side, as there is not much available on the subject. On the other hand, there are a number of articles on Thai medical tourism industry, which is sufficient to establishing the pull factors. Therefore, in this literature review, much will be on the Thai side.

2.1 Commodification and Tradability of Healthcare

This thesis is based on the concept of healthcare is being tradable. Hence, it is important to look at why healthcare is has become part of market products. Without this understanding, healthcare will remain its humanitarian picture, which is in sharp contrast with the present state of healthcare industry, especially the private hospital sector, and thus would resist its status as one type of services.

In considering the medical tourism as a service, according Chee Heng Leng in *Medical Tourism in Malaysia: International Movement of Healthcare Consumers and the Commodification of Healthcare*, commodification of health service is often referred "to the increasing use of the market to organize the provisioning of healthcare services in society."[1] In the general sense of meaning, commodification refers to the becoming of commodities that are "produced, … in factory-like circumstances, … for sale, … on a

[1] Leng, Chee Heng, Medical Tourism in Malaysia: International Movement of Healthcare Consumers and the Commodification of Healthcare (Asia Research Institute, National University of Singapore, 2007), 5.

commercial market."[2] Healthcare service is thus considered as a product, patients as consumers, doctors as service providers, and hospitals as markets. Ultimately, satisfaction for money becomes the engine of the system. The accompaniment of distant relationship, therefore, ensues diminishing the notion of doctor as helper of humanity.

While healthcare commodification is "inextricably linked"[3] to the growth of the healthcare market, tension between healthcare as commodity and humanitarian offer must be balanced as to gain success in medical tourism. Medical tourism embodies not only the service but also hospitality as commodities. Hospitality intrinsically hovers over the line dividing personal and distant relationship. Relationship of doctor, nurses and hospitals with patients are essential as to gain trust and attract patients. The notion of the commodification of medical tourism should therefore be questioned. While market establishes a portal and entices patients to enter to the purchasing world, close relationship between two sides makes the deal happen.

Another necessary foundation of this thesis is the concept of healthcare being tradable. The specific meaning of healthcare services in this thesis is on the consumers making consumption abroad, i.e. patients travel abroad to receive medical care. Mattoo and Rathindran in "Does Health Insurance Impede Trade in Health Care Services?" identify two important factors of consumers that deters healthcare from being traded, i.e. misconceptions about medical tourism. These two factors, which are termed by Mattoo and Rathindran as myths, are the inability to travel of the sick and the low quality of healthcare in developing countries.

It may be true that some medical treatment requires treatment in the home countries. These types of treatment are mostly the ones requiring immediate treatment such as accidents or when the patients are not capable of travel. There are many other treatments that time is not an important factor and patients can travel. In fact, the care in some countries might be slower than going to another country because of the long waiting list. In 2004, there were more than 41,000 patients in the UK under the National Health Service (NHS) in need of surgeries that have to wait as long as six months or

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[2] Schaniel, William C and WC Neal, Quasi commodities in the First and Third Worlds (Journal of Economic Issues, 33(1): 95-115) Quoted in ibid.

[3] Pellegrino, Edmund D, The commodification of medical and health care: The moral consequences of a paradigm shift from a professional to a market ethic (Journal of Medicine and Philosophy, 24(3), 1999: 243-266, 252. and Keany, Michael. "Are patients really customers?" International Journal of Social Economics, 26(5): 695-704) Quoted in ibid., 6.

longer in order to receive operation. The NHS had to fly some of these patients to neighbouring countries such as France, Spain and Germany for treatments such as eye surgery and orthopaedic and otolaryngological procedures.

It is, however, necessary to export their patients to developed countries for the reasons that the quality can be guaranteed. The two authors firstly argue that in the United States the proportion of foreign-educated doctors is as high as 25%, which is roughly tantamount to 213,000 doctors and the proportion has been increasing over the years. A number of these doctors are from the countries where medical tourism is promoted such as India, Cuba, Korea and Germany. Secondly, hospitals nowadays are standardized globally. International accreditation such as the Joint Commission International (JCI), an international division of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a leading organization in certifying hospitals in the US, provides a quality benchmark guaranteeing their level of standard. In a number of leading hospitals in the medical industry, their facilities and equipments are of the state-of-art. The quality and success rate of treatment is also magnificent. The Apollo hospital chain has a success rate of over 99% of over 50,000 cardiac surgeries, a success rate rarely achieved. If the plan for medical tourism is planned and the hospital is chosen carefully, patients can receive better care at better rate than treatment at home.[4]

2.2 3As Healthcare Indicator: Availability, Affordability and Accessibility

While looking at the specific industry itself, it is important not to neglect the general notion of overall healthcare evaluator in order to have a conclusive overview of the industry. Healthcare evaluator should be considered from both the moral and the economic point of view. From a moral side, healthcare should be available, affordable and accessible. Kirtiputra, in *European Healthcare Trends and Thai Medical Tourism*[5], defines each as follows: Availability refers to the adequacy of standard treatment i.e. the know-how. Affordability refers to price-level of the treatment. And accessibility refers to the immediacy of health services. However, the notion of availability should be slightly modified as to also cover the availability of medical personnel and facilities. Merely

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[4] Mattoo, Aaditya and Randeep Rathindran, Does Health Insurance Impede Trade in Health Care Services? [online], 20 March 2010. Available from: http://www.wds.worldbank.org/servlet/WDSContentServer/

[5] Kirtiputra, Trip European Healthcare Trends and Thai Medical Tourism (The interdisciplinary department of European Studies, Graduate School, Chulalongkorn University, 2006)

know-how cannot satisfy the medical needs of the public mass. These three As should be considered in measuring the success of any healthcare system.

2.3 Origin and Definition of Medical and Health Tourism

Less than fifty years ago was the notion of flocking sick western patients to developing countries situated in a different hemisphere hardly imaginable. Such a ludicrous idea being hospitalised in countries where basic sanitary system is lowly available would not register well with those who travelled to the past exotics that took days to travel. It was the rich from developing countries to travel for the care not obtainable domestically. Nowadays, the situation has flipped: Escaping high-priced medical care, western medical tourists forsake domestic care opting for an alternative at a more economical rate plus great hospitality and a vacation to exotic tourist attractions. Globalisation together with the push and pull factors, which includes prices, quality of care-taking, healthcare system capacity and many others, have changed considerably over a few decades. This new medical tourism industry has induced a change in both global and domestic healthcare environment. There are opportunities for the industry to exploit as well as obstacles to overcome.

The industry is still evolving and experiencing rapid growth. It was estimated that the medical tourism industry generated as much as US$ 60 billion globally in 2006 and is experiencing high growth of around 20 percent per year.[6] McKinsey & Company estimated similarly that in 2004 the industry's revenues was more than US$ 40 billion and will reach US$ 100 billion by 2012.[7]

Kirtiputra identified the problem of healthcare system with the clash of socio-economic classes in receiving medical treatment. While the rich have access to all, the poor on the other hand are constrained by economic means and government's aids. Arising together with urbanization and development is the middle class, whose choices can be made upon local or abroad healthcare, thus the medical or health tourism is born.[8] This concept is utterly illogical. First, medical tourism can be classified in economic

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[6] MacReady, Norra, "Developing Countries Court Medical Tourists," The Lancet (June 2007): 1849-1850.

[7] Herrick, Devon M., Medical Tourism: Global Competition in Health Care, National Center for Policy Analysis, NCPA Policy Report No. 304, Nov 2007 [online], 25 January 2010. Available from: http://www.ncpa.org/pdfs/st304.pdf

[8] Ibid., 5-6.

terms as a type of trade in service. It did not start because of the need for alternative choices of the middle class consumers. Any consumer who can afford the service has the rights to that service. Economically speaking, the rich have the rights to cheap and good healthcare. There are also circumstances where medical tourism is beneficial to this group of consumer. For example, a rich lady in her fifties travels to South Africa to get a face-lift and come back with a youthful look. While her excuse may be enough of relaxation and fresh air, the real reasoning is to hide her swollen face from her friends during the recuperation period. The poor can also opt for medical tourism as an option for them in case of astronomical price of health in the home country. Some medicines cost considerably less in foreign countries due to the exception in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) that allow poorer countries to produce certain drugs cheaply. Some procedure is cheaper due to the prevalent and expertise of that countries' doctors. This is such as sex-change operation in Thailand, even though this is not the procedure for the poor. The second problem lies in the definition of health and medical tourism. While health tourism refers to a larger coverage of services, medical tourism refers to a more specific coverage of medical services, mostly involving doctors and hospitals. It does not always refer to the utilization of health services in other countries due to the cheaper costs. Therefore, costs as choices are wrong. Consumers can choose on various bases such as specialization, better medical attention, or travel trips after their surgery. There are many factors included in the decision process. Some of them are illogical and irrational, quantitatively immeasurable. It might be true as stated in his research that price is the most important determinant in choosing to receive medical care abroad. However, it should be taken into account that under certain circumstances of failing healthcare system, medical tourism is the only options.[9]

[9] The notion of prices as an important factor is confirmed by Sangkakid's study. Sangkakid, Jittra, A case study of German tourists' expectation relating to Thai medical tourism, based on Aachen residents (Chulalongkorn University, 2006)

2.4 Demand and Motivation for Medical Tourism

Bookman and Bookman, in *Medical Tourism in Developing Countries*[10], generalize the determinant factors of demand for medical tourism into two categories: demand in general and demand in one particular country. The demand in general refers to common determinants, which all consumers have toward medical tourism. Four determinants in this category include income, taste, propensity to medical tourism and expectation. Income determines what kind of service they would purchase. Taste refers to many subjective factors such as preference for travel, privacy and immediate gratification. Propensity to medical tourism points specifically to the ability to receive medical and health service abroad far away from the medical tourists' home countries. Lastly is the expectation about economic situation and prices such as their personal income after receiving treatment and the expectation about prices of the treatment both at home and abroad. The second category, the demand in one particular country, includes cultural affinity, distance, specialization and reputation. Cultural affinity refers to the connections between the service demander and supplier, which maybe their ethnicity and religion. Close connection between two parties would make the tourists more comfortable. Distance plays an important role in attracting medical tourists within the proximity. However, it must be realized that with the change and development in airline industry, distance may be defied. Since patients often look for the best doctor, specialization is an important factor for medical tourism. Thailand, for instance, was known for gender reassignment or simply sex-change surgery. The last determinant, reputation, deals with news and information. If there is a case of medical malpractice resulting in a death of a patient who happens to be a celebrity, the hospital may be severely affected and tainted by bad reputation.

These factors, in the author's opinion, constitute a number of major determinants for demand of medical tourisms. There are nevertheless factors such as marketing strategy, particularly its tie with medical tourism agency. As pointed out by Bookman and Bookman, this industry is subjected under quasi-perfect information or looking from another side asymmetric information with the Internet providing endless information from consumers to read. Already inherent within the healthcare and pharmaceutical industry, consumers do not have complete understanding of what and

[10] Bookman, Milica Z. and Karla, Bookman R., Medical Tourism in Developing Countries (New York: Palgrave Macmillan, 2007)

why they purchase or consumer these particular products and services. Medical tourism is similar in that they make choices on incomplete information. Travel agents may feed them information that might please them only. This goes as well for Internet where only good sides are presented. Therefore, how information is portrayed and delivered affect the demand for medical tourism tremendously.

Sangkakid, in her study of the medical tourists from Aachen, Germany[11], took consideration in her research the motivation for travel and the buying decision process in tourism theory. While personal subjectivity constitutes a large portion inherent to the motivation and decision making process, there are common factors shared by groups of persons. In Gilbert's Model of consumer behaviour referred to by Sangkakid, four factors that dictate consumer behaviour are: socioeconomic influences, cultural influences, reference group references and family influences. If common factors of each group can be identified and they cover a substantial group of population, these factors could be a supplement to the push and pull factors in the analysis. However, due to the scope of the research that focuses on the effect of the Directive on the push factors that instigate or drive citizens of the EU to receive healthcare outside of the Community, these influences with the exception of the socioeconomic one would be largely irrelevant to our discussion. The socioeconomic influence that will be used in this thesis includes income and education as in awareness of health.

2.5 Medical Tourists Typology

In determining who is medical tourist and who is not as well as their number, there is no common category prevalently used. More pessimistic is that there is no differentiation when it comes to the notion of medical tourists as long as they are foreigner who utilize medical or health services. The difference between medical tourism and health tourism has already been explained briefly earlier. Erik Cohen in "Medical Tourism in Thailand"[12] devised a typology of medical tourists based on purpose and utilization of medical services as follows:

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[11] Ibid.

[12] Cohen, Erik, "Medical Tourism in Thailand," in Turk-Kazakh International Tourism Conference 2006 on new Perspectives and Values in World Tourism & Tourism Management in the Future, 20-26 November 2006, Alanya, Turkey, (Antalya: Alanya Faculty of Business, Akdeniz University, 2006)

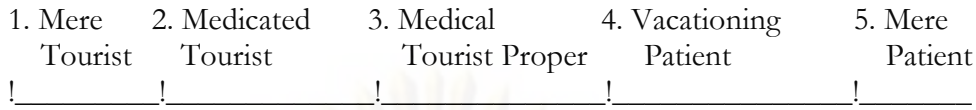

Figure 1 - Typology of medical tourists
Source: Cohen, (2006).[13]

A Mere Tourist refers to tourists who do not utilize any medical services during their travel in the host country; *A Medicated Tourists* are tourists who receive medical treatment due to incidental need of medical attention during their trip, including accidents; *A Medical Tourists Proper* travels to the host country to receive medical treatment as well as to travel. Whether the decision to receive treatment is made prior to or during the trip does not matter; A Vacationing Patient has the initial and main goal of receiving medical treatment, but later decides to take a trip as part of or after their recuperation; lastly, a *Mere Patient* is an individual coming to the host country for the sole purpose of receiving medical treatment and does not take any vacation trip during their stay.

While there is no exact number regarding medical tourists into each category, Cohen observed that Western tourists tend to be medical tourists proper. Patients from the Middle East, on the other hand, are mostly vacationing and mere patients.[14]

In *Medical Tourism in Developing Countries*[15], Bookman and Bookman comment that medical tourists who seek medical treatment in developing countries are heterogeneous. Gender, age and income vary. The authors divide the medical tourists into groups according to their incomes and countries of origin in associating each group with the demanded treatments as illustrated in the table 1 below. Elective invasive refers to the procedure not necessary to maintain good health such as cosmetic surgery. Diagnostic refers to the identification of illness, which could be either as in preventive screening or diagnosis when symptom has already surfaced. Lifestyle treatment refers to spa treatment, yoga and other wellness activities. Low-tech invasive refers to the treatments that do not need high-tech or sophisticated equipments, which could not be available in the poor patients' home countries. Border medical care refers the use of health services in the nearby countries as of convenience or lack of capability to treatment of the home

[13] Ibid., 89.
[14] Cohen, op. cit., 90.
[15] Bookman and Bookman, op. cit., 48.

countries. It is important to realize that the definition of border medical care could have a different connotation in that, for example, the country is rich but still does not want to over-invest due to the small population and availability of healthcare in the neighbouring countries. These countries are such as Luxemburg and the Netherlands.

Table 1 – Medical treatment provided in developing countries according to income and origin of patients

	Rich Patients	**Poor Patients**
from More Developed Countries	Elective invasive, Diagnostic, Lifestyle	Low-tech invasive, Diagnostic, Border medical care
from Less Developed Countries	Elective invasive, Diagnostic, Lifestyle	Border medical care

Source: Bookman and Bookman, (2007).[16]

The categorization, as already implied, however, cannot be applied to the medical tourism and cross-border healthcare in Europe. As the equality and welfare support differs from other regions. Such creates a different structure of medical tourism and cross-border healthcare. Figure 2 provides an example of treatment types received by the customers of the Techniker Krankenkasse (TK), a German insurer. The customers of TK should be categorized as rich patients from developed countries as the insurance policy provides luxury treatment such as spa.

[16] Ibid.

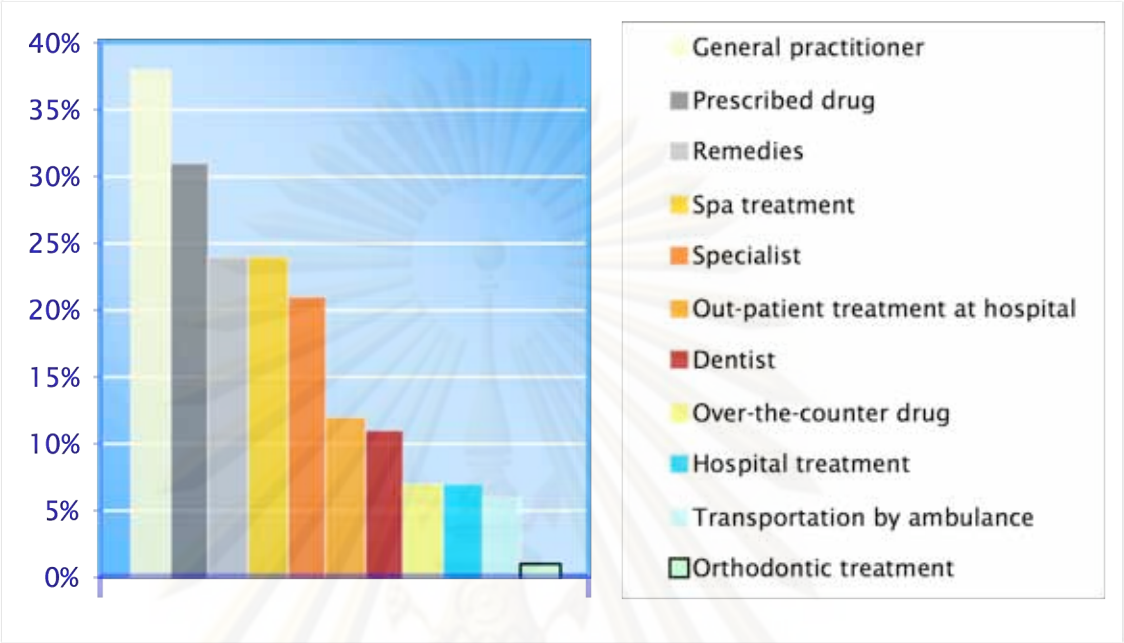

Figure 2 – Types of treatment in other EU countries of TK customers
Source: Techniker Krankenkasse, (2007). [17]

Under the General Agreement on Trade in Services (GATS), they are all categorized under Mode II: Consumption Abroad.* (Table 2) As already stated earlier in the scope of the research, the best possible data available is the number of foreign patients in Thailand, i.e. medicated tourists, medical tourists proper, vacationing patients and mere patients are lumped together.

[17] Techniker Krankenkasse, op. cit., 18.
* Please refer to the scope of this study and limitations for coverage under the GATS categorization.

Table 2 – Categorizing trade in health care in the language of GATS

Mode of Supply	Specific Health Services
Mode 1: Cross-border services trade	o Telemedicine – telediagnosis, surveillance and consultation services; o Electronic care delivery; o Medical education and training; o E-health (products and services available over the internet)
Mode 2: Consumption abroad	o Movement of patients seeking treatment abroad; o Movement of medical students and health professionals studying and training abroad
Mode 3: Commercial presence	Foreign direct investment, cross-border mergers or joint ventures for: o Establishment of hospitals, clinics, nursing homes o Management and insurance
Mode 4: Movement of natural persons	o Skilled health personnel, i.e. doctors, nurses, paramedics, midwives, consultants, trainers, management.

Source: Davis and Erixon, (2008).[18]

The author also would like bring attention to expatriates and retirees living abroad. The author believes that from a financial point of view, some of them should be treated and included as medical tourist while some are not. Generally, the perception is that all foreigners utilizing medical care abroad are medical tourists. However, from another perspective, they can be considered domestic patients. The expatriates' and retirees' needs for healthcare are the needs or convenience to receive treatment to receive treatment in the host country, which puts them in the same situation with domestic patients.

The author believes that the distinction can be made from the source of payment. Economically speaking, medical tourism is trade in health services. Revenue

[18] Davis, Lucy & Fredrik Erixon, The health of nations: conceptualizing approaches to trade in health care, [online], 20 January 2010. Available from: http://www.ecipe.org/publications/ecipe-policy-briefs/the-health-of-nations-conceptualizing-approaches-to-trade-in-health-care-by-lucy-davis-and/PDF

from foreign countries automatically qualifies the payers as foreigners. That is if their social security or private insurance paying for their treatment are their home countries, they should be considered medical tourists. On the other hand, if the payments are out-of-pocket generated from their income generated in the host countries or from the host countries, they should be considered domestic patients. This case of out-of-pocket payment might be controversial as it is almost impossible to distinguish or identify the sources of money.

2.6 European Healthcare System

Throughout the twentieth century to the present, the global as well as European medical industry has gone through a rapid transformation expanding beyond conceivable. Rapid urbanization of rural areas and technological innovation through flows of capital, personnel and technology has levelled the development and medical capability gap existed in the past. The once scattered and uncoordinated health industry in Europe has grown and unified as part of the European integration process. Initially, through the free factor mobility across member states' frontiers, capital, labour, technology and enterprises are able to move as to utilize competitive advantages of each member states.

In Europe, difference in social models lead to difference in healthcare services offered. The social-democratic model of the Scandinavian, the conservative model of the Continental, the liberal model of the Anglo-Saxon and the family-centred model of the Mediterranean[19] together with difference in social insurance programmes of each form contrasting pictures of demands for health service and thus medical tourism. Of course the Nordic model, which offers abundance of social services, would render the demand for medical tourism lower than the liberal model, which gives check to social benefits neglecting social cohesion and isolating the poor.

Considering intra-European medical tourism as a whole, two groups of countries can be identified by their wealth and thus the difference in healthcare system. According to Kirtiputra, the first group is the rich Western European, whose slogan is health for all and common defects are high costs and small private sector. The other group is that of

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[19] Institut d'Etudes Politiques de Lillen, Mardellat, Patrick, European Social Model(s): From Crisis to Reform [online], 8 January 2010. Available from: http://www.cesfd.org.cn/teaching/European%20Social%20Models%20Part%201%20ppt.ppt

the poor Central and Eastern European States (CEES), whose system is plagued with failing healthcare system but whose medical tourism industry is on the rise.

Provided as a model of Western European healthcare system, that of the French is characterized by its state-oriented and inefficiency. Most of the services available are virtually free after refunds. The system of chartered doctors allows all licensed doctors have the rights to public expenditure through prescriptions and doctors' fee. Therefore, the distinction between public and private sectors do not exist. Patients can consult doctors as much as they want without paying a single Euro. The burden, on the other hand, is on the system. Even though the quality is high, the budget always remains red. If the government could keep financing this scheme, there should not be a problem. However, with the prospect of changing demography and the increase of immigrants, who also have equal rights in the system, the French will eventually question their system whether is sustainable and rightful. The possibility of bottlenecks will drive patients abroad as some medical treatment cannot be delayed.[20] The neighbouring CEES are the solution of the problem, with the relatively low price and their propinquity. However, most of the services utilized remain minor. Most of the complex procedures remain at home.

The CEES, despite its rise in medical tourism, is suffering from the failure of overall healthcare system. Most of the population cannot afford basic healthcare. Due to the accession to the European Union, many are forced with "decentralization, privatization and commercialization of healthcare, with rather detrimental consequences…."[21] Escalating costs and desegregation of private sector from most of the population have left the system decrepit. The medical tourism industry in these countries grows with the increasing influx of Western European patients escaping soaring prices.

A case study of German tourists' expectation to Thai medical tourism based on Aachen residents by Jittra Sangkakid[22] provides a substantive confirmation of the push and pull factors identified by many literature through her case study. By focusing her research on German medical tourists from Aachen, a number of insights can be used as a basis for general induction. While Aachen tourists could not embody characteristics of all

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[20] Kirtputra, op. cit., 8-11.
[21] Ibid., 9.
[22] Sangkakid, op. cit.

European medical tourists, they at least represent German medical tourists, which ranks 8th in terms of total foreign patients of Thailand in 2005.[23]

Sangkakid illustrated the picture of Germany as an independent unit unattached to that of the European Union. It may be true that much of the Member States' autonomy on health policy remains largely intact. However, with the increasing exercise of power by the Union and the spillover, this area will eventually be integrated. Nevertheless, the author would like to emphasize the importance of change to the push factor as a result of the change within the system.

In 2004, Germany launched a controversial healthcare reform with an aim to reduce the heavy burden of the medical bills on the government budget. Patients now have to partially pay directly to the usage of the health services and also have to contribute more to the system as the government slashed the subsidy. The coverage of statutory health insurance became smaller. Doctors' and nurses' pays are chopped and they also have to work longer hours. This has resulted in a movement of medical staffs from public into private sector. The efficiency of the system reduces due to the lack of personnel. Patients have to wait longer before they could receive treatment. There is also an increase of medical mistakes and faulty treatment, which substantially ruining the well-accumulated reputation of the German medical care. All of these contribute to the intensification of the push factors. As a result, there is an outflow of patients into neighbouring countries and other medical tourism hubs.

Nevertheless, according to the 2007 survey by Techniker Krankenkasse, a leading German insurance company, the main reasons for planned treatments in other EU countries of their customers, which are mostly German, are greater comfort in treatment (14%) and savings on services for which co-payments required in Germany (13%).[24] (Figure 3) It therefore can be implied that the 2004 healthcare reform, which leads to the

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[23] Other important groups of European foreign patients are from England, France and Scandinavia, which rank 3rd, 10th and 12th in 2005 respectively. The top two are from Japan and the US, respectively. Department of Export Promotion, Thailand, "Foreign patients of Thailand (by country)." Quoted in Suraphong Amphanwong, Thai Government Policy and Support still lacking to truly support Thailand's position as Asia's Medical Hub (interview report, translated by Dephi Health Services) [online], 10 January 2010. Available from: http://www.business-in-asia.com/medical_tour/medical_interview.html

[24] Techniker Krankenkasse, TK in Europe: TK Analysis of EU Cross-Border Healthcare in 2007 [online], 20 March 2010. Available from: http://www.tk-online.de/centaurus/servlet/contentblob/48308/Datei/1695/TK_in_Europe.pdf, 16.

undesirable condition of the healthcare system and the co-payment scheme reducing the use of healthcare in the country.

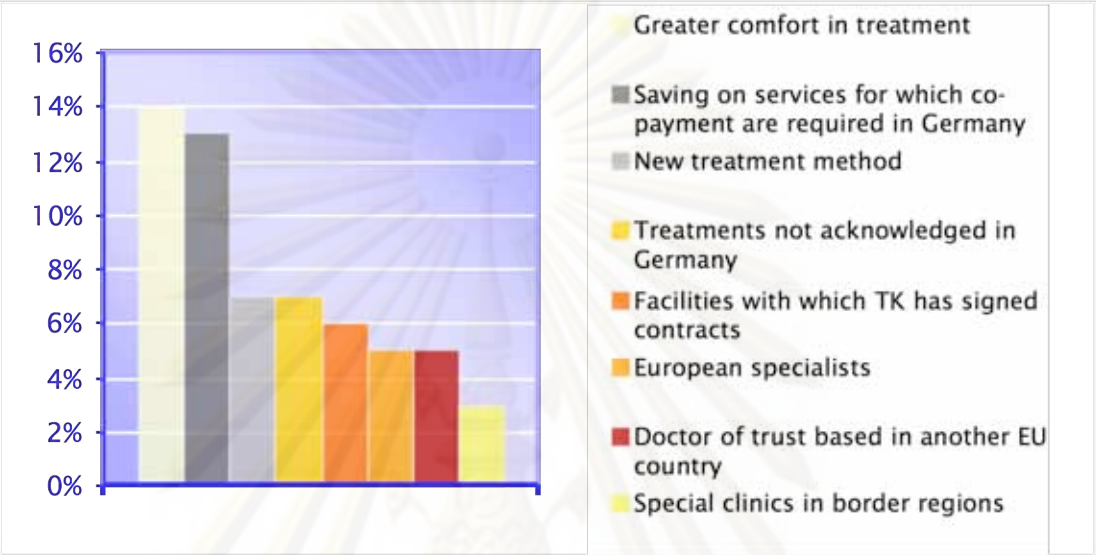

Figure 3 – Reasons for planned medical treatment in other EU countries of TK customers.
Remarks: multiple responses, other reasons: 40%
Source: Techniker Krankenkassen, (2007).[25]

2.7 Medical Tourism Industry in Thailand

It has been less than two decades since Thailand's medical tourism industry has embarked and thriven serving patients from all around the world. Each year over 400,000 medical tourists choose Thailand as their destination.[26] In 2005, there were approximately 12.5 million foreign patients in Thailand.[27] The Kasikorn Research Center

[25] Ibid.
[26] Bookman, Milica Z. and Bookman, Karla R., Medical Tourism in Developing Countries (New York: Palgrave Macmillan, 2007), 3.
[27] Foreign Patients refer to all foreigner utilizing medical services in Thailand, including expatriates and normal tourists. This yields in a much higher number compared to the number of medical tourists. Department of Export Promotion, Thailand. Quoted in Amphanwong, Suraphong, Thai Government Policy and Support still lacking to truly support Thailand's position as Asia's Medical Hub (interview report, translated by Dephi Health Services) [online], 10 January 2010. Available from: http://www.business-in-asia.com/medical_tour/medical_interview.html

had estimated that in 2007 Thailand would gain around THB 36 billion from the medical tourism industry.[28] *

Before the Asian Financial Crisis in 1997, Thailand already has a comparatively high level of health infrastructure as well as high level of access to health service. Tax advantage and influx of foreign investment due to the financial liberalisation led to the accumulation of medical equipment and the proliferation of health services. Once the investment and debt incurred could no longer be financed, the financial reality had hit the sector. A number of facilities were left unutilized due to the oversupply of healthcare infrastructure. Already well equipped with highly qualified doctors and abundance of nurses with renowned hospitality, hospital could deftly mobilize these resources in conjunction with the competitive advantages of the tourism industry to resuscitate the slumping industry by drawing foreign medical tourists and their family into the country. A number of Thai hospitals are now internationally accredited, which indicates the high-level services of international standard. For instance, in 2002 the Bumrungrad International Hospital became the first hospital in Asia to be accredited by the Joint Commission International (JCI), an American international healthcare accreditation service. They are ready to compete internationally in the fierce global medical tourism market.

Medical tourism has become a significant industry of Thailand; not only does it generate substantial amounts of revenue from the utilisation of medical treatment; it also involves the revenues generated from the tourism side as well. Erik Cohen's "Medical Tourism in Thailand"[30] provided a broad yet insightful overview of the medical tourism industry in Thailand. The article provides a number of case studies of bridging hospital and hotel in "hotel-spital" model depicting a vivid illustration of the healthcare industry transforming into the medical tourism industry. Cohen's notion of tourism and

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[28] Kasikorn Research Center, Medical Tourism: Generating more than THB 36 million (Business Brief No.2010, 6 July 2007) [online], 7 January 2010. Available from: http://www.kasikornresearch.com/EN/K-Econ%20Analysis/Pages/ViewSummary.aspx?docid=9504

* According to Entrepreneur, it is stated that in 2008 "foreign patients generated an estimated $6 billion USD for Thailand." That is which is equivalent to almost THB 200 billion. The author could not reconcile the data provided with the 2007 estimation of THB 36 billion. Therefore, it should be chary of the data provided. Entrepreneur, Thailand's Medical Tourism Growth Rate Continues to Increase [online], 10 January 2010. Available from: http://www.entrepreneur.com/prnewswire/release/216164.html

[30] Cohen, op. cit.

healthcare industry is intertwined: without any of the two, the industry could not be successful.

The growth of the industry also is spectacular; it grows at a high-speed rate. (Table 3) Out of the number of all foreign patients, the Kasikorn Research Center estimated that 60% of them are expatriates. According to this estimation, in 2007, out of 1,540,000 foreign patients, 616,000 are foreigners who come to Thailand specifically to receive healthcare. While revenues generated from medical services are expected at THB 16 billion, other revenues are expected at THB 20 billion.[31]

Table 3 – Number of foreign patients coming to Thailand and revenues generated

Year	Number of Foreign Patients	Revenue (Billion Baht)
2001	550,161	-
2002	630,000	18
2003	973,532	26.43
2004	1,103,905	30
2005	1,249,984	-
2006	1,450,000	-
2007	1,540,000	36
2008	1,400,000*	64
2009	2,000,000	-

Source: Department of Export Promotion, (n.a.).[32] Kasikorn Research Center, (2007).[33] Ministry of Public Health, (2007).[34]

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[31] Kasikorn Research Center, Medical Tourism: Generating more than THB 36 million (Business Brief No.2010, 6 July 2007) [online], 7 January 2010. Available from: http://www.kasikornresearch.com/EN/K-Econ%20Analysis/Pages/ViewSummary.aspx?docid=9504

* The drop in 2008 is a result of the global economic downturn.

[32] Amphanwong, Suraphong, Thai Government Policy and Support still lacking to truly support Thailand's position as Asia's Medical Hub (interview report, translated by Dephi Health Services) [online], 10 January 2010. Available from: http://www.business-in-asia.com/medical_tour/medical_interview.html

[33] Kasikorn Research Center, op. cit.

[34] "Picture of Health: Thailand's top hospitals are seeing fewer foreign medical tourists this year but they continue to innovate in other ways," Bangkok Post 17 August 2009): B12.

According to the Bangkok Post, the 1.2 million patients visited Thailand in 2008 and they spend on average THB 200,000.[35] According to the Bangkok Post also, the reported 2008 number of foreigner travelling to Thailand specifically for medical treatment was 1.4 million, a conflicting number. Out of this number, the Bangkok Dusit Medical Services (BGH), which consist of 19 hospitals under the name of Bangkok Hospitals, Samitivej Hospitals, BNH Hospitals and Royal Hospital, served around 700,000 of them. Bumrungrad International Hospital served 400,000 of them. The other 300,000 utilises other hospitals.[36] It must be noted that even though Bumrungrad hospital seems to be the second in this race, it actually is a single hospital; Bumrungrad actually gained the most patients, if the number is tagged individually.

According to Kenneth Mays, senior marketing and business development director of Bumrungrad, out of 1.2 million that Bumrungrad serves per year, 60% are Thais, 10% expatriates and the other 30% medical tourists. However, the revenue generated from this 30% accounts for 45% of the hospital's BTH 8.6 billion revenues in 2008. Currently, the hospital is targeting at the growth markets such as China and the Middle East.[37] BGH's executive vice-president John Lee Koh Shun states the similar contribution of medical tourist to their revenue: even though foreigners account only for 33% of their customers, their contribution to the group's 2008 THB 21.83 billion revenues is 40%. The three leading markets of BGH are the Middle East, Japan and Europe. While the numbers of patients from Australian and China are rising, that of America is dropping.[38] It is estimated that in the end after subtracting all the costs, the hospital in the medical tourism industry will get around 18% of the total revenues.[39]

Dr. Pongsak Viddayakorn, director and executive adviser of BGH, states that Thailand's ability to offer high quality medical services at prices 30-60% lower than those in Europe and America together with the total lower net costs, plane ticket and

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[35] Chinmaneevong, Chadamas, "State backs medical tourism promotion," Bangkok Post, (24 November 2009): B10.

[36] "Picture of Health: Thailand's top hospitals are seeing fewer foreign medical tourists this year but they continue to innovate in other ways," op. cit.

[37] Ibid.

[38] Pitsuwan, Pitchaya, "BGH expects more foreign customer in H2," Bangkok Post (17 August 2009): B12.

[39] Amphanwong, quoted in Nation Multimedia, Thailand: Global Medical Hub [online], 10 January 2010. Available from: http://blog.nationmultimedia.com/print.php?id.=4459

[39] "Picture of Health: Thailand's top hospitals are seeing fewer foreign medical tourists this year but they continue to innovate in other ways," op. cit.

accommodation include, are the reason why patients from abroad should come to Thailand to receive medical care.[40]

Table 4 – Comparison between BGH and Bamrungrad in 2008.

	BGH	Bumrungrad
# of hospitals	19	1
# of foreign patients	700,000	400,000
% of foreign to total patients	33%	30%
% of foreign patients revenues to total revenues	40%	45%
Total revenue	THB 21.83 Billion	THB 8.6 Billion

Source: Bangkok Post, (2009).[41]

Table 5 – Foreign patients of Thailand 2001-2005

Foreign patients of Thailand

(by country)

Ranking	Foreign patients of each year					
	Country/Region	2001	2002	2003	2004	2005
1	Japan	118170	131584	162909	247238	185616
2	USA	49253	59402	85292	118771	132239
3	South Asia	34857	47555	69574	107627	98308
4	England	36778	41599	74856	95941	108156
5	Middle East	NA	20004	34704	71051	98451
6	ASEAN	NA	NA	36708	93516	74178
7	Taipei/China	26893	27438	46624	57051	57279
8	Germany	19057	18923	37055	40180	42798
9	Australia	14265	16479	24228	35092	40161
10	France	16102	17679	25582	32409	36175
11	South Korea	14419	14877	19588	31303	26571
12	Scandinavia	NA	NA	19851	20990	22921
13	Canada	NA	NA	12909	18144	18177
14	East Europe	NA	NA	8634	6728	6120
15	Others	220367	234460	315018	127054	302834
	Total	550161	630000	973532	1103095	1249984

**Information from Department of Export Promotion*

Remarks: the number of patients in 2003 included those having multiple treatments

Source: Department of Export Promotion, (n.a.).[42]

[40] Ibid.

[41] Chinmaneevong, op. cit. and Bangkok Post, op. cit.

[42] Amphanwong, op. cit.

The Strategy + Marketing magazine identified the overall trend of private hospital industry in Thailand as a transition toward specialization and segmentation, while the industry consolidated through merger and acquisition. It is estimated that within 2017, there will less than 10 major hospital groups.[43] Each group has created a sub-brand as to differentiate each brand through specialization. Some of the notable sub-brands are the Wattanosoth Cancer Hospital and Bangkok Heart Hospital under the Bangkok Hospital Group. The number of the players in the Thai medical tourism industry is small. Only 33 out of 218 members of Thai Private Hospital Association have foreigners as their targets.[44] Once the industry has become consolidated, an oligopoly structure in the nation will arise. However, due to the nature of the market and the competition, the market is global and therefore the market state of oligopoly will have a much less effect on the Thai healthcare system as a whole. Nevertheless, this trend does not limit itself within the medical tourism industry; therefore, the rise in price might happen. While the profits from domestic patients may increase, the profits from foreign patients might not. This is because in order to remain competitive in global medical tourism, price is a very important factor.

2.8 SWOT Analysis of the Thai Medical Tourism Industry

The SWOT analysis is the key to the understanding of the industry. From a number of sources and the author's derivation, the following four sections will be dedicated to Strengths, Weaknesses, Opportunities and Threat of Thai medical tourism industry.

2.8.1 Strengths

- **Low prices:** one of the most important factors of medical tourism is price. In general, costs of medical care in Thailand are 30-60% cheaper than Europe. Against competitors, prices of Thailand are 20% cheaper than Singapore[45], but higher than India and Malaysia.[46]

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[43] "Revolutionalized Healthcare," Strategy + Marketing 6, 68 (April 2007): 35-58.
[44] Cohen, op. cit., 102.
[45] Bangkok Post, op. cit.
[46] See Appendix B price.

- **High quality:** the high quality of medical care does not solely come from the money factors. According to Prof. Dr. Adisorn Patradul, Thai physicians have good skills comparable to those of the first world.[47] Most of the doctors working in the medical tourism industry are Thais that graduated from or and have been practiced abroad. The hospital in the industry is equipped with state-of-the-art facilities. The hotel-spital attitude makes patients feel important; patients will feel like they are in a hotel full with service-minded staff. Furthermore, most of the hospitals in this industry are now accredited by the Joint Commission International (JCI), which certifies that the hospitals are of the US standard. Bumrungrad is the first hospital in Asia to receive such accreditation. Bangkok hospitals and Samitivej hospitals have followed suit and received the accreditation a few months later. In 2010, the Medical Travel & Health Tourism Quality Alliance named Bumrungrad and Bangkok Hospital as number 6 and 7 of the Top 10 World's Best Hospitals for medical tourists.[48] Such accolade means a lot to the reputation of the Thai industry.
- **Capacity of Thai private hospitals to receive more patients:** in general, private hospitals in Thailand do not operate at full capacity. Supply of private healthcare facilities is in excess of domestic demand. Therefore, it is possible for the industry to expand without disturbing the domestic market. Excess supply coupling with fierce competition will drive the price down making Thailand even more attractive to foreigners.[49]
- **Availability of domestic supply:** most of the input factors for the medical tourism industries are available locally. Local supply chain is good in that supply can arrive fast and cheap due to the proximity. Human resources, drug, medical equipment or ordinary supply necessary for everyday operation such as office supply, transportation and food, most of them can be acquired

[47] Business.com. "Hospital revolution." Vol.18, 221 (July, 2007), 81.
[48] Medical Travel & Health Tourism Quality Alliance, MTQUA Announces the Top 10 World's Best Hospitals for Medical Tourists [online], 5 April 2010. Available from: http://community.mtqua.org/page/mtqua-announces-the-top-10
[49] Bumrungrad, 2006. Quoted in Homrossukhon, Nooch, Enhancing Competitive Advantage of the Medical Tourism Industry in Thailand (Chulalongkorn University, 2007), 51.

locally. The only exception is drugs, 65% of needed drugs need to be imported.[50]

- **Thai hospitality:** Thai people are well known for being service-minded. This factor contribute to the success of the hotel-spital model, especially that medical care requires attentive attitude toward patients. Service-mindedness will allow patients to feel less as a customer being serviced for the sake of money.
- **Tourism:** that Thailand is a major tourism and airport hub of the region contributes to the success of medical tourism. The intertwinement of both industries is the key to mutual development. As patients usually do not go abroad for the sole purpose of medical care, if tourism is attractive enough, they will choose Thailand as a destination of medical tourism. Bangkok, the main destinations of medical tourists coming to Thailand, has many tourist attractions. Culture, Thai people and Thai food also play a role in attracting tourists.
- **Supporting activities:** The scope of medical tourism is very wide and involves a number of supporting sectors.[51] Wellness sector, which includes spa and the famous Thai massage, can be offered as part of the rehabilitation. Herbal medicine as well as Thai traditional can also be introduced as an option for patients to try. Other activities may include normal tourism activities such as shopping and sightseeing.

2.8.2 Weaknesses

- **Lack of support from the government:** one of the most clamoured for factor is the need for government support. The medical hub policy of the Ministry of Public Health plans to make Thailand the hub of wellness and medical tourism. Since its issue in 2004, much, however, has remained stagnant and largely unimplemented. Public sentiment, political cyclical and political instability of Thailand has rendered constant policy change in the Ministry of Health. Currently, the populist ideology prevails within the

[50] Nation Multimedia, op. cit.
[51] See Appendix E: Medical Tourism in Thailand.

Ministry favouring the majority of the population. Little incentive and privilege was given to the medical tourism sector, which is considered to provide high cost service for small number of the privilege population. The Ministry does not favour large private hospitals, which provide medical tourism service. The medical tourism industry concentrates itself on the foreign tourist per se. By giving incentive to this industry, resources could be diverted to foreigners and thus would leave the remainder of the population with healthcare inequality. Since most of Thai population could not afford the higher prices of medical tourism sectors, a dichotomy of health system or the two-tiered system would be exacerbated. The internal brain drain of specialists and highly qualified doctors into the medical tourism industry could aggravate the existing division between doctors in the public and the private sectors. The populist administration within the Ministry believes that this sector should be heavily taxed to create equality in opportunities to healthcare as well as equality through wealth transfer. Most of the policy is focused on the public sector, which provides most of the service to the population. This best demonstrated by the Universal Healthcare project. Fortunately, due to its size and its importance, the medical tourism industry was not distracted by such policy. Rather, apathy and non-involvement can be used to describe the actions and the attitude of the Ministry toward Thai medical tourism industry. For in depth discussion on the issue, please refer to interview summary in Appendix A. Nevertheless, the Tourism Authority of Thailand and the Department of Export Promotion, Ministry of Commerce, still provides support to the industry. Supports through exhibition and trade fair as well as the supported provisions of travel linkages constitutes important boost to the industry. The image of healthcare and tourism was portrayed in conjunction with each other forming solid synergy that allows both industries to stand alone as well as with each other.

- **Only Thai Physicians & Brain Drain:** while Thailand does not prohibit foreign physicians to practice in Thailand, the regulation and requirement for the license virtually drive away all the candidates. They have to understand Thai language. This results in almost all of the doctors in Thailand Thai. One

problem often discussed when medical tourism is mentioned is the problem of brain drain, which mostly refers to the diversion of human resources from the public to the private sector, if mentioned under domestic context. In 2004, the doctor to population ration of Thailand was 1:3305.[52] In order for the number of doctors to be enough, Dr. Amphanwong states that for Thailand the rate should be at 1:1000.[53] However, the problem remains. Therefore, it is the diversion of resources could pose a problem to the system, particularly when the brain that was drained is the crème-de-la-crème, often they are those that teach in medical schools. By depriving these talents from the system, the overall quality both at the present and in the future could reduce drastically. While the shortage of doctors may be a problem of Thailand especially in the rural areas. According to Cohen, Thai medical tourism industry, on the contrary, does not have a problem of doctor shortage. In fact, there is a surplus of medical staffs in the industry. More and more doctors want to enter this industry and cause an internal brain drain within the country. Nevertheless, with relative smallness of the medical tourism industry when compared to that of Thai healthcare system, only less than a half percent of the total medical practitioners in Thailand involves in the medical tourism industry. Therefore the effect will be mostly minimal, but at the very high professional level.[54]

- **Language:** the problem of language barrier should not be overrated for the Thai medical tourism industry. Most of the hospitals in the medical tourism industry unlike those in public sector are of high calibre. Bumrungrad International Hospital and Bangkok International Hospital, the two leading hospitals in the industry, have full-time interpreter available 24-7. The doctors working in this sector graduated or hold certification from abroad. Language should not be counted as a big weakness to the industry. On the other hand, if it is counted as the weakness of the tourism side, the problem

[52] Health Resource, Ministry of Public Health. Quoted in International Labor Organization Subregional Office for East Asia, Thailand: Universal Health Care Coverage Through Pluralistic Approaches (Social Security Extension Initiatives in East Asia Series) [online], 24 January 2010. Available from: http://www.nhso.go.th/eng/content/uploads/files/research_pub_04. pdf

[53] "Hospital revolution" Business.com 18, 221 (July 2007): 101.

[54] Ibid., 111.

might be more appropriate. Nevertheless, it is still a small problem compared to many other countries.

- **Innovation:** regarding research and development (R&D), Thailand is not in the forefront of the industry, whether it is in term of medical machinery or pharmaceutical. While this does not affect the operation of the medical tourism industry as much, innovation can be a plus-asset in the future as in the case of experimental treatments.
- **Law enforcement, transparency and bureaucracy:** the lack of regulation is a double-edged factor: while it allowed the industry to grow exponentially and freely, it might cause uncertainty and weariness to patients as well as over exploitation of legal gap by the hospital. Malpractice and unethical doings, such as coercing patients into receiving non-necessary surgery, could arise as some unscrupulous doctors and hospital administrators could exploit from their patients. Due to the information asymmetric nature of healthcare, doctors may involve patients in unnecessary procedures or procedures that are more expensive when comparable procedures are available at cheaper prices. If legal battles between Thai hospitals and foreign patients happen, it is rare that the foreigners would win. Chariness and lack of trust would prevail and jeopardise the industry in a long run.

2.8.3 Opportunities

- **Aging global population:** foreign aging population can be an opportunity for Thailand. With the rising cost of healthcare, the wealth hold by aging population might not be able to follow the rise in cost. In attempting to cut costs, travel abroad to healthcare might be better. This group of patients is increasing, but they may not be so easily to reach to. Beyond temporary stay to receive treatment, they can also choose to stay longer as in long stay or even to move and live here. Due to the relatively low cost of living and Thailand being a tourist hub, Thailand is a good destination. Nowadays, a number of aging populations have to live under financial constraints. With limited pensions and savings, it might be better to live abroad. Long stay can

be beneficial to both the visitors and the Thai industry. The medical tourism industry can benefit from catering this group of people.

- **Contract with insurance company or foreign national healthcare system:** contract with foreign insurance company or national healthcare authority will serve as a boost to both the number of patients and the reputation of the hospital. For instance**,** BlueCross BlueShield of South Carolina created an alliance with Bumrungrad Hospital in 2007 allow the costs of the insurance to be lower under the increasing costs of healthcare in America.[55] Not only will the insurers benefit from the cost saving, the patients will also receive high-quality treatment plus an opportunity to travel. Similarly, a number of firms contract with foreign hospitals to provide care for their employees. National healthcare system also can derive benefits of having contracts with foreign hospitals. They can put more pressure on domestic healthcare facilities in terms of price and quality, as the competition has be come fiercer with the introduction of hospitals from abroad. For example, in 2007, the Japanese government allow the claim of medical costs incurred abroad.[56]
- **Experimental treatment:** Due to its openness and lack of regulation, the industry could tap into the unknown fringe region without going through protest and strict government's regulation like Western country. For instance, stem cell therapy for heart condition has been on the market in Thailand since 2006 while being experimental in most countries in the world. In country with the procedure in trial process, only a few patients can enter the trial process. For some other that could not enter the programme, there is no other choice but death. Despite no guarantee of success, patients choose to go for it.[57] A number of them thus came to Thailand for the treatment. The early start of the availability would lead to the accumulation of skills and

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[55] Tourism Authority of Thailand, Tourism Thailand : News > Major US Health Insurer Promotes Thai Hospital to its 1.3 Million [online], 15 March 2010. Available from: http://www.tourismthailand.org/news/content-224.html, accessed March 15, 2010.

[56] KResearch. Quoted in Homrossukhon, op. cit., 55.

[57] 101 East, Al Jazeera, Thai Stem Controversy (31 January 2008) [online], 5 February 2010. Available from: http://www.youtube.com/watch?v=CrS_5zoZ6jE and http://www.youtube.com/watch?v=shLprUkC44M

expertise. With the prospect of the profits generated, other experimental procedure would soon take place here making Thailand the leader in innovation and experimental treatment. Without the openness of the regulations, Thailand might not be the location where these procedures are offered.

- **Capacity to improve cost efficiency and quality:** Thailand still has ample opportunities to improve cost efficiency as well as quality. With the introduction of technology and good human resources, efficiency can be achieved, while the costs are kept low. As one of the negative factor mention by Piyavej hospital, Thai personnel still has low level of professionalism.[58] If human resources could be improved, efficiency can then be achieved.

2.8.4 Threats

- **Competition from India, Malaysia and Singapore:** the three countries listed are the main competitors of Thai medical tourism industry. While Singapore emphasise on the superiority of care due to its higher costs, Thai and India are at the same level. India has the advantage in terms of costs. Thailand has advantage in terms of tourism and environment. Malaysia, on the other hand, has advantage in terms of cultural affinity with the Middle East. Table 6 compares medical tourism in 6 countries. Each has its own specialty and group of customers. However, the info is no longer applicable as every country are trying to give all the treatments needed and reach out as much as possible. For example, the BGH is now receiving more patients from Australia and China.[59]

[58] Strategy + Marketing, op. cit., 46.
[59] Pitsuwan, op. cit.

Table 6 – Medical tourism in the developing world

Country	Estimated number of foreign patients ('02-'03)	Estimated number of foreigners visiting specifically for healthcare ('02-'03)	Countries of origin of foreign visitors	Treatments sought by foreign visitors
Thailand	632,000	126,000	South & South East Asia, Europe, US	Cardiac surgery, post-op care, cosmetic surgery, dentistry, cataracts, bone-related procedures
Singapore	200,000	20,400	South & South East Asia, Korea, Japan, Australia, UK, US	General surgery, cardiac surgery, ophthalmology, orthopaedics, gynaecology and urology
Malaysia	103,000	75,000	Indonesia, India, Middle East, UK	Cardiology, haematology, gastroenterology, neurology and cosmetic surgery
India	150,000	62,000	Bangladesh, Middle East, UK, Europe, US	Cardiac surgery, joint replacements, ophthalmology alternative medicine
Jordan	N/A	70,000	Yemen, Sudan, Libya, Algeria, Tunisia, Iraq	Cardiac surgery, correction of spinal injuries, cornea transplants, alternative medicine
Cuba	N/A	3,500	Central & Latin America, UK	Cosmetic surgery, Vitiligo treatments, ophthalmology, joint replacements, neurology

Source: Tourism Authority of Thailand, Singapore Ministry of Health, Khoo (2004), Malaysian Department of Statistics, Confederation of Indian Industry, South Asia Network of Economic Research Institutes (SANEI), the Jordan Times, and Cuba Travel US.[60]

[60] Mattoo, Aaditya and Randeep Rathindran, Does Health Insurance Impede Trade in Health Care Services? [online], 20 March 2010. Available from: http://www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/07/19/000016406_20050719140725/Rendered/PDF/wps3667.pdf, 12.

Table 7 - Competitive Advantage of health facilities in Asian countries providing health care service to foreign patients

Competitive Advantage	Thailand	Singapore	India	Malaysia	Hong Kong
Service & Hospitality	*****	**	*	*	**
Hi-technological Hardware	**	***	**	*	**
HR Quality	****	***	**	**	***
Intl. Accredited Hospital	**	**	-	*	*
Preemptive Move	**	***	*	*	*
Synergy/Strategic Partner	*	**	*	*	*
Accessibility/Market Channel	**	***	*	**	**
Reasonable Cost	****	*	****	***	*

Source: Modified from Private Hospital Association and Business Council of Thailand, (2004).[61]

Table 7 summarise the comparative advantage of Asian countries providing care to foreigners. Overall, Thailand seems to have edges over others in terms of services & hospitality, quality of human resources and costs. Notably mentioned is the synergy and strategic partner, Singapore has an advantage over this category because of its investment in other countries' hospitals, which also includes Thailand.

- **High dependency on foreign patients:** due to the focus of the industry on serving foreigner, the over-dependency on it could be developed. If at a sudden, the flow of patients stops, the hospitals could be facing a tough time.
- **Political instability and pandemics:** if the levels of the political instability and pandemics have reached an alarming level, the flow of patients could stop and hit the industry directly.
- **Lawsuit and reputation:** in this cyber age, any misstep can cause a long-term impact on the reputation of the hospital. For example, news of a major lawsuit on an issue such as malpractice can hurt the hospital for a long time due to the availability of the new on the Internet.

[61] Bureau of Policy and Strategy, Ministry of Public Health, Thailand, Health Policy in Thailand 2009 [online], 3 February 2010. Available from: http://bps.ops.moph.go.th/Health%20Policy%202009.pdf

2.9 International Integration and Acquisition as Potential Advantage

In the age of open market economy, foreign direct and portfolio investment is inevitable. Corporation becomes multi-national. Their investment or subsidiary in other countries creates an international synergy. Healthcare industry is nevertheless transnationalized. Leng pointed out to the nature of Malaysian healthcare industry as well as those of others such as India, Singapore and Vietnam that it involves a significant share of foreign investments. Singaporean investment, which already includes investments from western countries, has created an east-west linkage. Regional medical integration through Singaporean investment has leaded to the transfer of patients within the region through cross-reference of hospitals. Furthermore, with the east-west link, western patients would feel more comfortable receiving healthcare abroad knowing it is money from their countries and thus the possible availability of standard comparable to their countries exists.[62] Policy-wised, the investors understands the potentials and advantages of foreign resources. Although not making a connection between foreign acquisition and the utilization of comparative advantage which underlies the rationale principle of foreign investment, Leng indirectly substantiated this notion with a story of emphasis shift. A couple of Singaporean newspaper articles cited in Leng's research have pointed out to the shift in emphasis toward international patients after the acquisition of a Malaysian hospital's share by a foreign holding. One hospital embarked on building of a new patient wing devoted solely to international patients after the acquisition. The results have been positive with a significant growth due to shift. In Thailand, for example, the Bumrungrad International Hospital's shares are now partially owned by Temasek holdings of Singapore, Asia Financial Holdings from Hong Kong and Istithmar World from Dubai. The Bangkok Dusit Medical services group, which includes the Bangkok hospitals, Samitivej hospitals, BNH hospitals and the Royal hospital, are invested by foreign firms such as the State Street Bangkok and Trust Company from the US and the HSBC Singapore. However, whether the foreign investment in this case translated in the diversification of patients or not remains questionable.

[62] Leng, op. cit., 21-23.

CHAPTER III
METHODOLOGY AND DATA COLLECTION

3.1 Methodology and Conceptual Framework

The nature of the topic of this research and the provision of the data available leads to the research being qualitative. Building upon existing literature, documentary research will form parts of data collection and analysis. Due to the interdisciplinary nature of this research, cross-sectional analysis, which focuses on different levels and characteristics of the subject, will be used.

The complexity of the issues and the lack of literature have called for the author devising a specific conceptual framework in exploring the issue effectively.

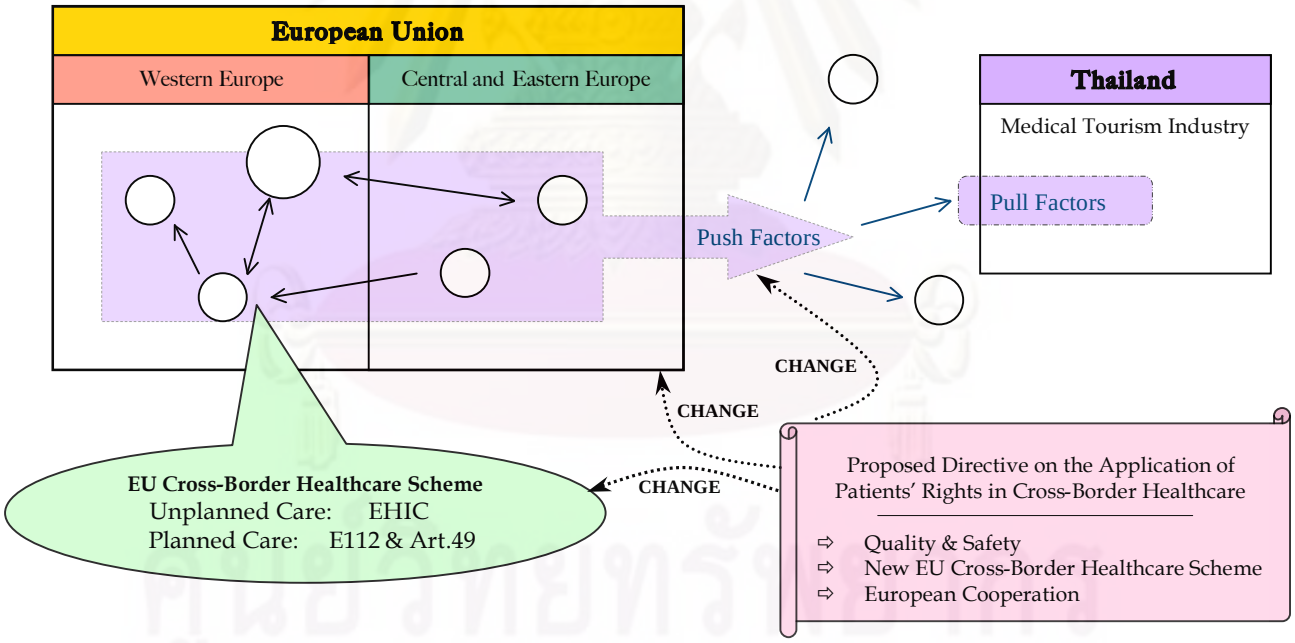

Figure 4 – Conceptual Framework

Source: Author, 2010.

This thesis is divided into two parts: the European and the Thai healthcare sector. In the first part, the methodology used is the analysis of elements within the European healthcare system as well as its reasoning. In chapter 4, all of existing elements will be investigated as to lead to chapter 5, which is the impact analysis of the Directive on the European Union Healthcare system, the Cross-Border healthcare scheme and the push factors driving European patients to receive healthcare outside of the Union. In doing so, the strengths and weaknesses of the healthcare system of the European Union will be identified.

Chapters 4.1 and 4.2 cover the first box titled European Union on the left side of Figure 4. It is important, firstly, to establish how healthcare policy is decided, conducted and implemented in the European Union. What is the interplay between the national and the European level? Who is the important actor on the issues? Who has the actual powers of implementation and legal issuance? All of these questions will be explored in chapter 4.1. Chapter 4.2 will be on the reasoning behind cross-border healthcare and patients' mobility. Why does the EU need to cross-border healthcare and healthcare integration? What are the costs, benefits and obstacle to the process? And how is healthcare delivered in the EU? In giving a broad yet conclusive picture of the system, the author divided the system into those in the Western European Countries and the Central and Eastern European Countries. Within the Western group, countries can be subdivided according to their social model and their healthcare model. Each has a specific problem of its own. The Central and Eastern European countries, on the other hand, are more unified. The investigation on the systems will be bring about the actual reality of the flow as well as why there is a flow.

In chapter 4.3, represented by the lower left-side oval box in the conceptual framework figure, cross-border healthcare scheme at the European level will be discussed. Three schemes are of concerned here: the European Health Insurance Card (EHIC), which allows healthcare in case of unplanned care; the E112 scheme based on Regulation 1408/71 (EC), which allows planned care after authorization as well as guarantee reimbursement; and the recently established scheme based on the free movement of services, Article 49, which allows access to healthcare without authorization. All of the scheme will be used as a basis of analyzing the change in cross-border healthcare scheme induced by the Directive.

The next chapter, chapter 4.4, deals with the proposed Directive on the Application of Patients' Rights in Cross-Border Healthcare. This is as presented in the lower right box in the conceptual framework, figure 4. The discussion included the rationale, objectives, and details of the Directive. How would the Directive deal with: standard of healthcare provided, the formal cross-border scheme and the cooperation among Member States. Policy options, progresses and hindrances will be explored.

In Chapter 5, all of the elements investigated will be used in deriving the impact on the Thai industry. Firstly, in chapter 5.1, the research attempts to look at how the push factors through the strengths and weaknesses of EU cross-border healthcare and the changes in the system and the EU medical tourism industry induced by the Directive. In the end the push factors after the implementation of the Directive will be identified. Secondly, in looking at the impact on the Thai medical tourism industry, the discussion on the pull factors of European medical tourists coming to Thailand is necessary. The basis for this chapter is based on the literature review on the Thai industry and results of the interview conducted by the author with key informants. Secondly, in chapter 5.2, the pull factors, which explain why Thailand is attractive to European patients, will be measured as in looking at the importance of each factor to Thailand. Unlike the European section, a number of analyses on medical tourism in Thailand have been made. It is logical to base the analyses on the existing data as to draw out the part specific to European patients: the pull factors. In confirming the validity of the analyses as well as collecting data that is not available publicly, data from interview will be used as a supplement. Finally, the push and pull factors will be explored as to measure or indicate the effects on Thailand.

3.2 Data Collection

3.2.1 Collection of Documents

Despite the importance of the medical tourism industry, academic literature are still lacking behind general and commercial information. Data thus will be collected from all possible sources including books, journals, research papers, websites, advertisements, newspaper, magazines, and many more. Existing data will be used in conjunction with each other to form a conclusive assumption relating to the research.

3.2.2 Surveys and Questionnaires

The analysis will be based on the data from already existing surveys and questionnaires: the 2001 Eurobarometer #210 "Cross-border health services in the EU" and the Techniker Krankenkasse's "TK in Europe: TK Analysis of EU Cross-Border Healthcare in 2007."

3.2.3 Interview

The author will conduct interviews on the topic of Thai medical tourism industry and the European medical integration. The purposes of the interviews are: firstly, to gain in-depth information on the responsiveness and awareness of the industry toward the Directive proposal and the notion of the European medical integration. The second purpose is to gain understanding of the medical tourism industry from the internal point of view through hospital administrators and related personnel within the medical community.

The interview will be a semi-structured interview. Formal set of questions will be answered in conjunction with the flexibility that allows new questions during the interview to come up as a result of the set or previous questions. The sampling method will be purposive sampling as there are a limited number of players in the field. Key informants are selected. The first groups of interviewee consist of administrators or marketing officers from Thai private hospital, whose aims are at medical tourists. The second group is personnel and experts relating the medical community and medical tourism industry, such as experts from the Medical Council of Thailand.

The result of the interview as well as the interview questions and the documents provided as a basis for the interview are provided in Appendix A. Due to confidentiality, name of the interviewees as well as their organizations will not be revealed. Sensitive information that is unnecessary to the thesis will not be included. The result of the interview will come in form of interview summary categorized according to the issues. Only the necessary part will be drawn in making an analysis within the thesis, particularly the discussion on the pull factors.

CHAPTER IV
THE EUROPEAN UNION, HEALTHCARE INTEGRATION AND CROSS-BORDER HEALTHCARE

In achieving healthcare integration within the European Union (EU), an organisation characterized by economic and legal integration, cross-border healthcare lays an important aspect of it. Remaining at the gist of the European integration, the free movements of economic factors, which are goods, services, labour and capital, trigger the needs for such unforeseen area of healthcare integration. This chapter is formed with an aim to lead to the establishment of the push factors of European patients to utilize medical services abroad. The scope of analysis will be based on the medical tourists who plan the trip in advance to receive medical treatment outside of the Union. In attempting to explain the impact of the European Commission's draft proposal on the Application of Patients' Rights in Cross-Border Healthcare on the push factors, only relevant healthcare scheme and background will be analysed. Most of them will be public system as the scheme rarely covers private healthcare scheme.

Healthcare integration Cross-border healthcare forms a strategic importance of long-lasting growth and all-round prosperity as required by the European Union being a single market. However, the struggle for preserve national interest has overshadowed and complicated the health policy of the EU, notwithstanding the cross-border healthcare or trade in health services, which is the subject this study. The progress of European integration is legalistic in nature and thus deserves a thorough investigation. In chapter 4.1, the politics of health policy in the EU will be observed as an attempt to delineate the underlying complexity of healthcare policy in the EU, the related actors and their bases being importance. Chapter 4.2 focuses on the background of the European system in understanding of the rationale and the costs and benefits of European cross-border healthcare. In chapter 4.3 the scheme and existing rights of EU citizens to cross-border healthcare will be examined. Previous schemes and attempts to integration will be included as to lay down a foundation for the next chapter, chapter 4.4, on the most recent attempt: the proposal of the Directive on the Application of Patients' Rights in Cross-Border Healthcare.

4.1. The EU and the Member States: the Struggle for Power over Healthcare

4.1.1 The EU and Power Politics

The European Union (EU) exemplifies the world the prosperity brought about by economic and legal integration. By sacrificing parts of the member's sovereignty in certain areas, a powerful legally effective supranational organization under the sectoral integration concept was brought to life. Through the contractual nature of the legal agreement, state members and their citizen shift toward Europeanism and less toward nationalism. The interests of the nation become synonymous with those of the Union. However, this statement has not become completely true. On certain sensitive areas such as healthcare and financial sectors, changes remain stagnant as Member States have not yet identify common interests. Several circumstances such as the enlargement make it harder for the Member States to share their prosperity. The endeavour to integrate in these areas is thus much of a struggle. In conventional intergovernmental structure subjected under international law, unanimity is often required in order to reach an agreement. States think in terms of national interests and thus the process becomes a political stage struggling for power. Less was achieved for the community. National wounds and rivalries root themselves deeper. Supranational method, on the contrary, reduces such tedious fight by binding themselves to common goals and creating a high authority with power exceeding that of the member states. In signing Treaties, the member nations accede to transfer portion of their sovereignty to a particular institution governing the area of which all agree upon, often on low politics issue such as culture. Such limited integration is a sectoral approach, whereby common interest was put under common management. Integration in one sector will soon lead to that in another sector. National governments will gradually have less authority on the issues and must follow the principles that they themselves had formerly laid down under the lead of a non-partial organization. Cynically saying, one duty of the Union is to limit and control behaviors of individual Member States that contradict with what they agreed in other words philosophy and objective of the Community. Due to the intrinsic differences of countries within the Community, it is questionable that the common interests of the Community are totally common. There are both costs and profits resulted from the integration. The balance between the two is thus necessary.

In legal terms, in the states where the monist approach is adopted, international law functions as another set of law applicable once ratified. On the other hand those that adopt the dualist approach must integrate international law into their domestic law. As a result, conflicts may arise with former laws or even with the constitution. Even such preliminary obstacles were eliminated, problems still prevail, for instance the inequality of implementation, the hierarchy of law and the disparity of interpretation. Foreseeing these matters, the European Court of Justice (ECJ) was established along with the European Coal and Steel Community, the first form of the Community in the Treaty of Rome in 1952 to provide legal resolutions. Being a supranational organization whose power rises above that of individual nation, the ECJ must protect the European citizens' and the Community's interests as well as the equality and fairness of application through its power of legal interpretation to smoothen the progress of the integration. The community law also must be universally applicable within the territory and be uniformly interpreted. Thus, one important characteristics of the community law that differentiate itself from traditional international law are its supremacy over national law.

4.1.2 The EU and its Competence in Health Services

Concerning health services and trade in health services, the competence is a constant tug of war with the EU on one end and the Member States in the other. It is therefore impossible to know how much the health services could or should be opened to trade. There are a number of players in the determinant equation of trade in health services at the European Union. Like other policy areas, the key player in controlling the trade in health services is already determined and indicated within the Treaty.

The European Union is based on the agreement of its Member States in joining within the Union to integrate into a single market, harmonize under specific framework and be partially subjected to the common authority of the European Commission, which is entitled to protect the interests of the whole community, i.e. the citizen of the Member States. This legal agreement, known as the Treaty, forms a basis for nearly everything in the Union from rights to the operation of European institutes. Since the Treaty is a relatively concise, details need to be work out at the lower level of operation through secondary community laws such as by the European Commission in conjunction with the Council of the European Union, which represents the interests of the Member States. Unquestionably, arguments and uncertainties abound as not everything is foreseen

and conflicts might be inherent within the Treaty. This is the job of the European Court of Justice to clarify the Treaty.

The European Union (EU) in general has residual competences in the health sectors. Degree of competence depends on the specific nature of those health-related issues. Under the Lisbon Treaty, which was recently ratified in 2009, there are three levels of competences of the EU as described by Article 2A:

(a) Exclusive Competence of the EU – Only the Union may legislate and adopt the acts legally. The Member States may legislate and adopt the act by themselves only if given the power by the Union to do so;

(b) Shared Competence between the EU and the Member States – the Union and the Member States may legislate and adopt the acts legally. However, the Member States have the rights to do so only if the Union has not done so. Once the Union has legislated and adopted the acts, the acts of the Union will prevail over that of the Member States;

(c) Member States and Supporting, Coordinating and Supplementing Competence of the EU – the Union has the competence to support, coordinate and supplement the actions of the Member States in the competence areas. If there is a legally acts of the Union based on the Treaties in these areas, these acts should not result in the harmonisation of Member States' laws and regulations.

The Treaty of Lisbon categorises the areas of competences of the EU in Title I: Categories and Areas of Union Competence, Article 2A to 2E as follows:

Table 8 - Categories and Areas of the European Union Competence

Exclusive Competence (Art. 2B)	Shared Competence (Art. 2C)	Supporting, Coordinating and Supplementing Competence (Art. 2E)
(a) customs union; (b) the establishing of the competition rules necessary for the functioning of the internal market; (c) monetary policy for the Member States whose currency is the euro; (d) the conservation of marine biological resources under the common fisheries policy; (e) common commercial policy.	(a) internal market; (b) social policy, for the aspects defined in this Treaty; (c) economic, social and territorial cohesion; (d) agriculture and fisheries, excluding the conservation of marine biological resources; (e) environment; (f) consumer protection; (g) transport; (h) trans-European networks; (i) energy; (j) area of freedom, security and justice; (k) common safety concerns in public health matters, for the aspects defined in this Treaty.	(a) protection and improvement of human health; (b) industry; (c) culture; (d) tourism; (e) education, vocational training, youth and sport; (f) civil protection; (g) administrative cooperation.

Source: European Union, 2009.

Due to the breadth and the sensitivity of health-related issues, the area of health spans over three competences. And within the competence of the European Commission, Directorate-General for Health and Consumer Protection or DG-Sanco is not the sole authority dealing with the health issues. If it concerns trade, then Directorate-General for Trade will also be involved. This results in the overlaps of authorities and complexities of the issues.

The first one is the trade in health services that falls into the category the Common Commercial Policy (CCP) under the exclusive competence of the EU. In the Niece Treaty, The exclusive competence refers to areas in which the EU to has the sole competence to legislate and adopt the acts on its own. Contrasting with the former Treaties, which provide explicit exception of health services from the CCP exclusive competence, the Lisbon Treaty instead includes a safeguard clause for the aspects of the

health services.* For instance in the voting system of the Council, whereby the qualified majority voting (QMV) is mostly, unanimity is applicable when the agreement on specific health services issues risks "seriously disturbing the national organization of such services and prejudicing the responsibility of Member States to deliver them". Due to the sensitivity of the health service, the EU's limited competence and the unwillingness of the Member States to let go of control are also seen by the exclusion of the Health Services from the 2006 Service Directive in the Internal Market, which grant the Commission power over the issue.

The common safety concerns in public health matters, for the aspects defined in this Treaty, is the second area. It falls under the shared competence in which both Member States and the Union have the authorities over. Despite its invdvement with public health, it concerns the subject of the trade in health services at a very low level. This second area involves mostly the standard and safety for medicinal products and medical devices such as that involves organs, substance of human origin, blood and veterinary and phytosanitary fields and policies such as the Sanitary and Psytosanitary measures (SPS).

The last concerned area is the protection and improvement of human health. This is a very wide area and entails laws and regulations that could create conflict with those under the Common Commercial Policy. The issues of health and specifically public health fall mostly into this category, whereby Member States practically have exclusive competence and the Union can only provide support, coordinate and supplement the actions of the Member States only if they do not involve in harmonisation. Nevertheless, it must be recognised that a number of rules on public health need not fall under specific chapter of public health. Such can be under that of the internal markets, which delineates the mobility freedom of four production factors.

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* The ratification of Lisbon Treaty by the Member States affirmed the commitment of the Union to the Cross-Border healthcare. In general sense, under the Lisbon Treaty, cooperation among Member States on health services is encouraged in cross-border areas. Specifically, the Lisbon Treaty amends Article 152, which concerns public health with a clear statement on the trade in health services as follows "It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas."

However the amendment also includes the following phrase, which endows the Member States to the rights to organise and manage the health system of their own: The "Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them."

Trade in health services will therefore be regulated at both national and European levels from various angles. Nations have the rights to provide health service for their citizens in the way that fit their social modes. At the European level, for example, framework for standard and safety will be implemented to ensure the rights of European citizen as well as to regulate the trade in health services. Naturally, there is an involvement of two levels of regulations in cross-border trade in health services. Conflicts might arise as national regulations are not always compatible with those at the European levels. While systematic harmonisation scheme is not valid under the Supporting, Coordinating and Supplementing Competence, it is still possible to outlaw conflicting national rules if the European Court of Justice determines that the national regulations in question are in conflict with the intention of the Treaty.

4.1.3 The ECJ, the Member States and the Development of Healthcare Legislations

The European Court of Justice (ECJ) has the sole rights and the duty to interpret the Treaty. Its duty, even though seems confined within legal context, has an extensive impact on the Union. In the field of healthcare, the ECJ rulings necessitate the Member States to transform their healthcare systems both legislatively and administrative as to accommodate the affirmed rights of European citizens to healthcare across border.

In a number of cases, the ECJ rulings[1] confirm and extend the rights of European citizen to cross-border healthcare and reimbursement. From the recognition of the need to receive medical treatment in another Member State as part of the freedom to service provision[2] to the rights to receive equivalent reimbursement tantamount to the treatment cost in the home country[3], the ECJ lays a legal foundation for the whole community to follow.

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[1] For more details see: DG Internal Policies of the Union, The ECJ Case Law on Cross-Border Aspects of Health Services (Briefing Note) [online], Available from: http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_ecj_en.pdf.; DG Internal Policies of the Union, The Impact of the European Court of Justice Case Law on National Systems for Cross-Border Health Service Provision (Briefing Note) [online] Available from: http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_briefingnote_en.pdf.; van der Velde, Roos., ECJ Judgements concerning cross border Health Care 1998-2006—Summaries [online], Available from: http://www.soziale-dienste-in-europa.de/dokumente/Aktuelles/EuGH_Urteile_summary_en.pdf

[2] See C-158/96 Raymond Kohll v Union des caisses de maladie.

[3] See C-368/98 Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC).

However, due to national interests and difference in what is perceived to be part of social welfare, Member States still adhere to the notion of their system being closed. The issue of healthcare is politically sensitive in its nature. National citizen is perceived by the Member State to be of priority, yet according to the Treaty and the ECJ rulings all European citizens whether citizens of the home Member States or not should receive healthcare on equal footing. This notion is ideal but impossible in reality. Each Member State maintains its own system. While some treatment is available as part of social welfare or social security, some are treated as luxury medical process and excluded from the system coverage. Cancer preventive screening and early detection is an example of this. Article 35 of the Charter of Fundamental Rights of the European Union states "Everyone has the *right of access* to preventive health care and the right to benefit from medical treatment *under the conditions* established by national laws and practices."[4] Despite such recognition of rights to these preventive treatments, nations still regulate and give benefits under their own conditions, which allow them to limit the treatment and filter the number of patients. These treatments, which could result in economic burden to the system, are appropriate only when the system is capable of paying extra Euros.

With the future prospect of increasing healthcare cost, demographic change and increased proportion of immigrants in various Member States, a number of issues arise. The first one is how the system could sustain itself when the number of population contributing to the central fund decreases while the proportion of the aging population that no longer have to contribute to the fund increases. This problem of sustainability is especially of concern for countries with pooling system and high level of social welfare benefits. The second one is a political problem, discriminatory in nature, concerning who should receive the benefits. Many nationals treat immigrant as second-class citizen and believe that they should not receive total benefits. Along the line with this is the notion of the citizens from other the Member States to receive national treatment and utilize the service, which is originally intended for the citizen of the home country. These constitute as part of the problem why nations have reservation and apathy for cross-border healthcare.

To aggravate the problem further, the lack of legal certainty and common standards on the EU level sustain the conflicts between and incompatibility of healthcare

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[4] Charter of Fundamental Rights of the European Union [online], 20 March 2010. Available from: http://www.europarl.europa.eu/charter/pdf/text_en.pdf , Italics mine.

systems. This is an important deterrence to the prospect of smooth cross-border healthcare. Despite this problem, the EU and the ECJ are not to be completely blamed. First, this area of health is very politically sensitive and complicated as demonstrated earlier by the complexity of the EU competence on health-related policy area. Second, the progress has been gradual while the resistance from the Member States high. In the 2006 Directive on Services in the Internal Market, commonly known as the Bolkestein Directive, the health service was excluded for a number of reasons such as the differences among the systems of each Member States and the size of the work force working in this industry[5]. According to the Eurostat, around 20.1 million EU citizens worked in the area of health and social work in 2007.[6] Third, to change an already-in-placed healthcare system, an industry with such size, takes time. The history of the European Union seems utterly pale and insignificant when compared to the long establishment of the healthcare system. Since the original form of the European Coal and Steel Community, the community gradually transforms itself and expands gradually its scope coverage. The coverage of healthcare, as with other areas, was not intended. The need to facilitate other areas of integration is the main drive behind such inclusion. This is called the spillover effect. To be specific, the main body that triggers this spillover is the ECJ through the rulings made in response to the request for judgment and interpretation of the Treaty. This brings us to the last reason: the limitation of the ECJ in expanding the rights of the European citizen. The ECJ shares common characteristics with other courts in that they only can only judge only on what has been brought before the courts. Thus, the relevant law can only be developed on basis of particular cases and particular laws. In addition, the judgment of the ECJ, known as the preliminary rulings, concerns only whether the law or regulation in questions are compatible with the Treaty or not. It cannot enforce the change or rectify the concerned national laws and regulations. Thus, the direction of the change will be based only on a general guideline as interpreted from the Treaty by the ECJ. Member States will transpose rulings of the ECJ into national legislations by themselves. The Union can only provide guidance and

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[5] See Committee on the Internal Market and Consumer Protection, European Parliament, Draft Report on the impact and consequences of the exclusion of health services from the Directive on Services in the Internal Market (2006/2275(INI)) [online], Available from: http://www.europarl.europa.eu/meetdocs/2004_2009/documents/pr/656/656490/656490en.pdf

[6] Eurostat Labour Force Survey, cited in European Commission, White Paper – Together for Health: A Strategic Approach for the EU 2008-1013 [online], 16 March 2010. Available from: http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf, 8.

recommendation. For all these reasons, the legal certainty and common standards in the health area is lacking behind other areas and remains problematic forthe policy makers.

According to the analysis of the ECJ impact on national legislations by the Commission, the Member States concerned are "cognisant of the ECJ rulings and the necessity of considering their impact on healthcare."[7] While some Member States such as France and Germany changed their legislations as a result of the rulings, some such as Spain have not yet accommodated themselves with the rulings. This is logical as nations prefer to maintain their own system as stated above. As they are not the party the rulings have been made upon, they are not obliged to make any change. The rulings will be effective in effacing a national legislation when there is a statement saying that particular regulations within their system are incompatible with the intent of the Treaty. The Court might also give general comments extending the rights or giving clarity on the rights of the citizen not yet clarified within the treaty. For example, in the rulings of C-372/04 "Watts" in 2006, the ECJ stated that the system that provides free healthcare treatment for their citizen is in principle obliged to reimburse treatment costs in another Member State if their citizen request such reimbursement. This makes it clear that Member States cannot deny reimbursement on basis of not charging their citizen cost of health treatment.

It is clearly shown in the Commission's analysis that the Member States understand the implications of the ruling. However, "a balancing act is occurring between addressing ECJ rulings and the perceived needs of national systems: in effect, attempting to balance patients' rights and State interests."[8] For the countries that have a waiting list system, which basically imply the ability to provide immediate care or the scarcity of resources, the attempt to keep the waiting list short might be hindered by the influx of cross-border patients from another Member States. There are many reasons for this balancing act, some particular to some system as with the States with waiting list system. This is why the adjustment has been progressing faster in some Member States than in the others. "Increasing rights to cross-border healthcare may not…be universally perceived as a positive development."[9]

It is also important to note that while former Member States may have no obligation to change their legislations, the new Member States must accept and interpret

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[7] DG Internal Policies of the Union, op. cit., 9.
[8] Ibid., 11.
[9] Ibid.

the Treaty along the line with the ECJ rulings as part of the *acquis communitaire* accession requirement. In 2004, when countries such as the Czech Republic and Poland entered the Union, they must accept the rulings wholesale.[10] The system must be changed accordingly with the rulings and the legislations as part of the transformation process. For instance, upon joining the EU, Hungary adopt more than 200 health-related legislations into its legal system. According to the Hungarian Secretary of State, Zsuzsanna Jakab, Ministry of Health, Social and Family Affairs, the adoption of the legislations is nothing but "a public health reform in itself."[11] The adoption of the legislations, which lead to the change in public health standards and practice, can be called a harmonization with the European standards. Whether the harmonization contrasts with the national interests or not, it is part of the requirement as they can incorporate into the community and then can operate smoothly with other systems under the same standard.

If legal clarity were to be achieved, there would be a number of advantages leading to the achievement of cross-border healthcare. Member States would have a clear direction to which their healthcare systems should develop. There will be a systemic coherence within the Union allowing a smooth flow of patients, which could lead to the development of overall European healthcare system through knowledge and technology transfer. From another perspective, patients would understand more of their rights with a legal certainty and system in place. This will give them confidence in cross-border healthcare and opportunities to make a choice of their treatment.

4.2 Patients' Mobility and Healthcare Mobility in the EU

If one were to measure the success of the European Union's success in social integration, one important evaluation criterion is the degree of population movement within the European Union (EU). One possible aspect can be measured from the number of patients planned to utilize medical services in another Member State. If the number is high, there is a high level of mobility. However, looking from another facet, the high number of patients seeking healthcare abroad also implies the inadequacy of the home healthcare system and the inequality of healthcare within the Union. If the costs of

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[10] Ibid., 9.

[11] Jakab, Zsuzsanna, Health Challenges in an Enlarged: Europe Investing in population health [online], 19 March 2010. Available from: http://www.eum.hu/health-challenges-in-an.

healthcare treatment in one Member State are sufficiently higher than that in another Member State, outflow of patients will be sequential if the system of transferring patients and reimbursement scheme is in place. The other possible reasons include, for example, the scarcity of resources leading to the long waiting time and the unavailability of innovative procedures that is considered experimental in some countries while not in the others. Global medical tourism testifies that this notion hold true. For example, in the case Thailand, a high number of British patients can be traced back to the notorious long-waiting list. These are some of the rationale that should be investigated in examining cross-border healthcare in the EU.

A number of distinctions must be clarified before proceeding to the discussion of the topics. European healthcare integration refers in general to the path toward a unified healthcare system operating under one European-wide framework. Cross-border healthcare, on the other hand, refers to trade in health services. Under the World Trade Organization's General Agreement on Trade in Services (GATS), there are four modes of health services: cross-border services trade, consumption abroad, commercial presence and movement of natural persons. In this research, the focus will be on mode II: consumption abroad, which includes movement of patients seeking treatment abroad or patient mobility. In the case of the EU, patient mobility refers to the movement of patients receiving healthcare in Member States other than the home countries of the patients. The idea of cross-border healthcare and healthcare integration should not be conflated: while cross-border healthcare constitutes part of healthcare integration, vice versa is not true. However, the process and measures leading toward healthcare integration may form or boost cross-border healthcare whether in terms of number of patients, the freedom to mobility or the standard of care.

In this chapter, five main issues will be discussed in detail. The first is the legality and inherent reasons of the healthcare integration and the cross-border healthcare in the EU. The second are the costs and benefits of cross-border healthcare specific to the EU. In contrast to the overall picture of the Union in the first and second sections, the third issue will be specific to groups of Member States with similar social models and welfare system in order to understand and create a model of the EU medical tourists. This section also pertains to reasons for cross-border healthcare besides the inherent reasons as discussed in the first section. The fourth focuses on the cross-border healthcare scheme both current and previous. Lastly, the fifth section tries to identify problem of

the system that contribute to the push factors for the European medical tourists to utilize the medical services outside of the Union.

4.2.1 Factor Mobility and the Inherent Need for Cross-Border Healthcare

According to the Treaty on the Functioning of the European Union, updated by the Lisbon Treaty, "the internal market shall comprise an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured in accordance with the provisions of the Treaties." This fundamental philosophy, which is the free movement of production factors, is aimed at the smooth integration of the market and the European community. Four freedom of production factors movement are that of goods, services, labour and capital. The movement of goods refers to the ability of goods to move freely within the community without any hindrance. The other three factors fall under similar notions. However without one of the freedom, an integrated market would not be able to operate efficiently to maximize the use of resources and enhance the competitiveness of the products. Freedom of goods mobility, however, does not imply maximal efficiency. This is because some production resources such as natural resources situated only at that location could not be moved or transferred physically to other countries and therefore movable production factors such as labour should be moved instead. Resources such as oil, iron, spring water or even intangible one such as scenery, culture and history are some of the example of the production factor that constitute a competitive advantage over other countries. Such directly refers to the needs of services, labour and capital mobility. These factors must be able to move to the factors that cannot. Capital, which in this case is the financial capital, is the key to investment, both foreign direct investment (FDI) and portfolio investment. Without capital, it is impossible to operate and produce products and services on a large scale. Investors cannot use their funds to generate works and utilize the resources abroad efficiently if there is a high level of protection. Skilled labour should also be able to move in order to utilize their skills to the fullest. Unskilled labour however can be more complicated as normally they can be found everywhere. Nevertheless, it is often that the costs of unskilled labour are influenced by the location. In the rural area, the costs of labour could be much cheaper than in the city area. This also applies to the movement of unskilled labour that move to other countries in search of better salaries such as the outflow of construction workers to the middle east where there is a lack of unskiled

labours or the cost of hiring the locals are too high. Services, our subject of interest in this study, if treated as products, should falls similarly under the same treatment as goods.* However, some sectors such as the financial and health sectors are sensitive and much protected nationally. Freedom of mobility thus could not be achieved maximally.

The inherent need for Healthcare integration and cross-border healthcare are resulted from a combination of the heightened level of labour mobility on one hand and the increase in private activities in the form of travel and tourism on the other. While labour mobility and tourism unavoidably demands healthcare integration, the needs stemmed from the insufficiency of national healthcare system do not necessary required cross-border healthcare. This notion is based on the traditional assumption as long as the home system meets the needs of the patients, they will most likely not consider healthcare abroad. But since the system is never perfect, demand for cross-border healthcare would exists and that constitutes for the non-inherent factors, which will be discussed in chapter 4.2.3.

In the Treaty, movement of labour or workers is under the title "Free Movement of Persons, Service and Capital." Such implies the complete movement of EU citizens whether as a worker or a traveller, even though there is no such clear statement of it. Nevertheless, whether they are workers or travellers as long as they are citizens of the European Union, they are entitled to cross-border healthcare. The EU, as confirmed by the European Court of Justice's rulings, guarantees the provision of medical attention in the event of illness in another Member States. The mobility of workers and tourism share similar features in that they create economic activities and require access to healthcare. The need for healthcare in the former case requires a well-integrated structure in order that systems can interact and serve the healthcare needed efficiently. While workers abroad require periodical medical attention similar to what they receive at home country, healthcare in the case of tourism, on the other hand, is based on impromptu and immediacy. Regardless of their difference in the nature care, they both induce healthcare integration. If workers or travellers were to receive healthcare abroad and to be reimbursed, the care must be recognized by the home system. Standard of cares must be acceptable to guarantee the quality of care. Therefore in achieving a smooth cross-border healthcare, a degree of contact and harmonization must be satisfied in creating healthcare integration.

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* Please refer to the implications of the healthcare commodification in Chapter 2.1

The first combination to cross-border healthcare is labour mobility. Article 48 of the Treaty on the Functioning of the European Union stated the duty of Union in facilitating the mobility that:

> The European Parliament and the Council shall … adopt such measures in the field of social security as are necessary to provide freedom of movement for workers; to this end, they shall make arrangements to secure for employed and self-employed migrant workers and their dependants:
>
> (a) aggregation, for the purpose of acquiring and retaining the right to benefit and of calculating the amount of benefit, of all periods taken into account under the laws of the several countries;
>
> (b) payment of benefits to persons resident in the territories of Member States.

While the framework laid down in the Treaty is vague, its intention is obvious: social security should be sufficiently provided to ensure labour mobility. In general, the duty of providing healthcare is that of the Member States. Therefore, actual implementation varies from state to state.

The key ingredient to success in labour mobility is adequate welfare support. The level of welfare the labour should receive when working abroad in other Member States should be fair such that they receive benefits and non-discriminatory treatment similar to working in their home countries or their foreign co-workers. If the compensation from working in another Member States is not high enough so that they can finance their dependants' and their own healthcare with ease, adequate welfare support will be an important factor allowing them to utilize their skills in economic activities abroad. If not, despite well-planned structure for mobility, labour would not move. Also, one must not neglect the possibility of becoming a resident of the host country, which allows that person to partial or full healthcare treatment similar to that of the country's citizen. However, commitment to meet the conditions and time period must be taken into consideration. Only small portion of labour would opt for or be able to apply for this benefit. If healthcare integration were achieved, this scheme would not be necessary in terms of health.

The second significant factor inducing healthcare integration is the high level of travel and tourism. With the age of tourism no longer perceived as überluxury and the rise of low-cost airline industry, travel becomes in reach of mass population.

Destinations nearby their home countries are undeniably the first choices because the costs are less and the period of time needed shorter than far away exotic countries. Therefore, the level of travel and tourism within the EU is high. Consequence is growth in the need for immediate medical attention, which may result from minor injuries to accidents. However, public healthcare is not necessary the only option. Nowadays, the offerings of travel insurance scheme allow flexibility not provided by the public system. For example, private hospitals can be utilized. If the health facility is affiliated with the insurance company, patient may not need to pay a single cent or only the extra cost beyond insurance coverage or out-of-the-pocket cost. This might be a better way to circumvent the bureaucracy and avoid the risk of not receiving any reimbursement due to the denial by the home system.

Another form of travelling, which is interesting and significant to the healthcare integration, is seasonal relocation, second home, home stay, retirement resettlement and the likes. In the past, it was the rich who can afford a second home or seasonal relocation to escape the cold and painful winter. Nowadays, things have changed. Due to the reduction of obstacles to relocate, the increased cost of living and the embrace of cosmopolitanism, Europe is experiencing a movement of people into another region. This is prominent in case of the Northern Europe moving southward: the Scandinavian becoming Mediterranean. An increasing number of people have moved to the cheaper, warmer and better place in the south. Unlike the past, they are connected with their families in the north via modern technology such as e-mail and facebook. Either party can easily travel to visit each other on a low-cost airline. Obstacles in the past are no longer barriers.

This kind of travel differs from the earlier in that it involves a longer period of time. The type and range of medical attention also differs from that of normal tourism. It is, on the other hand, similar to that required by the movement of labour. That the author does not include it in the former category is due to the status of the patients; while the labour constitutes economic production factor, this group of people is not and thus is not covered by the Treaty under the mobility of workers. They are subjected under the healthcare scheme of normal tourists, if they are not permitted resident status.

With the two inherent reasons of labour mobility and travel and tourism, healthcare integration triggered by the need of cross-border healthcare must kick off itself in order to fulfil the philosophy laid down in the Treaty. However, the effect of the

integration and cross-border healthcare do not confine itself only within the two groups of medical tourists because the scheme must also include those with different purposes such as the medical tourists in the mere patient group. The effect is widespread and creates a chain reaction, which might be either beneficial or detrimental to the Union and the Member States.

4.2.2 Costs, Benefits and Obstacles to Healthcare Integration

In devising or implementing a policy, a weighing of costs and benefits is an important part in the decision making process. Path to triumphing over obstacles, which commitment and resources, also needs to be considered. No matter whether costs staggers over benefits or obstacles are excruciatingly painful to pass over, in the case of healthcare integration and cross-border healthcare, the needs derived from labour mobility and tourism are inherent and therefore requires an action. While the policy may satisfy the needs, its ramification expands beyond the scope of that needs. In this chapter, the costs and benefits as well as its implication will be discussed. Since this research is focussed on the European linkage to the medical tourism industry outside of the Union, only medical tourism or GATS' mode II—consumption abroad—will be the main focus. Costs and benefits of cross-border healthcare and healthcare integration are intertwined. There is no clear division between them. One issue can affect one party in negative way, while positive for another.

This chapter is based on the advantages and obstacles analysis of medical tourism in developing countries by Bookman and Bookman in *Medical Tourism in Developing Countries*[12]. While Bookman and Bookman's analysis emphasized on those of specific developing countries, the analysis in this chapter involves both developing and developed countries under the context of a single European market. Some aspects of Bookman and Bookman are not applicable to under this context. Tourism aspect of cross-border healthcare is included in this analysis as tourism now signifies the new era of cross-border healthcare. Regarding the integration and public system, Kirtiputra's concept of 3As Healthcare Indicator: Availability, Affordability and Accessibility[13] will be constantly referred to along with the healthcare equality within the Community. Despite the novelty

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[12] Bookman, Milica Z. and Bookman, Karla R., Medical Tourism in Developing Countries (New York: Palgrave Macmillan, 2007), Chapter 2 and 3.

[13] Kirtiputra, Trip, European Healthcare Trends and Thai Medical Tourism (The interdisciplinary department of European Studies, Graduate School, Chulalongkorn University, 2006)

and the speculative nature of this analysis is due to the novelty and on-going process of the issue and the lack of comparable data available, this analysis will provide a basic framework for those interested in furthering investigating issues as well as those who wants to gain basic understanding of the costs and benefits of cross-border healthcare and healthcare integration in the EU.

4.2.2.1 Prices

Prices remain one of the most significant determinants in cross-border healthcare as in other economic sectors. Ceteris paribus, the quantity demands for a normal good or service falls when the price of that good or service rises. However, in the field of healthcare, patients sometimes need astronomically expensive treatment in order to survive. This makes consumers' demand insensitive to price. In a closed market, this notion of price insensitivity may hold true, but in an open market economy where patients can opt for similar treatment abroad, price becomes sensitive again.

Another important characteristic of healthcare sector is government intervention within the system with social security and welfare provided for the population. The actions of the government result in market segmentation and often a dual healthcare system: private and public sectors. The rich utilized healthcare in private sector through their own money or private insurance. The consumer in the public sector on the other hand varies from one country to another depending on the government's social welfare scheme.* Generally, the rest of the population utilizes public service. However, there are some areas of healthcare that are not always included in social benefits such as orthodontics and cosmetic surgery. For the sake of simplicity, it is thus assumed that there are healthcare areas in which people of all economic status utilize and the economic assumption of price sensitivity holds true.

In an international market, lower prices can be achieved beyond what exists within border. Low costs of production can be utilized assuming that supply for service is sufficiently available in that economy. Resources thus can be more efficiently used and reallocated. Under an integrated market, where

* This issue will be discusses in detail in the next sub-chapter as this chapter focus on the region-wide level.

patients' mobility is guarantee, patients truly have more choices without the worry of normal medical tourists. Patients with lower income also have more chance of access to healthcare. This can be done privately or through the government's program. By outsourcing medical care to other member states where supply is abundant and less expensive, the government can cut cost, reduce the crowdedness of the system, and give its citizen more access to healthcare. It is estimated that for selected 15 tradable, low-risk treatments, if one tenth of American patients choose to receive healthcare abroad, the cost saving would be as high as $1.4 billion per year.[14]

If the market is truly integrated and sensitive to prices, competition will be reflected in price reduction and improvement of quality until equilibrium or equality is reached. It is also possible for prices to converge under free market economy. But in reality, it is impossible as market will never be completely integrated. This is due to a number of reasons such as boundaries of language and distance. Nevertheless, the integration will by itself require the Member States to commit themselves to high standard without economic impetus.

One difference in term of prices that make the EU different from global medical tourism market is currency fluctuation. This is perhaps a down side as patients cannot benefits from lower price due to change in the values of currencies. Although not all EU Member States use Euro as their currency, the Member States with other currencies have to commit themselves to monetary integration with an aim to integrate and convert their currencies into Euro. Their currencies therefore fluctuate within a narrow range to keep the Union's economic stability.

4.2.2.2 Human Capital

In an integrated healthcare market, patients are not the only mobile factor; doctor, nurses and medical workers also have the rights to do so. Workers in the healthcare industry are in fact even more legitimate and granted more rights to mobility according to the Treaty for they are labour. At the secondary

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[14] Mattoo, Aaditya and Rathindran, Randeep, Does Health Insurance Impede Trade in Health Care Services? [online], 20 March 2010. Available from: http://www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/07/19/000016406_20050719140725/Rendered/PDF/wps3667.pdf, 1.

level, the EU mutual recognition of qualifications facilitates the movement of health professionals between Member States. Quality healthcare as a result can be achieved. Technology and knowledge transfer will progress at a much faster rate. Contacts and communications within the medical circles will be enhanced A British surgeon can now hop on a plane to perform an operation in Sofia and fly back within the same day without unnecessary bureaucracy between countries. There is no need for gravely ill patients to risk their lives flying to another country to receive treatment. Specialization can be gained and utilized through a larger group of patients. Research and development can also be conducted at a faster speed through the number of patients increased from national level to trans-European level.

International medical tourism, on the other hand, normally entails and experiences a wider range of medical issues. Foreign patients from a far away country may have a condition or a disease that the doctors in that country have never experienced before. This problem may result in the cost of consultation of a specialized doctor or a need to import a special medicine, which may not generate much profit and cause inconvenience to the hospital. On the bright side, the doctors learn and experience raising the level of their ability and thus the whole country to treat patients. This is a different story in the EU; healthcare integration in the EU is within the Member States whose locations are within proximity. Symptoms and type of diseases are very similar. Therefore, the effect cause by a wider range of medical issues as in international medical tourism does not apply to cross-border healthcare in the EU.

In an international arena of medical tourism, brain drain and brain gain play an important role the dynamic of competition for the best brains. If medical tourism is a boom and compensation is high in one country, doctors may emigrate himself to that country resulting in a brain gain of that country and a brain drain for the source country. The story is different in a truly integrated market. The problem of brain gain and brain drain would not be as severe or even it can be negligible because medical personnel are mobile. Given that the condition of the patients allows the to travel, if one treatment is not available in one country, patients can resort to either treatment in another Member State or a visit of a doctor from another Member State. Instead of brain drain and brain

gain, it can be called a circulation of brain instead.

On another level is the problem of internal brain drain from the public sector to the private sector. In an economy where medical tourism industry is on the boom, public resources often get diverted into the private sector. This creates a problem of inequality. People, who could not afford private healthcare, thus will be left with lower quality of healthcare. Again, this problem is less significant since patients and medical personnel are mobile. Also for a country where public system constitutes a large part of the healthcare sector such as France and Germany, this problem is insignificant. Private sectors in these countries are so small that the movement of brain drain is inconsequential. However, in the system where public healthcare is privatized, the problem might be more severe. These countries are mostly in Eastern Europe.

4.2.2.3 Tourist Appeal

While labour mobility is supported with guarantee's access to healthcare, tourists can be sure as the scheme for them has been increasingly devised and implemented to give them access to social benefits. For example, the European Health Insurance Card provides all EU citizens with necessary medical care during their travel within the European Economic Area, which includes all of the EU Member States and Iceland, Liechtenstein, Norway and Switzerland. The EU travellers can be assured that they will receive proper treatment and thus facilitate the movement of traveller. With healthcare integration

In having an integrated healthcare market and coordinated social welfare through cross-border healthcare, the level of novel tourism and resettlement has become higher. People can move around the EU freer than ever. By having a second home or resettle themselves in other Member States, wealth is spread because of their consumption. In general, there are two schemes of reallocation, that of the rich and that of the one who wants to save money. The first involves extensive spread of wealth travelling and living abroad as to relax themselves. This is prominent in the movement of northern European moving southward, which is often the Scandinavian moving to the Mediterranean region. This can be characterized as a true spread of wealth and a reduction in inequality as they induce and increase economic activities in the poorer areas transferring money to

the poorer. The second, on the other, involves logical economic thinking of cost saving. The retiree who no longer work and generate no further income can opt to maximise their savings by living in places that incur lower costs of living. With the same money, they can enjoy more products and services. Problem may occur that by living abroad, they are not eligible or in a difficult situation to receive social welfare. This might cost them costs on healthcare. However, if the healthcare integration results in portability of social welfare, problems are solved. They can enjoy living abroad, where the weather is good and the sun always shine. Currently, pension scheme known as EUlisses allows for pension to be transferred within the European Economic Area[15]. Unfortunately, other social benefits are completely portable at the present.

4.2.2.4 Economy of Scale

There are many aspects of integrated healthcare system. Some of which are single healthcare market, multinational medical firms and trans-European insurance companies. All of these have one thing in common: economy of scale. Economy of scale refers to the reduction in cost per unit resulting from the increase in production, which can be accomplished through operational efficiency.

For hospitals, the effect might not be so perceptible as the nature of healthcare is labour incentive. Each worker has a very limited capacity to serve only a few patients per day. However, the benefits to the hospital will instead be the worthwhileness of physical structure and equipment accumulation. Hospitals with a large number of beds are not always occupied. Medical tourists can solve this problem keeping the occupation rate constant. The hospital can operate at a full capacity or an optimum rate depending on their preferences. And if the number of patients increases, medical equipments, which are expensive, can then be used more often. Because technology progresses fast and the costs of equipments are so high. It may not be worthwhile to have up-to-date technology. But with the increase in patients, this makes it worthwhile for the hospital to

[15] European Commisstion, EUlisses-EU Links & Information on Social Security [online], 24 March 2010. Available from: http://ec.europa.eu:80/employment_social/social_security_schemes/eulisses/jetspeed/portal/mediatype/html/language/en/user/anon/page/homepage.psml

invest in high-tech medical equipments. Local patients will be the main beneficiaries of this investment.

On a larger scale is the chance for countries with smaller healthcare capacity to contract itself with other systems. This will allow increased availability not only in terms of capacity but also capability. In "Trade in health services under the four modes of supply: review of current trends and policy issues"[16] by Blouin et al., Malta was given as an example for its special relationship with the United Kingdom in terms of healthcare. Prior to 1995, Malta was not able to perform cardiac surgery and thus have to refer its patients to foreign treatment. Through special arrangement with the UK, Maltese citizens have access to free healthcare in specialized hospitals under the UK's National Health Service. In return, the UK citizens visiting Malta have free access to free healthcare in case of acute conditions and for UK permanent residents in Malta the discounted rate for health services. As specialized services not being able to provide for within a small country such as Malta, contracts with countries with capabilities offer a solution to public care deficiency. Later on as the number of Maltese increased substantially, the arrangement evolved into reimbursement scheme. With the accession of Malta into the European Union in 2004, Malta became eligible for the EU cross-border healthcare scheme giving it opportunities to specialized services in other Member States.

Due to the integration of the healthcare system as well as to common regulations, Europe has become an interesting place to invest. The size of its economy grows meaning the number of production unit with the same specification increases. Firms can tailor their products to suit the regions and produced a mass number of the products. These products can be such as medical equipments and medicines which once approved by the common authority can be distributed and sold all over the Community. Unfortunately, the integration has not yet reached the level whereby everything is under one single authority of the Union. Some relating regulations and institutions are still under the administration at a local or a national level. This is such as the different requirement for product labelling and in the case of health services a rule to

[16] Blouin et al, "Trade in health services under the four modes of supply: review of current trends and policy issues," International Trade in Health Services and the GATS: Current Issues and Debates (Washington D.C.: The World Bank, 2006), 213.

submit a patient history or even the national health system itself. Another obstacle to this is the intrinsic differences within the Union, which act as a non-tariff barrier. For example, languages result in the cost of translations, which can be burdensome once it involves bureaucratic and legal matters. Out of all officials working for the European Union, approximately one third of them are language-related officials. In the field of health service, this is such as the prohibition of doctors from treating all the patients as not all of them can speak the same languages the doctors could. That hinders doctors from achieving the economy of scale.

Insurance companies gain a lot of benefits from the economy of scale. It is better for insurance companies to be big as they can offer better service in several countries as well as give them stability. They can become too-big-to-fail. In the European Union, where they offer private healthcare insurance, the synergy can be created among Member States. A network of hospitals affiliate with the insurance companies can mutually benefit both the insurance and the hospital industry. Patients can select the hospitals of choice in receiving service. Coverage is expanded.

4.2.2.5 Europeanization and European Policy

European integration is an ongoing endless process, whereby the ideal equality is the cornerstone. The process in itself requires a gradual transformation of many different areas whether they are political, social or economic. This transformation is all based on legal agreement between Member States. Common frameworks and regulations will therefore be made on the basis of compromise and thus result in a slower process. However, compromise and slowness are essential due to the problem of legitimacy, the willingness of the Member States and the period of transition, realignment and adjustment. A concept central to European politics is the topic of subsidiarity, which refers to the decision being made and implemented at the most suitable level.* This is how powers and duties are distributed while maintaining interests of everyone. Centralized system is not always a good thing. It is not easy to strike the right balance between the EU

* The problem of power politics has already been discussed in detail earlier in Chapter 4.1 so here would serve as recapitulation and a build-on with an emphasis on its effect on the healthcare integration.

level and national level. Therefore, subsidiarity must be employed carefully. Behind any decision-making, interests are the key word. However, as they shift and transit into the new bases modified by common framework and regulations, their interests shift as well. This shifting of interests is the true Europeanization in creating a unified and well-integrated Europe.

In the field of healthcare integration, the progress has been gradual. For example, the ban of tobacco advertisement across Europe is made possible only when it is a mandate from the EU level. It is very unlikely that every single Member State would put on such ban if they were not obliged to do so. Coordinated action and policy against cross-border would be less effective if made through international bilateral or multilateral basis. Disagreement and difference in the level of commitment would make it difficult to achieve high level of protection. Cross-border health threats such as pandemic influenza could not be controlled unless the policy is European-wide. This is due to the high-level mobility and interaction with in the Community and locational proximity. A common institute dealing with research and development as well as high-related committee will also help the EU to progress faster and smoother. Rather than relying on national experts, who may have nationalistic tendency, the insights and opinions will lead to the best decisions for everyone.

"I want my money back." This 1979 classic quote of Margaret Thatcher always reminds everyone of the fairness of money contributed and money received. Member States have to contribute to the EU accordingly with the size of their economies. However, money out is not proportionally distributed. Practically, rich Member States alleviate the burden of poor states even though they do not want to. The budget on health of the EU is currently not of prime concern. Most of the health schemes as demonstrated above are European-wide and therefore there is no bickering over this budget as the EU is the one who actually spends it for benefits of all.

4.2.2.6 Power Shift and National Security

The problem instead is in the cooperation of Member States' national healthcare system and social welfare. According to Atun (2004), cross-border trade in healthcare is the source of government's power on healthcare redefinition. Before the open up of trade in healthcare, the government has authority in managing their healthcare system. It can control and delegate power to the healthcare provider and purchasers within the system. If the government chose to provide the care itself, the power remains totally with the government. On the other hand, if the government opts for market mechanism, it decreases its own power on healthcare control. Either way, the government has no obligation to let go of their power. However, the open up of trade, which is obligated by international agreements such as the General Agreement on Trade in Services (GATS), has resulted in a shift in power. While the government officially has the power over criteria setting such as through law and regulations, the providers and purchases increasingly have more operational power. Providers and purchasers of healthcare have more freedom as trade restrictions have been partially lifted. Market trend can no longer be controlled. Healthcare provision has more factors influencing its direction. If the value of trade and the level of foreign investment have increased substantially, national authority could become meaningless. It will be harder for the government to guarantee the quality of care for its citizen. The organisation of supply will be harder as it will become more market-orients. Inequality could be exacerbated. The level of expenditure could be higher as there could be an increase in healthcare consumption due to more supply and choices available. The government will also have less power to protect national healthcare and pharmaceutical industry because of international competition.[17]

[17] Atun, Rifat, The Future of Health Sector in the Expanded EU [online], 15 March 2010. Available from: http://ihs2004.ihsummit.eu/content/prezentace/18_Atun.pdf

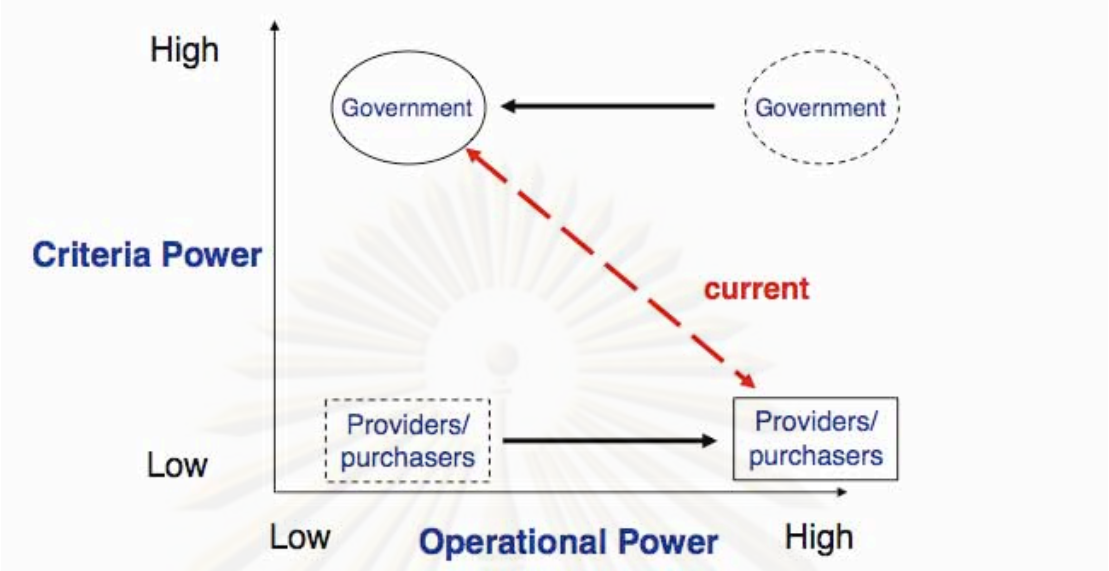

Figure 5 – Redefining roles: criteria v operational power

Source: Atun, Rifat, (n.a.)[18]

Cross-border care could undermine the provision of healthcare within their countries as well as potentially destroy the healthcare industry in their own countries. How should the system prioritise different patients? Are fair prices for cross-border care possible? What would happen if the system of countries with high-level of care got flooded with patients from poor nations? Could the system sustain itself under the new cross-border healthcare scheme? What would happen in case of malpractice? These are some of the hypothetical problems. So far these problems have not surfaced and become prominent as the level of integration is low. But once the systems are so integrated, what would happen? Many experts believe that the strong flux of patient movement would not be so high, as most patients prefer to receive treatment within their own countries; if is were not necessary or convenient, they would not have resorted to cross-border healthcare. However, we must take into consideration the possibility of change in consumers' behaviour. If the market is truly integrated and costs and transportation make travelling attractive, there might be a chance of surge in cross-border healthcare. Healthcare equality across Europe will be a stabilizer of this effect deterring patients from utilizing services abroad.

[18] Ibid.

4.2.3 European Social Models, Welfare System and Cross-Border Healthcare

The need for cross-border healthcare does not only stem from the inherent need such as from the movement of workers and tourists around the Union. In some cases, it may be more convenient to receive healthcare abroad if they live in the border area. Patients may sometimes demand healthcare that is not currently available in their country or could no longer wait for the treatment provided under the crowded national healthcare system. In this chapter, social models in Europe alongwith the welfare system will be discussed as to understand the reason for cross-border healthcare. Dedicated discussion on the Member States of the European Union is not sufficient as cross-border healthcare goes beyond EU borders and the cross-border healthcare scheme actually includes other countries, which are Iceland, Liechtenstein, Norway and Switzerland.

Healthcare in Europe is a complicated issue. The systems are run at the national level and each country has its own system differed by its believe in what it perceives as social welfare. States have an important role in managing and funding the healthcare systems. Universal healthcare or healthcare for all is an aim, which can be accomplished by some countries. For some, subsidization takes place in the form of public insurance. Public sector dominates the private sector, which constitutes a small portion of the industry. In some countries, the systems provide only basic coverage only, which means healthcare due to sickness. Citizens who want to extend the coverage can purchase supplemental insurance. Generally, according to T.R. Reid, there are four basic models of healthcare systems: Beveridge, Bismarck, National Health Insurance and Out-Of-Pocket models.[19]

The Beveridge model is named after William Beveridge who devised the British National Health Service (NHS). Under this model, the healthcare system is managed and financed by the government through taxes. Most of the healthcare facilities are public i.e. owned and run by the government. All citizens have the rights to all healthcare services provided by the system. This model is highly regulated, as the government is the sole sponsor of the system. As costs can be controlled, the system can curb their own bills. Countries using the Beveridge model and its variations include Cuba, Hong Kong, New Zealand, Spain, the United Kingdom and most of the Scandinavia.

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[19] Frontline, FRONTLINE. Sick around the world: five countries: health care systems – the four basic models – PBS [online], 25 March 2010. Available from: http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html

The Bismarck model is named after the famous Prussian Chancellor Otto von Bismarck who created the first welfare state, Germany. The Bismarck model employed insurance or pooling as a means of finance. Normally, both employers and employees contribute through payroll deduction to the insurers' sickness funds. Insurance will then pay for healthcare costs. This allows the healthcare industry to operate privately on its own without the government stepping in the system as in the Beveridge model. Citizens can decide the level of coverage and payment they can afford. The government of countries using this model instead relies on regulations on the insurance and healthcare provisions. Countries using this model are Belgium, France, Germany, Japan, the Netherlands, Switzerland, and some Latin American countries.

The next system, **the national health insurance model**, is a combination of both the Beveridge and the Bismarck models. As the name suggests, the model use insurance as in the Bismarck model, but instead of private insurance, the government steps in to provide the insurance itself. Every citizen contributes to this fund. Since there is a single payer as in the Beveridge model, the government has market power to negotiate prices. However, the scope of services provided is more limited than the Beveridge model as it is still an insurance model. This model can be found in Canada, South Korea and Taiwan.

The last model, the cruellest one, is **the out-of-pocket model**. Patients pay all the costs by themselves. Out of the world's 200-ish countries, less than half have well-established healthcare systems that can provide their citizens cheap healthcare and eliminate the need the burden of out-of-pocket healthcare costs on their citizens. Social inequality prevails rendering the poor less access to healthcare. No money, no doctor![20]

According to the 2000 World Health Organization's ranking of the world's healthcare systems, out of 190 countries, most of the Member States the EU—especially the EU-15[*]—rank well lists. France ranks first, Italy second. The lowest ranking for the EU is Latvia at 105.[21] However, it must be taken into consideration that the 12 new EU Member States have not yet gone through the transformation as part of the requirement

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[20] Ibid.

[*] The EU-15 refers to the group of EU Member States before the 2004 enlargement. The group includes Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

[21] World Health Organization, The World Health Report 2000: Health Systems: Improving Performance [online], 25 March 2010. Available from: http://www.who.int/whr/2000/en/whr00_en.pdf

yet and therefore their ranks can be higher at the present. Despite the change, according to the Health Consumer Powerhouse, "the cultural streaks have in all likelihood deep historical roots. Turning a large corporation around takes a couple of years– turning a country around can take decades!"[22] It is inevitable that the new Member States are still in the period of adjustment.

Table 9 – Ranking of health system attainment and performance in 29 selected European States

Countries	WHO 1997 – Performance on level of health	WHO 1997 - Overall health system performance	EuroHealth Consumer Index 2009 - Overall
Austria	15	9	4
Belgium	28	21	11
Bulgaria	92	102	33
Cyprus	22	24	19
Czech Republic	81	48	17
Denmark	65	34	2
Estonia	115	77	18
Finland	44	31	12
France	4	1	7
Germany	41	25	6
Greece	11	14	24
Hungary	105	66	20
Ireland	32	19	13
Italy	3	2	15
Latvia	121	105	31
Lithuania	93	73	29
Luxemburg	31	16	8
Malta	2	5	26
Netherlands	19	17	1
Norway	18	11	10
Poland	89	50	26
Portugal	13	12	21
Romania	111	99	32
Slovakia	88	62	28
Slovenia	62	38	16
Spain	6	7	22
Sweden	21	23	9
Switzerland	26	20	5
United Kingdom	24	18	14

Source: World Health Organization, (1997).[23] and Health Consumer Powerhouse, (2009).[24]

[22] Health Consumer Powerhouse, EuroHealth Consumer Index 2009 [online], 25 March 2010. Available from: http://www.healthpowerhouse.com/files/Index%20matrix%20EHCI%202009%20091001%20final%20A3%20sheet.pdf, 17.

[23] World Health Organization. op. cit..

[24] Health Consumer Powerhouse. op. cit.

The ranking portray one significant problem of healthcare system in the European Union. That is the healthcare inequality among the EU Member States. According to Kirtiputra, "… the accession of Central and Eastern European States (CEES) into the community in 2004 and 2007 integrated clear economic and social disparities into the community." Considering the general healthcare trend in Western Europe of rising cost and supply insufficiency and in the CEES the lack of advanced technology, a deduction that there is a need of cross-border healthcare can be made. On the surface, there should be a movement of western European medical tourist looking for cheaper healthcare in the Eastern Europe and a movement of eastern Europeans in search of high quality and high tech medic al care. However, if we look deep into the system of the Western European countries themselves, there is also a movement of medical tourists within the area, such as the labour mobility and tourism as mentioned early in this chapter. Disregard of such inherent needs, there is also an inherent difference in social belief and thus social models that creates the phenomenon of cross-border healthcare and medical tourism. Because each countries have different capacities of healthcare as well as different perspective to social belief of what perceive what the government should provide for their citizens, healthcare system in each countries are thus unequalled. Money and wealth alone cannot justify the success of the country's healthcare system i.e. creating a system so good that no one has to rely on cross-border healthcare. Success whether in reality or on ranking "seem(s) to reflect more of 'national and organisational cultures and attitudes', rather than mirroring how large resources a country is spending on healthcare."[25]

4.2.3.1 Western European Countries

In general, compared to American citizens, the Europeans receive a higher level of social welfare due to their acceptance of the state's important role as well as its intervention in the market economy. In general, European citizens pay relatively high level of tax. States take the job of redistribution the money in creating social cohesion. Public services are provided abundantly through healthcare, education, housing, and public goods such as water works, electricity and public transport. Social protection is provided in form of social assistance such as income support and social insurance such

[25] Health Consumer Powerhouse. "The Empowerment of the European Patient 2009 – options and implications Report." op. cit.

as retirement, unemployment and healthcare. Most healthcare systems in Europe are either provided through the Beveridge and the Bismarck systems.

The term European social model leads to the perception of Europe with high living standard with generous governments' welfare program together good working conditions. Specifically, the term alludes to the Western European countries or the EU-15. In reality, there exists no single European social model. Each country has its own approach toward health, education, pensions, unemployment benefits, and social securities, thus the difference in taxation, revenue and expenditure. This fact contributes to difference in healthcare benefits and services offered through public healthcare system. Common European Social Model however may exist in the future as the Europeanization and many EU policies result in the slow convergence of European social models.

The derivation of the European social model can be attributed to the common values shared by all European states. Such values are such as social cohesion, gender equality, equal opportunity and access to healthcare, education, and social benefits. All of these issues are now included in the Charter of Fundamental Rights of the European Union. Therefore, it could be said that there exists a legally binding common values shared by all the Member States of the European Union. These values if accepted and shared by every citizen of every Member State would create a real unified and integrated Europe and thus a single European Social Model.

In general there are two opposite movements of social models: the free market and the socialist. If we are to put Europe and the U.S. on the two sides, it is clear that the U.S. will be on the side of the free market and Europe on the other. Generally, the U.S. is characterized by its free market economy letting the invisible hand or the market mechanism determines the system. Inequality is thus the result with a clear separation between the winner and the loser. Its healthcare system is driven by market economy. Most of the healthcare facilities are in the private sector, which implies the rise and fall of healthcare costs driven by supply and demand.* In the U.S., there is no universal coverage for all of the population. Conversing in the language of four above healthcare models, the U.S. is using them all. If you are soldiers or veterans, you receive free

* It should be noted that in the U.S., States have the power over healthcare. In some states such as Massachusetts, universal healthcare is achieved through the states' regulation obligating all citizens to have healthcare insurance and the states' provision of insurance to the uninsured who could not afford to buy one of their own

treatments as in the Beveridge model. In terms of insurance, the government provides coverage in form of subsidized insurance to people over 65, as in the national health insurance model. The rest, which are most of the citizens, has to rely on purchasing their own private insurance, as in the Bismarck system. For those who could not afford insurance, they have to pay for the healthcare costs out-of-pocket i.e. by themselves. This reduces the opportunity to receive all medical care they require. With the 2010 healthcare reform by President Barack Obama, system will change as everyone is required to have health insurance. The reform will result in the near universal coverage.[26]

The European social model, on the other hand, is more generous than the past America. Most of the states intervenes the system as to provide social welfare to their citizens guaranteeing basic quality of life. However, the degree of provision varies from country to country. European economic and social policy debates have split Member States into two broad groups with opposite model in minds. On one side are those who want free and flexible labour markets, less regulation and more competition according to the free market economy principle similar to that of the U.S. On the other side are those who want higher social benefits, higher regulated markets, higher labour market protection and more rights for workers. Being tugged between two ideologies are the four main types of social models: Scandinavian, Continental, Anglo-American and Mediterranean.

The Scandinavian social model can be described politically as a social-democratic model. It is one of the expensive models out of the four. Countries employing this model include Denmark, Finland, Iœland, Norway and Sweden. It is based on the concept of equality, comprehensiveness, social inclusion and universality. The system supplies high affordable and high quality social services. Generous unemployment benefits and high level of healthcare are financed through tax. Taxation is based on a progressive model, where by the rich are taxed higher in proportion of their incomes than the poor. Personal income tax in Denmark could go as high as 63%, which is the highest in the world. Corporate tax, however, is low. The unemployment rate is low. High minimum wages are guaranteed, thus high replacement rate. Pension and healthcare benefits are generous. Most of these countries use the Beveridge model with the governments running the healthcare system. One essential element of this model,

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[26] Wikipedia, Health care reform in the United States [online], 25 March 2010. Available from: http://en.wikipedia.org/wiki/Health_care_reform_in_the_United_States.

however, is the heavy dependence on the homogeneity of the society as social equality results in similar taxation and therefore similar social benefits. This is demonstrated in Denmark, Norway and Sweden being the countries with lowest income disparity in the world. If the society were not homogenous, question of unfairness with the rich paying for the poor or the national paying for the newly immigrated would arise.

The Continental model, which includes that of Austria, Belgium, France, Germany, Luxemburg and the Netherlands, on the other hand, is based on preservation of social status. This conservative model aims at prevent social clash rather than solving problems through equalizing social status of their citizens. These states are after the welfare state ideology as initiated by Bismarck in the creation of Germany. Benefits from social insurance system for health, pensions and unemployment are based on individuals' contribution. The more an individual contributed to the system or the insurance, the more the benefits that individual will receive. Therefore, this results in a low level of income-related transfers. Income redistribution also is low. The system is also structured in a way such that there are low taxation on wealth and high taxation on labour and consumption. Social disparity could be exacerbated with the higher rate of wealth accumulation for the rich and the lower saving rate for the poor as taxation is high on income and basic consumption. Rich people will also be rich and richer, while the poorer get stuck in the same social status. Some benefits are given regardless of the needs for such social benefits. For example, both voluntary and involuntary unemployed are given the same unemployment benefits. While it is fair that everyone receives the same benefits, it does not refer to the needs of that person; the rich receive the same benefits as the poor.

The third model, **the Anglo-American or liberal model**, is based on market mechanism and thus the minimum role of the state. As the name implies, the model is similar to that of the U.S, which has been discussed earlier, and the countries employing this model are Ireland and the United Kingdom. This system is based on the economic ideology that market mechanism will regulate the system and lead to maximum efficiency by itself. Therefore, the government should intervene as little as possible. Nevertheless, the Darwinian concept, survival of the fittest, needs not be applied in reality. It is the job of the government to take care of its citizens. Social benefits, therefore, are provided at a minimal level for those who need them to guarantee their survival in the society. Social benefits are kept checked. This system provide workfare more than welfare, which

means that those receiving should involve in economic activity as an incentive for them to have better life. This does not prevent social problems that may arise; rather the system focuses on solutions by providing basic social benefits to keep the problem under control. The poor is literally excluded from the society creating a problem of inequality and social exclusion. Social cohesion therefore will never be achieved. On the bright side, there is a low expenditure to maintain this system. Income is guaranteed. There is a provision of services such publicly financed schools and as public health system, of which the state is the single payer for universal healthcare, as in the Beveridge system.

Lastly is **the Mediterranean model**, which is a family-centred one. Countries with this model are Italy, Greece, Portugal and Spain. In general, this model is similar to the Continental model. However, culture plays an important role in the existence of this model. Unlike the Continental model, the states provide generous welfare and pensions as can be seen from the table below. This is due to the close-knitted structure and supportive family networks within the society. Such is reflected into the paternalistic governing system of provide care for their offspring. Employment protection is rigid. There is also a high level of gender inequality and a low level of labour participation rate for female and the young.[27]

Table 10 – Social expenditure in % by European types of Social Security System

	Pensions	Family	Social Assistance	Unemployment Benefits
Scandinavia	**38.8**	**10.0**	**5.1**	**46.1**
Continental	**42.8**	**11.7**	**2.8**	**42.7**
Anglo-American	**37.0**	**10.5**	**6.1**	**46.4**
Mediterranean	**52.2**	**4.5**	**2.4**	**40.9**

Source: ESSPROS, (2004).[28]

[27] Mardellat, Patrick, European Social Model(s): From Crisis to Reform [online], 8 January 2010. Available from: http://www.cesfd.org.cn/teaching/European%20Social%20Models%20Part%201%20ppt.ppt

[28] Ibid.

Table 11 – Social and Healthcare Models of Western European Countries

	Scandinavian	Continental	Anglo - American	Mediterranean
Bismarck		Austria Belgium France Germany Luxemburg Netherlands Switzerland		
Beveridge	Denmark Finland Iceland Norway Sweden*		Ireland UK	Greece Italy Portugal Spain

Source: Author's own categorisation based Mardellat, Patrick. "European Social Model(s): From Crisis to Reform. (2010)[29]

4 Social Models and 2 Healthcare Models

Without digging too deep into the system of each county, these four models, which summarize western European healthcare philosophy, render a clear picture that countries with better healthcare system and could attract patients from countries where healthcare is insufficient, more expensive, lower in quality or limited in coverage. However, each model does not imply superiority of one model over another in delivering healthcare or the success of the system on the ranking. There are variations among countries within each model also play a significant role in determining the success of the system. These factors include size of the country, money put into public healthcare, system of the healthcare and many more. Nevertheless, the models imply a lot regarding cross-border healthcare.

One dimension is how each model embrace or reject people of different social statuses reflect social reality in which not all people are content with the system and thus some needs to seek healthcare abroad. In the Scandinavian model, where people are homogeneous, healthcare is provided on the same level to almost all the population. The

* Sweden is a country of a mixed model between the Beveridge and the National Health Insurance Model. While hospitals are run by county government, doctors are paid by the government. For the sake of simplicity, Sweden is listed under the Beveridge model.

[29] Mardellat, Patrick. op. cit.

Continental model, on the other hand, is constructed in a way such that the poor have lower access to healthcare and thus needs to seek cheaper care outside the system. If the insurance citizens can afford does not have a wide coverage, they might have to seek medical care outside their countries in search for cheaper care. Similarly is the Mediterranean. Despite the more generous level of welfare provided compared to the Continental model, low labour participation rate results in the stagnation in the same economic status. Last is the Anglo-American model, this model provides only basic welfare to its citizen and healthcare is one of its. Strictly interpreting the ideology, healthcare should be provided at the minimum level as well. However, in reality the system is more generous than that in providing their citizens healthcare. Nevertheless, problems would not happen if the government has well-managed system and sufficient funding for their healthcare system.

On another dimension is how healthcare systems are actually managed. In Europe, the discussion is often on which system rules over the other: the Beveridge or the Bismarck, the free market or the socialist. The Beveridge model is more socialist-based, while the Bismarck model is more free-market-based. It must be noted that healthcare model should not be confused with social model as it may seems contradictory that the United Kingdom, which has an Anglo-Saxon social model, liberal in ideology, employs the Beveridge system, which is socialist. No matter which social model or healthcare model a country has, the government all have to cater to their citizens adequate high quality healthcare under the budget.

According to the Health Consumer Powerhouse, in general, it can be said that the Bismarck beats the Beveridge system. The Health Consumer Powerhouse points out to the two inherent flaws of the Beveridge model: mismanagement and politics. Firstly, the management of a public organization of substantial size is not an easy task. For instance, the UK's National Health Service employs roughly 1.5 million personnel. Incentive is not an easy task to create with the available remuneration and resources provided. The directions of the administration and health profession do not necessary coincide.[30]

Secondly, the system handles both the financing and the provision of healthcare. Since the system is part of the political institution, it is subjected to political uncertainty.

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[30] Health Consumer Powerhouse. "The Empowerment of the European Patient 2009 – options and implications Report." op. cit.

It could become tools of politicians in gaining re-election.[31] The author would like to add that since the organization is the only one responsible for public healthcare, they must always make the right moves as there is no alternative if they have erred. In the Bismarck model, where there are multiple players, if one makes a wrong decision, consumers are not heavily affected as in the Beveridge model. Furthermore, since financing of the Beveridge model is not autonomous i.e. not detached from the government's budget, there is no separate funding dedicated solely for healthcare services. Thus, if the amount of fund fluctuates annually according to the revenue of the government and the annual budget allocation, healthcare service could not operate efficiently. Vice versa, what would happen if the healthcare costs rise beyond the acceptable level that they disturb budget in other areas?

All these problem of the Beveridge model leads to the question of under which conditions would this system perform. It is evident that the Scandinavian countries utilize the system well as demonstrated by the high performance of the system. One important factor is that their system is easily managed due to the small population size and the wealth that countries have.

Nevertheless, they could not detach itself from the perennial notorious that the UK is facing: the long waiting time. There are many reasons for long waiting time such as the inefficiency of the system due to its bureaucratic nature. Generally, in order to see a doctor, patients must book an appointment in advanced. The doctors that patients see at this state are general practitioner (GP). If there is a need for hospital care, the general practitioners will then refer them to specialists at the hospital. This system of referral is sometimes called the "GP gatekeeping." Regardless of the gatekeeper, it does not imply that the patients will receive treatment immediately. The UK, currently, aims to keep the referral period to treatment to less than 18 weeks.[32]

For those who cannot wait, cross-border healthcare is an option. However, it is not a sole solution. In "the Empowerment of the European Patient 2009—options and implications" by Health Consumer Powerhouse, under-the-table payments to doctors have been documented. These unofficial payments are made to the doctors in order to receive healthcare at all, better quality of care or to jump the waiting lists. This might not be a surprise, if this phenomenon happens in the Eastern European countries or

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[31] Ibid., 10.

[32] National Healthcare Service, 18 weeks patient pathway [online], 25 March 2010. Available from: http://www.18weeks.nhs.uk

countries where legal systems are less developed. However, even in Austria, France and Italy, the incidents can be found.[33]

The Bismarck model, however, is not flawless. France, Germany and Switzerland bear one of the most expensive healthcare costs in the world to maintain low price for their system. In the year 2007, France's total expenditure on health accounts is equal to 11.0% of total Gross Domestic Products (GDP), Germany 10.4% and Switzerland 10.8%. These three countries are topped only by the United States with the astronomical 16%.[34] Without careful management, the government could risk financial over-burden. For example, in Germany, patients are allowed to seek almost any type of care they wish and whenever they want it.[35] Similarly, France offers a highly accessible system giving almost unrestricted access to doctors. The refunds rates are high such that the service is virtually free.[36] This could risk the system being overcrowded. The doctors may overwork themselves or lower the quality of care for more cases as to gain more consulting fees from the government.

Costs could be pushed on to patients through the higher co-payment rate. Co-payment or cost sharing has been used widely to contain the rise in healthcare costs. Despite the benefits of cost containment, the scheme is double-edged. This system is in placed not just because the government could not afford total medical bills. Despite the extra money gained, the government actually reduces the utilisation of health services. Since the patients also have to pay part of the bills, not all would like to visit the doctors as often. Co-payment can be progressive as in progressive taxation rates. Such scheme makes healthcare services income dependent. Each income-group of citizens will have to adjust their utilisation of health services and pharmaceuticals according to their lifestyles and income. In some countries, the co-payment system is applied on specific costs. For example, Poland and the Czech Republic require co-payment for general practitioner appointment and pharmaceuticals, while they do not for specialist appointment and hospital in-patient service. Some such as the United Kingdom has co-payment system only on pharmaceuticals as patients never see medical bills due to the system. In the

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[33] Health Consumer Powerhouse, "The Empowerment of the European Patient 2009 – options and implications Report," op. cit., 48-49.

[34] OECD Statistics, OECD Health Data: Health Expenditure 2007 [online], 30 March 2010. Available from: http://stats.oecd.org/Index.aspx.

[35] Health Consumer Powerhouse, EuroHealth Consumer Index 2009 [online], 25 March 2010. Available from: http://www.healthpowerhouse.com/files/Index%20matrix%20EHCI%20 2009%20091001%20final%20A3%20sheet.pdf, 7.

[36] Kirtiputra, op. cit., 10.

United Kingdome there is a debate as whether to introduce co-payment system to expensive medicines and implementations or not. This is similar to the system in the United States whereby healthcare providers are paid accordingly to their performances. Hospitals with higher success rate will receive more payment, which could translate into higher rate of co-payment. So far the three richest countries with highest GDP per capital, which are Luxemburg, Norway and Switzerland, have "no-exemptions attitude" toward co-payment. Healthcare subsidy in these countries is so high such that everyone can afford the minute co-payment. However, what would happen if the costs grow so high that it no longer can be contained? Co-payment too high could substantially reduce the healthcare service utilisation rate and consequently reduce the quality of life. Coverage of insurance could become smaller. While the coverage of standard basic insurance required by all remain the same, higher premiums could be required in case of extra coverage.[37]

Cheaper healthcare abroad or medical tourism can be a solution. However, with the high costs and system inefficiency in the Western European countries, intra-regional cross-border healthcare might not be helpful. Where should Western European patients go to in order to receive quality healthcare at a cheaper price?

4.2.3.2 Central and Eastern European Countries (CEEC)

The Central and Eastern European Countries (CEEC), which consist of both the EU and non-EU Member States, could be an answer. A number of Western European patients travel to these countries for cheaper healthcare, however within the private sector not the public sector. Therefore, the integration scheme does not reflect the level of healthcare equality and European common standard. The CEEC are not the panacea for the inadequacy, the inefficiency and the rising costs of their neighbourhood, the Western European countries. The CEEC themselves are still facing a number of problems, both economic and political.

Historically, the regions have suffered tremendously during the cold war with the region either being part of the Soviet Union or under the Soviet Union's influence. The cruel pasts have left the region with torn apart system and massive loss of lives, accumulated wealth and chances to develop economically. A number of countries have recently been born or gained independence after the dissolution of Yugoslavia in 1992.

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[37] Health Consumer Powerhouse. "The Empowerment of the European Patient 2009 – options and implications Report," op. cit., 33.

The region can be subdivided into three groups: the Baltic States, the former Yugoslavia and the rest. The Baltic States include Estonia, Latvia and Lithuania. The former Yugoslavia includes Bosnia-Herzegovina, Croatia, Macedonia, Montenegro, Serbia, Slovenia and the disputed Kosovo.

The 2004 and 2007 enlargements of the European Union result in the stability of the region as well as the development, assistance and investment from the other Member States. The first wave of Eastern enlargement in 2004 accepted ten new members: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. Seven of these countries were part of the eastern bloc. Two, Cyprus and Malta, are Mediterranean islands. And one, Slovenia, is the only former Yugoslavia. The 2007 enlargement added two more countries to the EU: Bulgaria and Romania, both former members of the eastern bloc.

While the number of countries in this region exceeds that of the European, they still part of the global medical tourism, no matter how insignificant they are. However, since this thesis concerns the effect of the European Commission's Directive proposal, only EU members and certain countries, which are Iceland, Liechtenstein, Norway and Switzerland, are of importance to this study. Therefore, the discussion of this area will be on the EU Member States only. The context will be on the overall picture of the healthcare situation in the public healthcare system.

As part of the accession process in becoming a member of the EU, the country seeking the membership status has to transform itself conforming to the conditions of the Union. It must pass a number of criteria such as the Copenhagen criteria, which have three main criteria. One, there must be a political stability guaranteeing democracy, the rule of law and human rights. Two, the country must have a functioning market economy and could deal with the competitive internal market of the Union. And three, the country must accept all the community rules, *acquis communautaire*, and must be able to take on their obligations as a member of the Union, whether political, economic or monetary union. All of these requirements aim to reduce the gap or the inequality between the former Member States and the newcomers. Unity can be created to conformity. Not only that the standard will be of the high and acceptable level, the ultimate goal of a single market can also be achieved smoothly and within a shorter timeframe than accession without transformation.

In terms of Healthcare system, the Union has a recommend framework in the field of public health. The structure of the framework is provided in the figure below. One of the sections provides a general guideline on the healthcare system, which entails health financing, facilities and personnel, health expenditure, service utilisation, health promotion and disease prevention. Aids are poured into the regions through a number of funds. It is thus expected that the newly acceded Member States would be able to conform and step up to the standard of the early Member States.

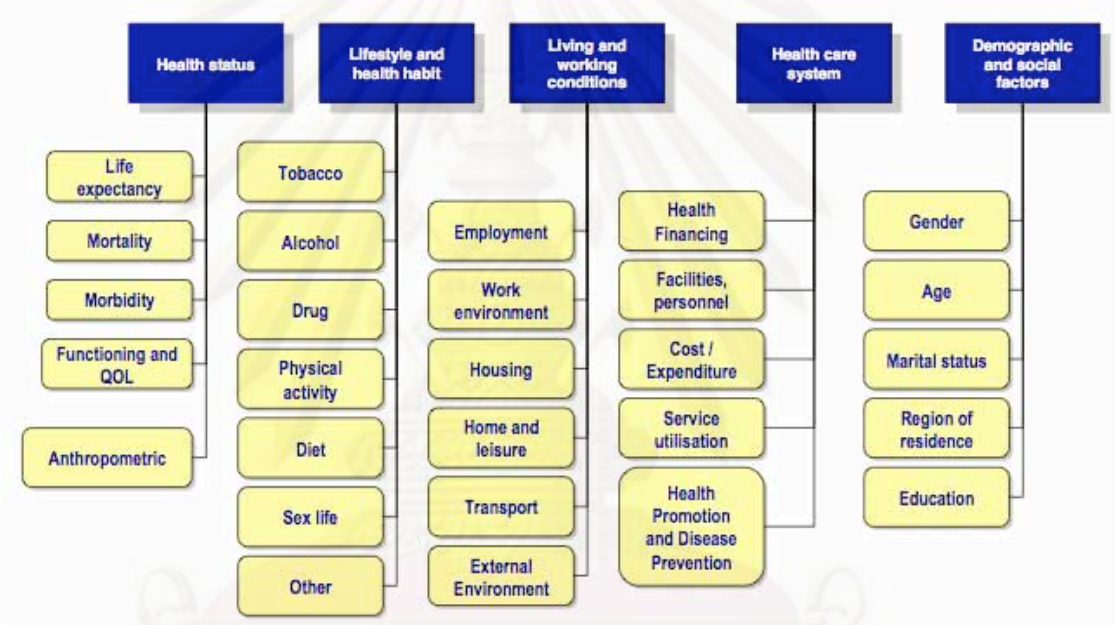

Figure 6 – EU-Acquis recommended framework - Decision No 1400/97/EC of the European Parliament an.d of the Council of 30 June 1997
Source: Atun, Rifat, (n.a.).[38]

Healthcare reality in the Eastern Europe however is unfortunate. The gravity of the problems inherent within their healthcare systems, such as the inconsistency and inadequacy of healthcare, as well as the privatisation scheme central to their healthcare reform detract them from achieving such expectation. Despite the introduction of healthcare systems into their countries, infrastructure and healthcare investment in the public sector remains a problem.

According to Kirtiputra, the overall economic reform in order to become a member of the EU created a negative impact on public healthcare. The already crippled healthcare systems were exacerbated by "the pressure of economic that pushes for

[38] Atun, op. cit.

greater decentralization, privatization and commercialization….'[39] Citizens have to bear higher costs of healthcare due to the shift from the socialist model, where the government provides healthcare for their citizens, to the insurance-based or the Bismarck model. As a result of this change, there is no need for the government to carry on the burden of unprofitable healthcare facilities. Privatisation through leasing the management of healthcare facilities or simple direct sell-off of these facilities not only can generate revenue for the government, it also gives good impression of shedding the much-loathed communistic elements from their countries. Centralized system is eliminated and let the invisible hands in the free market economy take care of it. Although this is good for the government, it is not for the citizens. Colloquially, the governments push their burden to their citizens. Citizens now have to pay not only taxes to the governments but also healthcare costs, which consists of the insurance premiums and the out-of-pocket costs if the treatment needed is not covered by the insurance.

Due to the privatisation, the governments do not have to spend as much on managing the care. Their job still is to control healthcare costs, which can be done through subsidization. Regardless of the health budget composition, the low health expenditure still points out to the inequality among nations. The EU-25 spends on average 7.76% of GDP on health expenditure. While the average of the EU-15 is 8.6%, the new Member States spends on average only 5.8%. The situation is much more distressing looking at the healthcare expenditure per capita. According to the following table on healthcare expenditure per capita by provider, in the year 2006, the 13 rich European countries spend on average 3102.11 Euro on each citizen, while the poor spend only 597.19. While not adjusting the power purchasing parity (PPP), the net amount screams out loud the inequality between the two groups. It must be realized that some health commodities such as new medicines and high-tech health equipments are available at one global price. If the amount of health expenditure translates directly and proportionally into healthcare, disregard of the mismanagement, corruption et cetera, such implies the inequality of access to high-tech high-quality healthcare.

[39] Kirtiputra, op. cit., 14.

Table 12 – Healthcare expenditure per capita by provider (Euro)

	2003	2004	2005	2006
United States	4795.53	4701.81	5081.60	5391.42
Norway	4086.94	4092.40	4475.81	4675.89
Switzerland	4412.82	4471.18	4519.63	4483.15
Iceland	3482.31	3611.11	4172.46	4001.64
Denmark	3115.17	3287.84	3472.52	3705.56
France	2725.27	2844.01	2963.80	3060.32
Austria		2819.44	2907.54	3022.52
Sweden	2771.90	2825.44	2874.00	3010.24
Netherlands	2640.94	2742.07	2842.03	2950.60
Belgium			2837.55	2870.92
Germany	2724.39	2722.92	2791.41	2867.06
Finland	2153.29	2272.59	2399.36	2488.52
Spain	1471.27	1566.09	1680.72	1796.37
Portugal	1219.67	1303.29	1367.44	1394.62
Slovenia	1047.65	1087.49	1157.10	1208.71
Cyprus	1003.10	1017.75	1072.88	1144.54
Czech Republic	566.68	600.22	683.42	747.77
Hungary	589.70	630.69	709.42	696.60
Slovakia			481.93	579.46
Estonia	319.15	366.41	414.64	494.99
Latvia			349.66	432.40
Poland		316.81	374.62	417.63
Lithuania		292.28	347.05	413.32
Bulgaria	173.00	186.80	214.01	232.32
Romania	119.60	139.77	189.83	201.35

Source: Eurostat, (2009).[40]

The systemic transformation from sole healthcare provider into multiple private healthcare providers has caused a drastic change in the nature of care given and the structure of health economy in that country. If the market economy were meticulously regulated and controlled as to drive into the right direction, that is to able to provide healthcare to those needed, the benefits would be to all. It is the job of the government to make sure that all care needed is within reach of every citizen, whether through direct provision as in the past or through insurance subsidy in the present. In general, basic healthcare services will be covered by the insurance, thus it is good for the low-income since the capability of the system for this level of care is already available or can be made available easily. Even though the standard public insurances cover basic services, both in-patient and out-patient, whether the services are of satisfactory level or not remains very doubtful with the little health budget of these countries. Private insurances also do not

[40] Eurostat, Health Expenditure by provider [online], 28 March 2010. Available from: http://ec.europa.eu/eurostat

cover all the procedures. Mostly, the private insurance policies cover some dental care, long-term hospital stays, serious illnesses and plastic surgery. High level of care, which requires complex procedures, high-tech medical equipment and specialists, will not be totally covered by private insurance, not to mention the standard insurance.

The healthcare sector will eventually evolve itself to achieve a scenario where profits are the keyword. In these countries, healthcare has been increasingly commodified. They have prices. They are subjected to demand and supply. Privatisation is the key element of this change as healthcare providers now have free rein over healthcare costs. Naturally, the prices would rise to the level the market sees fit, which is of course higher than of the past when the government provides them all and the prices are suppressed. Those who are poor will now suffer from inequality of access to healthcare and market segmentation. Only the rich can afford high quality healthcare, whether through out-of-pocket or private high-premium insurance. Sub-market will be created to supply this group of patients. For example, in Budapest, Hungary, private clinics are reserved for the wealthy. Some clinics dedicate themselves to serving expatriates.[41] This market segmentation will result in the diversion of public resources into this sub-market depriving the public of high quality medical professional i.e. brain drain. With scarcer resources, prices would of course become higher.

Diversion of human resources or brain drain should not be underestimated in this region, as there are numerous opportunities to escape the decrepit system into the already well-established system in Western Europe. The EU membership of these countries brings about the facilitation of professional mobility. Highly qualified doctors and medical personnel have become a rare species making them covetous by the rich driving their fees high. Most of them are specialists in the private sector. "As many good doctors in Eastern Europe are flocking over to the west to seek greener pastures, the pressure for better healthcare continues to rise, resulting to private medical insurance doubling in growth in the region."[42] The mechanism of this change is that people who could afford private insurance are no longer satisfied or content with the deteriorating public care system, whose human resources have been sucked dry, and therefore decide to make a purchase of private insurance in hope of security for better healthcare.

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[41] Moveforward, Healthcare in Eastern Europe [online], 28 March 2010. Available from: http://www.expatforum.com/articles/health/healthcare-in-eastern-europe.html

[42] Ibid.

However, according to the magazine Moveforward, they perhaps make the right decision:

> The shortage of competent doctors and health care workers are taking its toll on the general health of the public, which continue to complain of over crowded hospitals and clinics. These are also inadequately equipped due to under funding. … As healthcare workers continue to suffer from unpaid salaries for months, 'under the table' fees become more rampant. The general landscape is characterized by a chronic shortage of medicines and other substances while hospital equipments are in a general state of disrepair.[43]

The gravity of the situation of public healthcare in these countries is undeniable. Public hospitals are underfunded as already demonstrated in the health expenditure. With the lack of funds; facilities are not well maintained, medicines are not sufficient and medical staffs have no incentive to work. Long queue and crowdedness un-elevate staffs' working condition and heighten the state of patients' displease. Nothing could have been worse than working without salary. Under-the-table payment creates problem of mismanagement and reduces trust in public authorities. Furthermore, with privatization in mind, the governments do not have to make much attempt to maintain the public facilities; if they cannot survive, privatise them. All of these problems are definite components of a disaster. It is perhaps better to rely on private sector since there is incentive to compete and provide good services for money.

Under economic assumption, the private healthcare sector, like other business, operates for financial goal. There are many target groups according to price level and affordability. In a closed market where there is no cross-border healthcare, the richest of the country should be the one to obtain the best, the priciest healthcare services. Under the open market economy, there exists a certain someone abroad who is richer than the richest in the country. Applying this concept to all level of target groups in the country will exponentiate the opportunities to make money. Under limited resources, the business would of course be aiming for maximizing profits. Therefore, instead of limiting themselves underutilising their capacity to provide services, they can change their customer groups from those who could pay less to those who could pay more through price increasing. If the business could attract foreign tourists who can afford the higher

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[43] Ibid.

prices, they should do under the assumption that they are trying to maximise profits. This means either upgrading themselves to achieve higher level of standard or maintaining the same level of standard but increasing price. Either way would result in the movement toward normalising or standardising price across borders, which does not necessary mean achieving that standard price, just an increase in price to the level higher than before. With the increase in demand, price will adjust itself higher. All of these imply further market segmentation, further resource diversion and further inequality through cross-border healthcare.

Cross-border healthcare or medical tourism has a number of negative consequences on these countries. Firstly, public resources are diverted. Private resources will also be diverted from national to foreign population. Secondly, prices will be higher in general and therefore less people will able to receive the same level of care with the same amount of money they have. And thirdly, there is less incentive to provide service for poorer patients, as known as customers. With little left in the public sector, the private sector has an important role in provide quality service. But with the drive for financial remuneration, care might not be available to all, ergo inequality.

On the bright side, medical tourism might be good in a long run for the country. Firstly, there will be an internationalization of healthcare bringing the country higher level of healthcare through competition. Secondly, as medical tourism is not an isolated sector, revenue can be generated in a number of ways. Related industry such as the hospitality industry will receive more tourists and hence more money. The country will also have a better image through good association with high quality of healthcare and better tourism industry. And thirdly, the problem of brain drain could be prevented making the system more self-sustainable. These are only part of the inexhaustible list of consequences.

It might be assumed that medical tourism is a panacea to the healthcare failure in this region, however it does not. Medical tourism is a niche industry that only certain countries can have and succeed. The factors for success compose of both controllable and uncontrollable elements. Proximity can make some countries more attractive than the others. In this case, Eastern Europe is very attractive to Western Europeans. Tourist attractions can make the services if they are well packaged with medical services offered. Reputation and specialization also play a role in selecting one country over another. History can make play a role as a patient has deep down hatred or fear or even phobia

fear for former Soviet Union countries. And vice versa, long relationship between two countries can make the country very attractive. There are a number of factors to be considered in discussing the success of medical tourism.

A number of the CEEC have been competing to attract medical tourists from the West. These countries include Croatia, Cyprus, Czech Republic, Hungary, Latvia, Lithuania, Poland, and many more with Hungary and Poland as the leaders. However, the medical tourism in Eastern Europe is very small not only in terms of revenues, but also costs and types of procedures offered, when compared to major medical tourism destinations such as India, Singapore and Thailand. The maximum discount that this region could offer is around 50% of the price in Western Europe, while Asian destinations could offer much more. Still, proximity gives Western Europeans convenience in terms of travelling and number of days spent. However, since most of the patients going there are Europeans with heavily subsidized healthcare system, their needs are limited. According to Charles Runckel in "Where to go for medical tourism?," "Eastern Europe should only be considered by those who need very minor procedures or who are so busy they can't get away for a trans-Pacific flight and are willing to pay twice as much for the convenience."[44]

Hungary, a medical tourism leader in this region, offers relatively inexpensive yet reliable dental and cosmetic surgery. According to Reier in "Medical Tourism: Border Hopping for Cheaper and Faster Care Gains Converts," the usual benefits of having medical treatment in Hungary is the "availability of procedures rather than cost." Costs in general are expensive by medical tourism standard. If time is of concern, but not money, Hungary is a place for you. For instance, a dental treatment, costing £2,000 in the UK, would cost only £827 in Hungary and £750 in Poland. Regarding the possibility of Hungary becoming a major medical tourism hub, Reier points to the lack of tropical beach as in other hubs. Nevertheless, cultural tourism is available instead of "natural or decadent" ones. Sopron, which takes than an hour of driving from Vienna, is basically a medical tourism hotspot. Although the town has only around 20,000 people, there are more than 200 dentists and 200 optometrists in Sopron, 10 times of the normal rate.[45] [46]

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[44] Runckel, Charles, Where to go for medical tourism? [online], 31 March 2010. Available from: http://www.business-in-asia.com/asia/medical_tourism2.html

[45] Sharon Reier. "Medical Tourism: Border Hopping for Cheaper and Faster Care Gains Converts" International Herald Tribune (April 2004); Quoted in Herrick, Devon M. "Medical Tourism: Global Competition in Health Care," National Center for Policy Analysis, NCPA Policy Report No. 304 Nov 2007 [online], 25 January 2010. Available from: http://www.ncpa.

Similarly, Szczecin, Poland is favored by the Berliner as the distance is less than 100 miles and dental work is relatively inexpensive and of high quality. According to the Polish Association of Medical Tourism, as many as 330,000 visitors come to Poland each year. Each spends on average $1,500 for procedures such as dental crowns and implants and plastic surgeries such as breast augmentation. Most of them are from the Western European countries such as Britain and Germany and Scandinavian countries where the procedures are more expensive. Profits gained substantially increased in the healthcare industry. The association, the Polish Tourism Organization and the Health Ministry decided to join hand in developing the medical tourism industry in the country.[47]

In furthering the medical tourism industry in the CEEC, it is imperative that the governments revamp their system from the root, even radical than the transformation into the health insurance system. These actions will cover not just the medical tourism industry, but also all the healthcare mechanism in the country. The basic change has been done according to the accession requirement. More changes are taking places through legal impetus resulting in the pan-European Union healthcare program in improving the standard of health. Besides the commitment to the EU in improving healthcare in their country, the countries themselves must redress the other areas in need for better healthcare system.

In recent years, many of the CEEC have make a number of legislative changes giving their citizens patient empowerment resulting in the reduction of the gap between the East and the West. The Health Consumer Powerhouse report accounted some of these changes: In the Czech Republic, a systematic reform through healthcare legislation reduced the drug deployment speed energizing the process. Doctor Info service with register of doctors is now provided in Hungary as part of the attempt to create transparency and give patients access to information such as provider catalogue and pharmacopoeia. In Lithuania, patient organisations have become more active and involved in improving healthcare at a rate higher than that of the majority of the wealthiest Western European countries. In Slovenia, after the enactment of the Act on Patients' Rights in 2008, a sequence of reforms has upgraded the healthcare system in

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org/pdfs/st304.pdf, 8.

[46] The Times, Is medical tourism worth the risk? [online], 28 March 2010. Available from: http://www.timesonline.co.uk/tol/life_and_style/health/article4962341.ece

[47] UPI.com, Poland promoting low-cost medical tourism [online], 28 March 2010. Available from: http://www.upi.com/Health_News/2010/03/26/Poland-promoting-low-cost-medical-tourism/UPI-37521269615723/

areas such as access to specialists, no-fault malpractice insurance and the right to second opinion. Access to health information such as register of legitimate doctors and pharmacopoeia are also improved.[48] The changes in these countries reflect the improvement in the level of active healthcare. The governments invigorate their citizens by giving information making them active. Contrasting to the past when the governments controlled and regulated everything and when everything was always rights, people now have choices and have control of the fate of the industry. This is not because of the multiplicity of healthcare provided; it is instead the fact that they are given information and are now really part of the process through knowledge-based decision-making. This correction of information asymmetry is the key to free economy and the difference between the more and less developed countries.

The question now become: are they really working, these changes and reforms? The answers depend must be answered on the country-by-country basis. Some of these have been improving at an accelerated speed. Some are very slow. Some are stuck in political uncertainty. Some was badly beaten and has not yet fully recuperated from the 2008-2009 global financial crisis.

Overall, the CEEC countries are still transiting in terms of healthcare reform and privatisation. The situation does not seem so well for the poor, who have less and less access to healthcare. Inequality between the rich and the poor is increasingly widened. For some, medical tourism might perform a miracle. But for others that do not have it, it might not be easy for them. Truthfully, most of the Eastern countries are not capable of having success or even jumping into this industry. When it comes to health, people often become finicky. Failing healthcare infrastructure do not resonate well with medical tourism.

So, what are the current options available for the people of these countries? One, they are stuck within the system. If they are rich, they will do just fine. If they are poor, they will have trouble when they need expensive outside-coverage medical attention. And if they are in the middle, they will have to pay more to achieve the same level of care. All of these points to the second option: find an alternative outside of their countries. Under the EU scheme, citizens of the EU have the rights to receive care in other Member States under conditions and processes, which are obscured, bureaucratic and do not

[48] Health Consumer Powerhouse. "The Empowerment of the European Patient 2009 – options and implications Report," op. cit., 34.

guarantee that you are authorized to get reimbursed. Furthermore, if you have to pay the cost of that medical treatment upright, if you do not have money, then there is a problem. Another scenario is that if the care is much more expensive than it is provided in the country or it is determined in the country, you have to pay the difference. Trouble again, if you do not have that money. However, private cross-border healthcare might be possible, if you have enough money i.e. the difference in terms of costs for medical tourism and costs in the country are big enough and you can afford them. And probably, that place would not be in the Western European countries as the medical care there is much more expensive than in their own home countries.

4.3 Cross-Border Healthcare Scheme within the EU

In recent years, medical tourism has been on the rise. Through a number of media, especially the Internet, the image of this booming industry is that of an alternative high-quality medical treatment in foreign exotic country where costs of treatment is substantially less expensive than that of their own countries. The equation of money flow is however often patients' out-of-pocket equal private hospitals' revenues. Government and domestic insurers seems to be out in the background observing the phenomenon with drowsy eyes. However, there is a possibility of factoring in the government, public healthcare system and insurance scheme. In the United States, a number of insurance providers have added foreign hospitals as part of their network qualified for insurance. In 2007, BlueCross BlueShield of South Carolina created an alliance with Bamrungrad Hospital, a leading hospital in Thailand.[49] Not only that the insurers will benefit from the cost saving, the patients will also receive high-quality treatment plus an opportunity for travelling. Similarly, if the government and the insurers realize the potential of medical tourism, better healthcare could be achieved. The extent of cross-border healthcare could open the long-restricted, nationalistic and conservative healthcare systems to the better healthcare for all.

In the European Union, the drive for medical tourism or cross-border healthcare, however, is not because of cost, but because of the inherent need for mobility within the Union. Cross-border mobility within the Union brought about the need for corresponding healthcare scheme. It is the duty of all Member States to realise cross-

[49] Tourism Authority of Thailand, Tourism Thailand : News > Major US Health Insurer Promotes Thai Hospital to its 1.3 Million [online], 15 March 2010. Available from: http://www.tourismthailand.org/news/content-224.html

border healthcare scheme and implement them under the philosophy of the Union. At the present day, the inherent is accompanied by the unavailability and inadequacy of the system through long wait times and the high costs. While the drive for cross-border healthcare in the new Member States, i.e. the Central and Eastern European Countries, is the better quality of care, it is the cost and waiting time in the older Member States, i.e. Western European countries. Nevertheless, it must be taken into consideration the perception of Western European care as superior to the others and the possibility of the costs being too expensive for the Eastern European as the hindrance to the movement. However, all of these problems would be eliminated if the cross-border healthcare scheme were provided as part of public healthcare scheme.

Currently, the EU offers three possibilities of official schemes for cross-border healthcare within participating states, which are members of the European Economic Area (EEA) and Switzerland.

1.) The European Health Insurance Card (EHIC) in case of emergency during temporary stay in participating states.
2.) Regulation 1408/71 and E112 Scheme, which offers planned cross-border healthcare after authorisation of national authority
3.) Article 49 of the Treaty establishing the European Community through the legal interpretation of the European Court of Justice

While the first covers medical care in case of emergency, the other two are options available in case of planned cross-border healthcare. The two options for planned care work in a slightly different way. While the former is a well-established and limited scheme of cross-border healthcare, the latter is a recent phenomenon still subjected under development and evolution due to the extensive interpretation of the European Court of Justice. The landmark judgment of 28 April 1998 in case C-158/96 *Kohll* [1998] ECR I-1931 stating the application of Article 49 on free movement of services to health services has opened up a new possibility of cross-border healthcare. Since then a number of legal cases have gradually shaped and expanded the scope of coverage. It is this legal provision that gives rise to the 2008 European Commission's draft Directive on the Application of Patients' Rights in Cross-Border Healthcare, the subject of this thesis' interest.

It must be noted that from May 1, 2010, a new EU regulation will come into effect as a result of the ratification of the Lisbon Treaty. The names and Article will be

changed accordingly: The form E112 will become S2. Article 49 scheme is renumbered as Article 56 under the Treaty on the Functioning of the European Union (TFEU), commonly known as the Lisbon Treaty. As of the time of writing, the changes have not come into effect. Therefore, for the sake of simplicity and compliance with most documents, Article 49 and E112 shall retain their original names in this thesis.

4.3.1 European Health Insurance Card (EHIC)

The European Healthcare Insurance Card (EHIC) is an insurance card provided free-of-charge for people qualifying under national their home countries' national healthcare scheme. The EHIC gives access of free or reduced-cost healthcare treatment abroad to those with the card during their short stay in participating states in case of an emergency or immediate need of medical attention. This scheme is available and effective in all 27 Member States of the European Union plus Iceland, Liechtenstein, Norway and Switzerland, of which the last three are Members of the European Economic Area (EEA). The EHIC was introduced in 2004 as a replacement of the E111 scheme, which gives right of access to healthcare in emergency situations during a temporary stay in another EC country. This scheme aims to facilitate travel within the participating area as well as to guarantee their citizens' welfare abroad.

The EHIC covers any medical treatment that becomes necessary during the temporary stay because of either illness or an accident. Generally, the EHIC provides care in case of unplanned medical treatment. Travel as a disguised to specifically receive care abroad is not acceptable because advanced planning for medical care abroad is not eligible under this scheme. All treatments that are necessitated by accidents are covered. Other allowed medical cares are such as treatments required by chronic or pre-existing medical conditions. In case of medical conditions that require special medical surveillance and the use of special techniques or equipment, the organization of the treatment can be done to guarantee access to the equipment and treatment as to facilitate their journey. Routine maternity care oxygen and renal dialysis are thus qualified under the scheme.

The care covered, nevertheless, is not universally available; the EHIC provides only care that is part of the state system. Generally, the EHIC give the cardholders the same access to state-provided healthcare as a resident of the country they are visiting. This means that their status is equivalent to that of national citizen in case of healthcare. Thus, if the healthcare system in that country requires upfront payment or patient

contribution such as the co-payment cost, even the EHIC cardholder may have to do so. Depending of the legislation of the country where the person is staying, health care may not be free. If there is a need for upfront cost, reimbursement may be possible. The card will guarantee the cardholders reimbursement back in that country. If the reimbursement procedure cannot be completed in that country, health authority of the home country will be responsible for the reimbursement.

As each country's healthcare system is different, the functions and coverage of the EHIC vary accordingly. The EHIC might not be able provide and cover for all the related costs arise due to the need of medical attention. For example, some public hospitals in Europe have ambulance services that are privately operated. Cost of ambulance is separated from cost of medical treatment and thus not covered by the EHIC. The person is liable to pay for the cost of ambulance and this can be done through travel insurance. In the regions where public or state-provided healthcare is not available, the card will not cover anything. Repatriation is also not covered. Private travel health insurance is, therefore, a supplement, not a substitute to the EHIC scheme. Some insurers even require that EHIC is required. In case of excess medical cost burdened on the insurers resulted from the absence of the EHIC, the insurance policy may be waived.[50] [51]

4.3.2 Regulation 1408/71 and E112 Scheme

Contrasting to the European Health Insurance Card (EHIC), which give access to unplanned care, the E112 scheme enables European patients to receive treatment in another participating state after explicit and prior authorisation from competent national social security organisation—planned cross-border healthcare. Since the E112 scheme is based on agreements between governments it is valid only for state sector treatment. This scheme is based on the Council Regulation (EC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community. Similar to the EHIC, the participating states are all the member states of the European Economic Areas (EEA) and Switzerland.

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[50] European Commission, The European Health Insurance Card [online], 1 April 2010. Available from: http://ec.europa.eu/social/main.jsp?catId=559&langId=en

[51] National Health Service. European Health Insurance Card[online], 1 April 2010. Available from: http://www.nhs.uk/NHSEngland/Healthcareabroad/EHIC/Pages/Introduction.aspx

Article 22 of Regulation 1408/71 on the cross-border application of social security schemes allows nationals of EU Member States to travel to other Member States for treatment, at the cost of the relevant authority in the home Member State, as long as they have been authorised to do so by that authority. Authorisation may not be refused where the treatment is among the benefits normally provided within the home Member State and where the treatment cannot be provided within the normal time necessary, taking into account the current state of health and probable course of treatment. This is otherwise known as the "undue delay" clause. Atun summarized the set out principles in Regulations 1408/71 and 574/72 as follows:

1. Equal treatment: the host country should not discriminate against other nationals who have the right to receive social benefits.
2. Aggregation of insurance periods: safeguard of the cumulative acquisition and preservation of social benefit rights by obliging every social security institution to take into account all preceding periods of social insurance held in every other member state country
3. Exporting benefits: obligation of national security organisations to expand the provided social benefits beyond national borders by indemnifying services received in another EC country[52]

The three principles are used as a basis for the planned cross-border healthcare and resulting in the E112, which refers to the number of the necessary administrative authorization form.

In order to obtain authorization for planned medical treatment in another participating country, there are a number of points to be considered. In the UK, for example, in order for one to receive authorization, the National Health Service (NHS), the health authority of UK, must recommend treatment abroad and agree to cover the cost of treatment, given that the person is entitled to the treatment under the UK public health scheme. The process is that a UK NHS consultant recommends in writing the treatment in another participating country. A full clinical assessment must be carried out and demonstrate that the treatment meet specific needs of the patients. The treatment must also be available in the state-funded sector of the host country where the patient seeks healthcare. For example, John, a UK citizen, wants to receive a spa treatment in Germany. For John to be able to receive authorization, it is needed that Germany

[52] Atun, op. cit.

provides spa treatment as part of its public healthcare system. The UK also must recognize that spa treatment is a solution to John's conditions. Sounded simple as it may me, it is however controversial in case of experimental medical treatment and treatment using cutting-edge technology. Furthermore, the costs must be justified as efficiently spent against the interests of the patients, as the home country must pay for the cost incurred. If all the conditions are fulfilled, E112 will be issued.

Authorization, however, does not guarantee full cost reimbursement. Under the principle of non-discrimination, treatment will be provided under the same conditions of care and payment as residents of that country. If the residents of the host country have to pay upfront, the patients may have to do so. If the services are provided 100% free at the host country, as in the case of Beveridge healthcare model, upfront cost is not required. This, however, does not imply that the care is always free. If the same treatment in the home country costs less than that in the host country, the patient has to pay the difference. For example, a French patient who receives an operation in the UK, which provides free healthcare service for their citizens, does not have to pay any upfront cost. Given the costs of the same operation in France paid by the patient is €5,000, the patient has to pay the difference if the costs of operation in the UK exceeds €5,000. This implies that the scheme does not encourage economic inefficiency as well as rejects the creation of extra burden on the home system.

Nevertheless, this does not always hold true and patients are not always at disadvantage as authorisation allows reimbursement at the most favourable rate. In general, treatment costs will be reimbursed at the rate in the country providing the treatment. If the rate is higher in the home country, the home country's health insurer will reimburse the difference. For example, given the cost of treatment in both countries are equal at €100. France has the co-payment rate of 60% and Germany 50%. If a German citizen receives authorization to have the treatment in France, the patient has to pay the co-payment of €60 upfront and will receive a reimbursement of €10 from the German authority later. In total, he has to pay €50, which is equalled to what he has to pay at home. However, if the co-payment rate in France is 40% and Germany 60%, the German patient receiving treatment in France would have to pay only €40, €20 cheaper than what the patient has to pay at home. France thus has to bear the extra cost in this case. It can be assumed that as long as the costs of treatment in the host country are cheaper than those in the home country, the patients will always gain benefits from

cross-border healthcare.

In summary, under scheme set out by Regulation 1408/71, or E112 Scheme, planed cross-border healthcare treatment is provided in the state-funded sector. Patients must receive authorization from their home system in order to receive the benefits of equal treatment and higher rate of reimbursement.[53] [54]

4.3.3 Article 49 of the Treaty establishing the European Community

Unlike Regulation 1408/71, which has a limited scope of coverage, Article 49 of the Treaty establishing the European Community on the free movement of services provides a possibility of extended cross-border healthcare. Article 49 provides that restrictions on the freedom to provide services across borders within the Community shall be prohibited. This prohibition also applies to restrictions on the receipt of services. Despite its sensitivity and the involvement of states, healthcare is one of the services covered by this Article. Although the concept of healthcare as covered by Article 49 seems like it has been there since the establishment of the community, in fact it was only in 1998 that the European Court of Justice clarified that health services are covered by this Article. The legal impetus driven by the cases brought before the court has been gradually developing European Union cross-border healthcare scheme, alternative to that provided under the framework of regulation 1408/71.[55] [56]

Due to the novelty of the subject, there is much uncertainty regarding the cross-border healthcare scheme under Article 49 EC. There is no definite system in place as well as no common understanding of the prospect of the scheme. Under this scheme, there is no guarantee that reimbursement can be issued. Nevertheless, the extent of Article 49 is well recognized and valid in a number of situations enabling healthcare beyond originally provided in the system.

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[53] European Commission, Planned Medical Treatment [online], 1 April 2010. Available from: http://ec.europa.eu/social/main.jsp?catId=569&langId=en

[54] National Health Service, Planned Treatment Abroad [online], 1 April 2010. Available from: http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment/Pages/Introduction.aspx.

[55] For discussions of case laws related, please see Francis, John and Leslie Francis, Crossing State Borders and Looking for Health Care: the EU and the U.S [online], Available from: http://www.unc.edu/euce/eusa2009/papers/francis_03D.pdf, 16-23.

[56] Further discussion on legal interpretation and development of cross-border healthcare scheme under Article 49 EC by the European Court of Justice can be found at: Hatzopoulos, Vassilis. "The ECJ Case Law on Cross-Border Aspects of Health Services," DG Internal Policies of the Union, Policy Department Economic and Scientific Policy (Briefing Note) [online], Available from: http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_ecj_en.pdf

Instead of the E112 scheme, it is possible to apply Article 49 to medical expenses incurred in another EU/EEA country, i.e. planned cross-border healthcare may be reimbursed. It must be noted that this scheme is limited only to planned healthcare, which is opposite to unforeseen care already covered by the EHIC

The scheme requires that patients pay the costs of healthcare upfront and seek reimbursement from their home country after the treatment is completed and paid for. Reimbursement will cover only up to the costs that would incur if the service were to be provided in the home country, but does not exceed the actual costs incurred, even though it is cheaper. There is no benefit of equal treatment or higher reimbursement rate as in the E112 scheme. Another distinction is that this scheme does not restrict the reimbursement to be only for the costs incurred in the public service. Private healthcare services are also eligible for reimbursement.[57]

In the E112 scheme, there is no distinction made between hospital and non-hospital care. Costs of both cares will be reimbursed if authorization were granted before hand. In the case of Article 49, however, the difference between hospital and non-hospital treatment matters. Currently, there is no officially definition of hospital treatment and non-hospital treatment. However, under the proposed 2008 Directive on Application of Patients' Right in Cross-Border Healthcare, hospital treatment demands at least one night stay in the hospital.* This definition has been under a heated debate and as long as the Directive has not been passed, this definition will not be applicable.

For non-hospital treatment, authorization is not necessary. With authorization under the E112 scheme and without authorization under Article 49, the costs will be met. The only difference is that the E112 scheme could result in less expensive payment, while reimbursement under Article 49 will be at the actual cost paid. In case of non-hospital treatment without authorization, Switzerland is excluded from the scheme.

For hospital treatment, it is better to get authorization under the E112 scheme. Without authorization, there is no guarantee that the costs will be covered despite the application for reimbursement under Article 49. It is, therefore, the costs of private hospital treatment that is the most unlikely to be covered under the scheme.

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[57] National Health Service, Planned Treatment Abroad [online], 5 April 2010. Available from: http://www.nhs.uk/ NHSEngland/Healthcareabroad/plannedtreatment/Pages/Article49.aspx

* For definition of hospital treatment or hospital care by the Commission, please see Chapter 4.4.3.3.3 Hospital Care.

Table 13 – Points of difference and points in common between Regulation 1408/71 scheme and Article 49 EC scheme

Points of difference		
	Reg. 1408/71	**Art. 49 EC**
Scope of Treatment	All treatments	Mostly non-hospital
Sector Coverage	State-funded sector	All sectors
Level of refund	Host State (if more than home state)	Home State
Upfront payment	Depending on system of the host state	Always
Points in common		
Host Member State may not discriminate or refuse access to patient		
Host Member State may not charge different tariffs depending on the status of the patient		
The Home State determines which treatments it will reimburse		
The same principles apply to all kinds of health system, irrespective of whether they operate on a benefits-in-kind, reimbursement or free-of-charge basis		

Source: Author and National Heath Services (n.a.).[58]

[58] National Health Service, Planned Treatment Abroad [online], 5 April 2010. Available from: http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment/Pages/Compareoptions.aspx

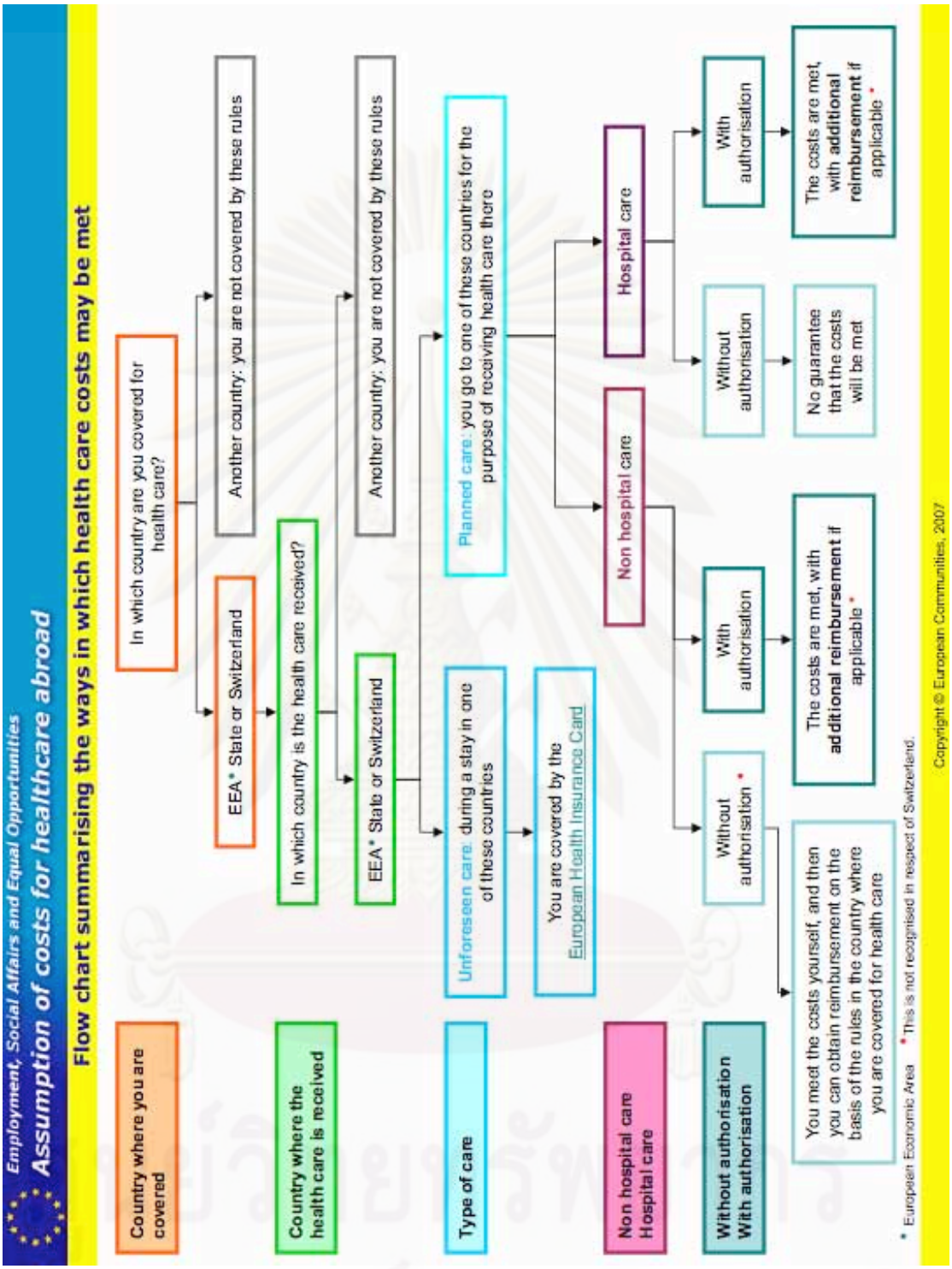

Figure 7 – Flowchart summarizing reimbursement of cross-border healthcare of the EU
Source: European Commission, (n.a.).[59]

[59] European Commission, Flow chart summarizing the ways in which healthcare costs may be met [online], 1 April 2010. Available from: http://ec.europa.eu/social/BlobServlet?docId =616&langId=en

4.4 Directive on the Application of Patients' Rights in Cross-Border Healthcare

Released on 2 July 2008, the Directive on the Application of Patients' Rights to Cross-Border Healthcare, as part of the 2008 Renewed Social Agenda, is aimed accordingly with Agenda's priority on longer and healthier lives by providing a framework for safe, high quality and efficient cross-border healthcare. The proposal is intended for the clarification, consolidation and realisation of patient's rights as part of labour mobility in the four freedom of the production factors movement. The failure to include healthcare in the 2006 Service Directive that aimed to lay out the framework of health service which includes cross-border healthcare is a drive to the need of this Directive proposal. The need for this Directive also stems from the European Court of Justice's rulings on the confirm of healthcare services as economic activity as well as the need the Member States to reimburse their citizens upon the utilization of medical treatment in other Member States. Once applied, the Directive would eliminate future legal cases concerning rights to seek healthcare in other member states. It therefore is the duty of the Commission to establish a framework in which rules and limits of patients' rights to cross-border healthcare are confirmed accordingly with the European and Member States' common goals of universal access to high-quality healthcare and financial sustainability of the national health system. In summary, the Directive tries to establish the system based on the consolidation of existing cross-border healthcare reimbursement framework as follows:

- For non-hospital treatments, the citizens of the EU can get treatment without applying for prior authorization by the home health system before going abroad. The reimbursement will be up to the equivalent costs in their national health system.
- For hospital treatment, prior authorization through a national contact point is needed for cross-border healthcare. The waiting period for the approval decision according to the Directive is fifteen days. Reimbursement will be at least up to the costs provided in the home system. For urgent cases, prior authorisation is not needed

- The European Health Insurance Card still exists. It covers medical treatment in the public service that is necessary during the stay in another participant country* because of either sudden illness or an accident. This scheme does not require prior authorization.

4.4.1 Rationale

4.4.1.1 Rulings of the European Court of Justice

In recent years, the rulings of the European Court of Justice (ECJ) have brought about the development of health legislations. The ECJ's power of legal interpretation results in the extension of patients' rights in cross-border healthcare, particularly the rights to reimbursement. However, the rulings have not manifested and clarified themselves in a well-established framework. Throughout the Union, the scheme varies in details making cross-border healthcare fragmented. While some countries allow their citizens to receive a particular treatment, some do not. It is up to their understanding of the rulings to implement them. It is therefore necessary for a common framework to be established in order to unify the cross-border healthcare scheme.

Despite the E112 scheme through the regulation 1408/71 and the framework based on Article 49 EC, the cross-border healthcare framework still undergoes constant development. For instance, in the rulings of C-372/04 *Watts*, 16 May 2006, the already established concept of undue delay was further clarified. Watts, a British citizen, sought treatment for her arthritic hip in France without the E-112 authorization. In the initial assessment, she had to wait for about a year until she could receive treatment. She went to France having another assessment and the result was that her condition had been worsening. She, therefore, received the treatment in France and claim for reimbursement. The British authority, however, refused her request for imbursement on the basis that she was not authorized to receive treatment abroad. The waiting time after the readjustment to suit her condition would be 3-4 months, which is considered not undue. Based on former case laws regarding the waiting time, the ECJ established that:

* The participant countries include all of the EU Member States and Iceland, Liechtenstein, Norways and Switzerland.

> "the waiting time, arising from objectives relating to the planning and management of the supply of hospital care pursued by the national authorities on the basis of generally predetermined clinical priorities, within which the hospital treatment required by the patient's state of health may be obtained in an establishment forming part of the national system in question, does not exceed the period which is acceptable in the light of an objective medical assessment of the clinical needs of the person concerned in the light of his medical condition and the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the authorisation is sought."[60]

The ECJ deprived total rights of states to authorization; the justification for rejecting the request for authorization on the basis of undue delay is no longer restricted by national capacity. The focus, rather, is on the actual medical condition, a fair and universal criterion.

The ECJ increasingly set out guideline for everything with its power of extensive legal interpretation. However, everything stems from the cases submitted before the court. If there were a clear established framework, there would be fewer requests for the ECJ to elaborate and decide on the rights of the citizens and the authorities. Currently, much information remains obscured. The authorization process and criteria for approving authorization remains fragments and obscures. Not many patients understand the basis behind it or could accept the rational of authorization denial, as in the case of *Watts*.

In spite of the legal development by the ECJ, there has yet been a clear conclusive established outline based on both the rulings of the ECJ and the Member States. It is, therefore, imperative for the Commission in consultation with the Member States to come together and create an institutional and operative framework for all beyond that already established. This will help not only to the citizens to understand their rights and the process of cross-border healthcare; it will also eliminate the possibility of future legal dispute.

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[60] ECJ, *Judgement Watts*, 16 May 2006, case C-372/04.

4.4.1.2 Exclusion of Healthcare from the 2006 Services Directive

In Directive 2006/123/EC on services in the internal market, commonly known as the Bolkestein Directive, healthcare services as well as pharmaceuticals were excluded. As a result, the level of regulation as well as common framework throughout the Union, as required and introduced by the rulings of the European Court of Justice, remains out-of-date, vague and unorganized. The exclusion, therefore, lead to the certain need of a legislative instrument clarifying the rights and obligations of patients and health professionals in the health insurance schemes, and of the competent authorities in the cross-border services.

The health services were excluded from the directive on services in the internal market because of their very particular sensitive characteristics, which should not be considered as ordinary services that can be bought and sold.

Firstly, healthcare is one of the most important aspects of life and social welfare. All European social models hold healthcare as one of the most significant elements in the model, as level of health quality contributes to the quality of life, social cohesion and equality. Any wrong step could cause a vital damage to the citizens. Moreover, with the amount of workforce in the industry, the impact would be tremendous. The open up of trade in health services may cause a serious disturbance in healthcare provision of some country, and therefore a significant portion of their population working in this industry and related industries.

Secondly, the healthcare sector and healthcare provision vary among countries. An attempt to regularised or Europeanise the healthcare sector would unavoidably upset some Member States as all the states would not be possibly agree on common guideline. Each country has its own values and believes on healthcare as discusses in the section on European social model. Furthermore, the level of difference could be exacerbated by political agenda of each country's governing body. Disagreement and inability to come to an agreement among Member States leaded the exclusion of healthcare from this Directive.

Thirdly, the open up of trade in health services and the increase in patients' and health professionals' mobility could lead to the over-commodification of healthcare. Health services could become a brutal business. Change in prices, due to the competition, could dilute the quality of care. Inequality between the rich and the poor could be aggravated as the poor could gain less access to healthcare of quality.

Due to these reasons, health services were rejected from the Directive on services in the internal market. As a result, the following issues need to be addressed: mobility of patients and health professionals, improving information for patients, reimbursement, legal liability and cooperation between the Member States.[61] The European Council and European Parliament therefore requested the Commission to solve some of these issues. The result is the proposed Directive on the Application of Patients' Rights in Cross-Border Healthcare, a separate legal instrument aiming to tackle the issue of cross-border healthcare.

4.4.1.3 Council Conclusions on Common values and principles in European Union Health Systems

In 2006, the European Council issued a statement underpinning the European Healthcare system with common values and principles (2006/C 146/01). This act is in response of the exclusion of the health services from the Directive on Services in Internal Market, which eliminates the opportunity to create an agreed guideline regulating the whole market. This is a complement to the rulings to the case law in that the statement provides a guideline agreed on a political level. This is beneficial in that the development of the healthcare scheme will be more legitimate as some of the bases are agreed among the Member States.

In this statement, the Council, with the agreement among all health ministers of the Member States, set out the common values and principles on how health systems should respond to the needs of the populations and patients. The common values are universality, access to good quality care, equity, and solidarity. It must be noted that universality means that "no-one is barred access to health care." This does not mean that healthcare should be provided to all. Equity again refers to equal access to all; everyone is provided with the same access to healthcare. Solidarity refers to the financial arrangement that would ensure accessibility to all. Overall, these common values focus on how access to healthcare should be administrated. There is no intention of barring access; however, there is no intention of providing healthcare. The meanings of

[61] Committee on the Internal Market and Consumer Protection, European Parliament, Draft Report on the impact and consequences of the exclusion of health services from the Directive on Services in the Internal Market (2006/2275(INI)) [online], 10 April 2010. Available from: http://www.europarl.europa.eu/meetdocs/2004_2009/documents/pr/656/656490/656490en.pdf

healthcare and access to healthcare should be carefully observed.

The operational principles, on the other hand, translate much more into the Directive as it gives guideline of for the implementation of healthcare. It gives the bases in which all care should be given along this guideline. The Council agrees on the following principles: quality, safety, care based on evidence and ethics, patient involvement, redress, and privacy and confidentiality. Quality should be ensured as to guarantee safety. Care given should be based on evidence and ethics. This means that the care should be balanced as some care such as those without scientific proof of treatment should not be given in excess. This is to prevent the diversion or dilution of financial resources, which could jeopardize the ability of the system to provide the care to all. Patient involvement is a means to create transparency in this sector. If there is something wrong, patients should be given rights to redress. Patient's privacy and confidentiality should be recognized within the European Union.[62]

With both common values and operational principles set out, the prospect of forming further regulation increases as both provide guideline for the healthcare proposal to construct upon. The proposed Directive on the Application of Patients' Rights in Cross-Border Healthcare also adopts and respects these values and principles into its spirit.

4.4.1.4 Renewed Social Agenda

In 2008, the European Union put forward the Renewed Social Agenda to launch a framework responding to the today's economic and social challenges including topics such as demographic change, rapid technological innovation and globalisation. In recent years, a number of issues on social well beings have been raised and presented to the European Court of Justice. In a number of cases, rights of the EU citizens are clarified and extended accordingly with the intention of the community's agreement, the Treaty. It is the job of the Union to keep up with and provide institutional and systemic supports based on the clarified and extended rights. This Agenda aims to help citizens of the EU to keep up with these changes by opening up possibilities for the citizens to adapt their lives under the changing society. The EU in conjunction with the Member States will implement policies accordingly to tackle the following seven social priorities areas:

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[62] European Council, Council Conclusions on Common values and principles in European Union Health Systems [online], 10 April 2010. Available from: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF.

- Children and youth – tomorrow's Europe
- Investing in people: more and better jobs, new skills
- Mobility
- Longer and healthier lives
- Combating poverty and social exclusion
- Fighting discrimination and promoting gender equality
- Opportunities, access and solidarity on the global scene[63]

The Directive on the Application of Patients' Rights to Cross-Border Healthcare was proposed under this Agenda with an aim to address the mobility and longer and healthier lives priorities.

4.4.2 Objectives

Based on the rationale bases, especially the case laws, the Commission structured the proposed Directive in following three areas: common principles for all EU health systems, specific framework for cross-border healthcare, and European cooperation on healthcare.

- **Common principles for healthcare system in the EU** have been partially clarified in 2006 by the Council in the Common values and principles in European Union Health Systems. This Directive would translate these values into legal reality by obligating the national authorities to setting and monitoring healthcare in the EU.
- **Specific framework for cross-border healthcare** will be clarified and implemented as delineated in the Directive. The framework will include the limits the national authorities can place in regulating cross-border healthcare as well as financial coverage and reimbursement.
- **European cooperation on healthcare** will be enhanced through cooperative framework in recognition of prescription issued abroad, European reference networks, health technology assessment, data collection and quality and safety.

[63] European Commission, Renew Social Agenda [online], 6 November 2009. Available from: http://ec.europa.eu/social/main.jsp?catId=547

Despite the wide scope and imposed framework on the Member States, the Directive still respect the "principles of universality, access to quality care, equity and solidarity," the values on healthcare pushed by the Council in the common values and principles in European Health System. The implication is that, Member States remains the key factors in healthcare provision and still have substantial power in regulating cross-border healthcare as long as they provide equal access to all.

Keeping all of the rationale and overall objectives in mind, the framework set out in this Directive is set to accomplish the following objectives:

- To provide clarity about rights to reimbursement in cross-border healthcare;
- And to ensure the necessary requirements for high-quality, safe and efficient healthcare in cross-border healthcare within the EU.[64]

4.4.3 Details of the Draft Directive

4.4.3.1 Chapter I – General Provisions

- **Aim** – The overall aim of this proposal is to ensure the existence of a clear cross-border healthcare framework within the EU. As uncertainty about patients' rights to reimbursement for cross-border healthcare abounds, the framework is to be provided to eliminate the uncertainty that acts as a hindrance to free movement of patients. Patients must be ensured in terms of: clear information so that they can make informed choices for healthcare; quality and safety of the healthcare provided; continuity of care between different healthcare providers; and mechanism ensuring appropriate remedies and compensation.
- **Scope –** All healthcare providers in the EU, regardless of their organisation, method of delivery or financing, are under the scope of this Directive as to ensure similar treatment through the Union whether it is in terms of quality and safety standard.

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[64] European Commission, Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/com2008414_en.pdf

4.4.3.2 Chapter II – Member State authorities responsible for compliance with common principles for healthcare

Responsibilities of authorities of the Member State of treatment

This chapter set forth the responsibilities of the EU Member States to comply with the common principles of healthcare provision in the EU. It is necessary to harmonize the system through common principles to ensure the mobility of health services. Lack of clarity and certainty, which constitutes obstacles to cross-border healthcare, must be rectified. Clarity must be made that it is the responsibility of the Member State authorities to ensure compliance to the common principles. Certainty should be ensured to a level that the common principles could be applied as to allow patients and professional from other Member State to trust. This will result in better circumstance in which free movement of health services can be taken.

Still, it is imperative that Member States have authority over providing and arranging healthcare to serve their citizens. The nature of the Directive itself, which pays respect to the principle of subsidiarity, allows flexibility in implementing the content of the Directive. A balance should be strike as to maintain both the European and national needs. Member States retains their rights to organise their healthcare system as they see appropriate. However, it must be done under the agreed basis stated in the Council conclusions on "Common values and principles in European Union Health Systems" of June 2006. Major transformation of European healthcare, therefore, should not be expected.

The common principles are as follows:

- The authorities of the Member States have to provide a clear definition of standards for quality and safety of care.
- Applicable standards for patients and professionals should be transparent.
- Member States should create a mechanism ensuring the translation of those standards into practice as well as a monitoring mechanism.
- Member States have to provide access to key medical, financial and practical information.
- Member States have to set up procedures and systems to be used in case of harm caused when healthcare is provided.

- Member States providing treatment must have mechanisms for patients to seek redress and compensation if they suffer harm as a result of receiving cross-border healthcare.
- Member States must respect privacy and give protection of personal data transferred between Member States in case of care continuity.
- Member States must ensure that all patients, whether a citizen of that particular state providing the treatment or not, are treated in a non-discriminatory manner. Economically, this is to avoid "either perverse incentives to prioritise patients from abroad ahead of domestic patients, or long-term undermining of capital investment in health."[65]

4.4.3.3 Chapter III – Use of Healthcare in Another Member State

4.4.3.3.1 Healthcare provided in another Member State

In this Directive, the scope of healthcare provided in another Member States concerns only the social security systems of insured patients. The Directive does not change the rights of the Member States to regulate or define the healthcare their systems provide to their citizens. Because this Directive does not provide transfer of social security benefits or coordination of social security systems, rights of citizens, therefore, are not extended or cut back when they receive healthcare treatment in another Member State. If State does not provide a particular treatment for its citizens under the system, the citizens are not entitled to such treatment in another Member State. Patients should be able to receive the same benefits provided at home abroad. Nevertheless, the Directive does not prevent the States from extending benefits to cover particular healthcare abroad, if they are willing to do so.

4.4.3.3.2 Non-hospital care

According to rulings of the European Court of Justice, prior authorisation of home-state authority to receive treatment abroad should not exist in case of reimbursement for costs of non-hospital care as long as that care is provided under the coverage of the home country. An assessment of the impact of cross-border non-hospital care without prior

[65] Ibid., 12.

authorization suggests no undermining of financial sustainability of the system. Prior authorisation as an obstacle to mobility of healthcare is not justifiable and therefore should not be required in case of non-hospital care.

Still, the Member Stats have the rights to impose limitations on foreign providers if the same limitations are similarly imposed domestically. These limitations may, for example, come in form of eligibility, conditions and regulations if they are proportionate, non-discriminatory and respect the freedom of internal market.

4.4.3.3.3 Hospital care

The problem of definition of hospital care plays an important role in controlling the level of cross-border healthcare as the hospital care and non-hospital care are subjected to different scheme of reimbursement. In establishing a common definition used throughout the Union, Article 8(1) of this Directive states that hospital care means "healthcare which requires overnight accommodation of the patient in question for at least one night" and "healthcare, included in a specific list, that does not require overnight accommodation of the patient for at least one night."[66] While the first meaning of hospital care refers to the common understanding of inpatient, the second meaning is much less common and specific for the purpose of financial safety. The second definition refers to "healthcare that requires use of highly specialised and cost-intensive medical infrastructure or medical equipment; … or healthcare involving treatments presenting a particular risk for the patient or the population."[67] This specific list of hospital care will be established, maintained and regularly updated by the Commission.

Unlike the earlier case of non-hospital care which prior authorisation is not allowed, the European Court of Justice recognised the possibility of cross-border hospital care undermining the financial stability of health systems and the ability to provide care to all. For example, the number of hospitals and their geographical distributions

[66] Ibid., 38.
[67] Ibid.

make the system fragile to surge of patients, as they might not be able to cope with the sudden influx and might result in lower quality or perverse economic incentive. For this reason, it is justifiable for the system to put a barrier to freedom of health services.

This Directive therefore does not preclude a prior authorisation requirement. Member States are allowed to establish system of prior authorisation for assumption of costs for hospital care provided in another Member State, however, under the following conditions:

- "had the treatment been provided on its territory, it would have been assumed by its social security system"
- "the consequent outflow of patients due to the implementation of the directive seriously undermines or is likely to seriously undermine the financial balance of the social security system and/or this outflow of patients seriously undermines, or is likely to seriously undermine the planning and rationalisation carried out in the hospital sector to avoid hospital overcapacity, imbalance in the supply of hospital care and logistical and financial wastage, the maintenance of a balanced medical and hospital service open to all, or the maintenance of treatment capacity or medical competence on the territory of the concerned Member."[68]

To elaborate on the first condition, the first condition does not limit the scope of coverage to that provided under social security system only. If the system were to extend the benefits of its coverage to a particular service not available in the country, that service must be recognized under its social security system. This condition allows not only the limit of the scope as to contain costs, but also the content of healthcare provided. The second condition constitutes a more of an expansive yet mystified excuse for not providing care as the outflow might create financial risk to the system. If the costs of treatment or level of reimbursement is not established in the system as the treatment is not available in the domestic system, the cost calculation mechanism must ensure that the costs are not less than what would have been assumed had the same or similar

[68] Ibid., 14.

healthcare been provided in the Member State of affiliation.

Procedures regarding cross-border healthcare established by the Member States should give patients guarantees of objectivity, non-discrimination and transparency, in such a way as to ensure that decisions by national authorities are made in a timely manner. "It is appropriate that patients should normally have a decision regarding the cross-border healthcare within fifteen calendar days."[69]

Hindrance to cross-border healthcare could be imposed if those criteria, regulations and administrative formalities are imposed in a similar manner to the domestic healthcare. However, they must respect the internal market freedom and must be necessary, proportionate and non-discriminatory.

4.4.3.3.4 Procedural guarantees

"According to established case-law, any national administrative procedures and decisions, that the access to cross-border provision of services is made subject to, are obstacles to the free movement of services unless they are objectively justified, necessary and proportionate. …National administrative procedures regarding use of healthcare in another Member State provide to the patients comparable guarantees of objectivity, non-discrimination and transparency, in such a way as to ensure that decisions by national authorities are made in a timely manner and with due care and regard for both these overall principles and the individual circumstances of each case."[70]

4.4.3.3.5 Information for patient and national contact points

The Directive sets out the requirements for essential information on cross-border healthcare to be provided to patients. This is to enhance and embody the spirit of the internal market through free movement of healthcare. The information should be easily accessible and therefore national contact points for cross-border healthcare should be formed to achieve this goal.

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[69] Ibid., 28.
[70] Ibid., 16.

4.4.3.3.6 Rules applicable to healthcare services

"Given that in accordance with the Treaty art.152.5 the organisation and delivery of health services and medical care rests upon Member States, the rules applicable to the actual provision of healthcare…of the Directive ha[ve] to be governed by the rules of the Member State of treatment."[71] The patients opting for cross-border healthcare must know in advance the rules they will be subjected to. This will ensure that informed choice can be made and will create an environment whereby smooth cross-border healthcare exists.

4.4.3.4 Chapter IV – Cooperation on Healthcare

4.4.3.4.1 Duty of cooperation

Despite the difference in national, regional and local administrative practices in the healthcare sector, safe, high quality and efficient care cross-border should be achieved throughout the Union accordingly with the common goals and principles in providing healthcare. It is therefore the duty of Member States to cooperate and "render mutual assistance necessary for achieving implementation of the Directive."[72]

4.4.3.4.2 Recognition of prescriptions issued in another Member State

Medicinal products as well as prescription of medicinal products constitute an important part of cross-border healthcare. As Europeans travel from one country to another, it is imperative that they have access to medicinal products and the products are of quality, safety and efficacy. Therefore, medicinal products licensed within the Community have to meet harmonised standards to ensure the three factors of quality, safety and efficacy. This will allow prescription in one country to function and result in dispense of medicinal products in another as all products are approved at the European level. Nevertheless, specific measures should exist as to confirm the validity and authenticity of the prescription. Patients should understand the information concerning the

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[71] Ibid., 18.
[72] Ibid.

pharmaceutical product and recognize the variations in names in other countries. It should be noted that some medicinal products are excluded from this scheme.

4.4.3.4.3 European reference networks and health technology assessment

The proposed Directive provides for the establishment of European reference network to maximise the speed and scale of transfer of innovation and providing high quality and cost-effective care across the EU. The European reference network will be used to refer patients in need of particular medical treatment, whether due to specialisation or the need of special equipment, to the right care providers. Economy of scale is the key ingredient in allowing the resource to be pooled and distributed. The benefits would be on both the healthcare receivers and providers. The High Level Group on health services and medical care has already developed general conditions and criteria that European reference networks should fulfil.

In addition, the Directives provides for the establishment of the Community network on health technology assessment. The network will support the cooperation between nations and provision of health technologies. Variations and duplication of health assessments constitute barrier to the free movement of new technologies. As different healthcare providers utilize different technology, basis and standard of safety and quality are therefore different. Such situation will perpetuate inequality in healthcare capability and detract the notion of free movement of patient and the concept of internal market from coming into reality. Technologies will help harmonising healthcare throughout the EU.

4.4.3.4.4 E-health

Cross-border provision of services or E-health refers to the provision of healthcare cross-border without the need of patient or health professional to physically cross-border in order to provide services. E-health, as the name implies, can be done through information and communication technology such as through the Internet. Lack of harmonisation of formats and standard for the technologies used in E-

health could cause an obstacle to trade and therefore should be prevented in order that interoperability can be achieved. Rather than obliging the introduction of E-health into the system, the Directive merely aims to ensure the interoperability of the systems.

4.4.3.4.5 Data Collection

One of the most prominent problems in the study and planning of cross-border healthcare is the lack of data available. Although the Commission has been able to estimate the likely extent and nature of cross-border healthcare, data on cross-border healthcare is not sufficiently available or comparable to enable long-term assessment and management of cross-border healthcare. As a consequence, it is imperative the Union requires the Member States to collect statistical and other data related to cross-border healthcare.

4.4.4. Policy Option

Despite the proposal being conclusive and to the fullest extent possible, the Commission acknowledges the possibility of the proposal being tossed around by the Council and the Parliament. In the impact assessment, which was put forward together with draft Directive, the Commission listed four ways in which the Directive could be actually implemented. The range begins with the bleak situation of the Directive being rejected and everything remains the same. At the other end is the Commission takes full rein over regulations or all healthcare legislation being directed at the European level. In between exist shades and nuances, which yield variegated levels of impact. The most plausible scenario that could happen is option 3, whereby general framework of cross-border healthcare will be issued accordingly with the rulings of the European Court of Justice. Nevertheless, the actual impact will depend on the actual regulations, which have not yet been discussed in details, and their being implemented. The Commission's impact assessment[73] describes each option as follows:

[73] European Commission, COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/commsec_20082163_en.pdf

4.4.4.1 Option 1: No further action, baseline scenario

This option represents one of the two extreme ends, whereby none will be further achieved and everything remains the same. Under this scenario, healthcare would continue to be operated according to the established cross-border healthcare schemes, which are the European Health Insurance Card, E112 form based on the Regulation 1408/71 EC and the interpretation of Article 49. There will be no additional coordination or harmonisation action from the Community level. Uncertainty in the interpretation of the cross-border healthcare scheme according to Article 49 and its implement will remain a problematic area for both the healthcare providers and the citizens. The prolongation of this problem could detract or discourage patients from utilizing the services. The only hope for development is further rulings of the European Court of Justice, which is slow and could be addressed only on the basis of cases handed before the Court. This option could be the worst-case scenario for the commission, but probably the best for the Member States that prefer to preserve their power and authority in healthcare. The Member States have more control, as there are no definite rules in denying the authorization in the E112 scheme or in granting the reimbursement of hospital care according to Article 49 scheme. This policy option is very unlikely because there is a need of the Member States for certainty and clarification. The current state can result in inefficiency in cross-border healthcare provision. The Commission could provide support, which does not result in the legally binding compliancy, as in the second option: soft action.

4.4.4.2 Option 2: Soft action

Under this option, the Commission will provide additional support and guidance at the Community level to facilitate cross-border healthcare within the Union. Formal framework will be similar to that delineated in option 1, whereby all three scheme will remain intact and the development be made by the rulings of the Court. The Commission will not propose new legally binding legal measures, but rather guidance in the following areas:

- Through a Commission communication, the Commission will issue a statement on its interpretation of the rulings' implication in order that cross-border healthcare would go along the same direction.

- The Commission will recommend and give advices to the Member States the incorporation of the ECJ case-law into their national legislation, which will facilitate the harmonisation.
- The establishment of a forum or a mechanism whereby Member States can share ideas and best practice.
- The Commission Working Party on Health Indicators will try to develop common data and indicators, which will allow the analysis of European healthcare system as well as European cross-border healthcare through harmonized data much needed.

It is expected that if these schemes were successful, they would boost the confidence of European patients in cross-border healthcare, despite some legal uncertainty.

Member States that support cross-border healthcare will have an easier time in implementing the scheme and allowing their citizens to receive healthcare treatment in another Member States. Vice versa, the other Member States with are frightened by the idea of cross-border healthcare could restrict the flow through their power of denial delegated by the uncertainty in common rules. Furthermore, there is no need for them to abide by or comply with the recommendation or guidance of the Commission. This might be the happiest scenario for the Member States opposing the Directive, as they allow the Member States with a different set of mind to progress in cross-border healthcare. While the Commission might not be so happy with the outcome that the Directive were mostly rejected, they can at least supplement and directly instigate the movement toward cross-border healthcare through non-binding attempt of harmonisation in hope that when the right times come their proposal would be accepted.

4.4.4.3 Option 3: General legal framework on health services

Option 3 represents the most possible framework to be implemented. This means that the Directive will be become a general legal framework in cross-border healthcare. Soft action under option 3 will be implemented along with or even become legally binding actions. Further actions under this option include:

- Common principles underpinning health systems in the EU will be ensure legally in terms of quality and safety of healthcare provided. Minimum standard for healthcare make sure that healthcare in the Union is universally up to standard. Not only that the care will be of good standard, the citizens can also be sure of that and therefore will feel comfortable receiving healthcare provided in another Member State.
- Cooperation between Member States as in the European reference network and E-Health will create an infrastructural support for the operation of cross-border healthcare as in the transfer of patient data. The harmonisations of healthcare data will bring about the new possibility in understand the movement of patients as well as the possibility to conduct comparative studies on any aspect of European healthcare.
- Clarity about rights to reimbursement will be established. Rules and criteria in granting or denying authorization or healthcare for both the sending and receiving countries will be codified. Redress and compensation mechanism will be in place. All of these constitutes environment in which administrative process facilitating cross-border healthcare and boosting patients' level of confidence in their benefits.
- A requirement for information on cross-border healthcare to be distributed as well as the set up of national contact points will be decrease the problem of information and knowledge deficit, which forms part of the decision making process in choosing whether to receive healthcare abroad or not.
- Instruments to manage the flows of patient are one of the most important aspects in making this Directive acceptable to the Member States. Mechanisms to control the flows can be in terms of legislations as in cross-border healthcare schemes under the EHIC, E112 and Article 49 as well as the authorization criteria; and in terms of definitions limiting the scope of cross-border healthcare as in the definition of hospital care. As these instruments are of importance, the Commission proposed to possibility of flow control through sub-options 3A and 3B. However, the actual manifestation of these two sub-options is uncertain. This is because, firstly, the actual result will depend on the comitology committee, which is a technical-levelled committee that is composed of members from Member

States and the Commission delegated with power from the legislation to work out the details from the main legislations later. Secondly, as amendments by the Council and the Parliament can be drastic, the actual translation and detail work out will differ in scope and direction tremendously.

Before proceeding further with the discussion of both sub-options, it is import to recall the existing cross-border healthcare framework as it serves as basis for the modification. Under the proposed framework, the emergency or the unplanned care under the European Health Insurance Card framework will remain intact. On the other hand, the two planned cross-border care under Regulation 1408/71 and Article 49 will change according to the two sub-options. Provided below is the consolidated table of all cross-border healthcare schemes:

Table 14 – Comparison of existing and proposed EU cross-border healthcare schemes

	Existing scheme			**Option 3A**		**Option 3B**	
	Unplanned Care	**Planned Care**		**Planned Care**		**Planned Care**	
						Non-hospital care	**Hospital care**
Legal Basis	Article 42, Regulation 1408/71	Article 42, Regulation 1408/71	Article 49, ECJ case law	Article 42, Regulation 1408/71	Article 95, ECJ case law	Article 95, ECJ case law	Article 42, Regulation 1408/71
Prior authorisation for hospital care	No prior authorisation	Obligatory	Maybe required by the Member States	Obligatory	No prior authorisation or prior authorisation by way of derogation	N/A	Obligatory
Prior authorisation for non-hospital care	No prior authorisation	Obligatory	Not needed	Obligatory	No prior authorisation	No prior authorisation	N/A

Source: consolidated and modified from European Commission, (2008).[74]

[74] European Commission, COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/commsec_20082163_en.pdf, 27, 30.

Table 14 (cont.) – Comparison of existing and proposed EU cross-border healthcare schemes

	Existing scheme			Option 3A	Option 3B		
					Planned Care		
	Unplanned Care	Planned Care		Planned Care	Non-hospital care	Hospital care	
Means of payment							
Benefits in kind provided according to the Member State of treatment (i.e. free of charge or out-of pocket) Direct cost settlement between the two countries	x	x		x			x
Out-of-pocket payment with subsequent reimbursement from the social security institution of the patients' home Member State			x		x	x	
Level of reimbursement							
According to the rules of the Member State of treatment	x	x		x			x
According to the rules of the patients' home Member States			x		x	x	
Only actual costs of treatment are reimbursed			x		x	x	
If this is less than what a patient would receive in his home MS, the additional reimbursement must be granted.		x		x			x

Source: consolidated and modified from European Commission (2008).[75]

Under the existing scheme, the regulation 1408/71, which is based on Article 42, free movement of workers, is stricter than the scheme based on Article 49, free movement of services. While the former has a prior authorisation system, while latter does not. However, under Article 49 scheme, patients have to bear the risk of not getting reimbursed and they also have to pay up-front. Regulation 1408/71 scheme, on the other hand, covers all the costs incurred regardless of the costs of treatment abroad being higher than those at home. It, therefore, can be assumed that the existing scheme is incentive-based: patients that really need the care, whether because of the undue delay or the lack of availability, should be authorised and will be receive the care needed in full according to the Regulation 1408/71 scheme, while patients that choose to go abroad because of choices or convenience will be subjected under Article 49 scheme, which provides limited reimbursement up to the costs of that treatment provided in the home state.

[75] Ibid.

4.4.4.3.1 Sub-Option 3A – Two parallel systems for financial aspects of cross-border healthcare (both hospital and non-hospital care)

Sub-option 3A embodies this spirit of need-based favourable treatment and therefore retains the Regulation 1408/71 scheme as the first system. Parallel with the first system is a new mechanism based on the European Court of Justice's rulings and Article 95 on internal market. This new system is similar to the Article 49 scheme: The limit of reimbursement is tantamount to the costs of treatment provided in the home state. Patients have to bear the additional costs as well as have to pay up-front. The prior authorization systems, however, are ridded for both hospital and non-hospital care. Nevertheless, Member States can employ prior authorisation by way of derogation if outflow of patients has significant impact on the planning and rationalisation of the system; financial balance of social security system; maintenance of a balanced medical and hospital service open to all; and maintenance of treatment capacity or medical competence on their national territory. This long list of derogation therefore signifies a certainty of the Member States to deny authorisation, however such denial much be limited to what is necessary and proportionate.

4.4.4.3.2 Sub-Option 3B – Two parallel systems for financial aspects of non-hospital cross-border healthcare, hospital care through the social security regulations

This sub-option takes the same approach with sub-option 3A; two parallel systems exist side by side: a framework under Regulation 1408/71 and a new mechanism. This new mechanism of the sub-option 3B differs from that of sub-option 3A in that he financial entitlements and prior authorisation in cross-border hospital care. For sub-option 3A, this directive would apply to the financial aspects of both hospital and non-hospital care. Under sub-option 3B, the financial aspects of this directive apply only to non-hospital care. For hospital care, patients would follow the Regulation 1408/71 scheme only. In other words, under sub-option 3B, patients will no longer have choices of private

facilities, as they are not part of the Regulation scheme. This means that the benefits of Article that extend to both private and public facilities will be curtailed substantially.

4.4.4.4 Option 4: Detailed legal rules at European level

Under this final scenario, the Commission, instead of a package of both binding and non-binding measures, would put out a detailed harmonisation framework of cross-border healthcare such as through regulations or legally binding "Charter of patient rights". These areas of legal harmonisation include:

- Rules on cross-border healthcare data collection
- Requirements on information provision to citizens
- Explicit criteria for authorization and authorization procedure, the maximum waiting time during the procedure, etc.
- Explicit standards for quality and safety defined at the European level as well as compliance monitoring
- A legally binding "Statement on patient rights" prescribing rights to preventive measures, to access care, to information, to consent, to free choice of care, to privacy and confidentiality, et cetera.
- Explicit measures for compensation in case of arising harm

Under this option, although accomplished with legal clarity, promulgation of cross-border healthcare and prescribed infrastructural environment for cross-border healthcare, Member States have no chance to adapt and transform themselves into the system in their own ways. Even though the legislations have a negative impact or do not suit their healthcare system at all, they have to accept the issued common regulations. It can be that this is an absurd and outrageous option and impossible in reality whether in terms of practicality or of being able to arrive at this scenario. Not only is not European, it does not go along with the principle of subsidiarity and proportionality. In fact, this option transforms a Directive into a Regulation.

4.4.4.5 Preferred Option

The four policy implementation options represent the spectrum of control the Union can exert on the cross-border healthcare and the Member States. While the first one represents inexistence of the Commission's action, the final one represents an absolute legal control. It is imperative that the right balance of agreeable compromise be accomplished: the Union should be able to standardize and guarantee the quality and safety of European-wide cross-border healthcare; the Member States should be able to provide the best possible healthcare for their citizens, while non-discriminatorily allows cross-border healthcare for the internal market to flourish without jeopardizing the financial sustainability of their healthcare system; and the citizens should have equal access to cross-border healthcare and be able to make an informed choice of care. For all these reasons, the European Commission conducts an assessment of each policy option's impact in order to demonstrate the outcome and convey to the Council and the Parliament why this Directive is worthwhile be passed.

Table 15 – Impacts of each policy option presented in financial terms

	Option 1	Option 2	Option 3A	Option 3B	Option 4
Treatment costs	€ 1.6 million	€ 2.2 million	€ 30.4 million	€ 3.1 million	€ 30.4 million
Treatment benefits	€ 98 million	€ 135 million	€ 585 million	€ 195 million	€ 585 million
Compliance costs	€ 500 million	€ 400 million	€ 315 million	€ 300 million	€ 20 billion
Administrative costs	€ 100 million	€ 80 million	€ 60 million	€ 60 million	€ 60 million
Social benefit	195,000 extra patients receive treatment	270,000 extra patients receive treatment	780,000 extra patients receive treatment	390,000 extra patients receive treatment	780,000 extra patients receive treatment

Source: European Commission, (2008).[76]

Provided above is the Commission estimation of the short-term financial impact of each policy option. In order to come to these numbers, a number of assumptions have been made; for instance, the number of cross-border patients is estimated at most 10% of patients with unmet medical needs and the average

[76] European Commission, COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT, op. cit., 63.

costs used as a basis for calculation are €7000 for hospital care and €800 for non-hospital care. Due to the vast difference in healthcare provision and the lack of data, the estimated values are therefore deficient. Long-term impact is also hard to predict as the change in the number in patients utilizing EU cross-border healthcare depends on various factors. For example, the money spent on cross-border care in the EU is accounted for about 1% of the total public expenditure on healthcare. With the rise in global medical tourism, medical tourists could turn instead to the cross-border healthcare in the EU, which is financed or subsidized by the social security institutes of their countries. Even though the assumption is that patients prefer to have healthcare at home, through time this factor can affect the degree of the impact tremendously. A slight change of one percent in cross-border healthcare, which means €10 billion per year at the current rate, could cost financial stability of public healthcare system.

Nonetheless, for the purpose of selecting the policy option, the Commission proclaimed that the estimation provided together with qualitative assessment have an indicative result and is sufficient for decision-making. It is clear that the needs for legal clarity of both patients and the Member States will remain under option one. This option is therefore ruled out. The fourth option, while achieved maximum legal clarity, does not respect the principle of subsidiarity and proportionality of the Union. Furthermore, the cost of compliance will be astronomically high without yielding higher the number of extra patients treated under option 3A. This eliminates the chance of option 4 being implemented.

Option 2, despite possibly preferred by the Member States as all actions are recommendations that have no legal binding power, is not preferred by the Commission for that it renders no guarantee that the quality and safety scheme as well as the clarity over rules on cross-border healthcare will be achieved. The quality and safety scheme necessitates not only full commitment of the Member States to change; it also demands a level of harmonisation that might not sound pleasant to some countries. The clarity over rules on cross-border healthcare is necessary in order to ensure patients' confidence, to allow smooth cooperation among countries and to avoid future legal disputes, which render cross-border

healthcare being imprinted with negative images. As option 2 does not guarantee these two requirements, it should also be ruled out.

Lastly, option 3 with two sub-options represents a compromised combination of legal-binding and non-legal-binding schemes. It is preferred not only because it allows all of the necessary cross-border healthcare elements mentioned above to be achieved, it also leaves room for the Member States to wiggle. Such flexibility will later be cherished by the Member States; despite their full attempt to detract the level of binding the Directive would yields and the attempt to resist the Commission throughout the process. With many hidden political agendas being part of the European-level politics, the outcome would be along the line of this option.

Without considering the content of the scheme, the estimation clearly shows that option 3A offers higher comparative benefits. While the two options result in comparable compliance and administrative costs, the benefits in option 3A outweighs that of option 3B in both social and treatment benefits. Option 3A allows for hospital cross-border care to be trade more openly, while in option 3B hospital cross-border care are under the prior-authorisation system under the Regulation 1408/71 scheme. According to the Commission, option 3A is the only option where "the likely value of the benefits of care to patients outweighs the overall costs of the system"[77] without disturbing the stability of the healthcare system in the long run. Option 3A therefore it is the preferred choice for the implementation of the Directive. It is therefore should be assumed that the most likely outcome, withstanding the further progress and amendments, will be along the line of option 3A. The impact analysis of this Directive in the later sections will be along the line with this policy option implementation.

[77] Ibid., 66.

4.4.5 Progress, Amendments and Obstacles

As a politically sensitive sector, it is unavoidable that the legislation regarding healthcare will be faced with hurdles, if not pitfall. The attempts to cross-border healthcare in the European are not unprecedented and have come up in various forms. Despite the exclusion of healthcare sector from the early integration process, healthcare is an essential element to free movement of people. It was therefore in a small area of protection of health and safety at work that healthcare policy at the European level took shape in the 1960s. In 1971, the Regulation No 1408/71 was issued to create the safeguarding the social benefits when they move intra-regionally within the Community. Not much has been achieved since from the administrative side of view. It is the rulings of the European Court of Justice that stipulate the need for clarification of patients' rights in cross-border healthcare. The first precedent case can be dated back to 1998, *Kohll*. Rights of EU patients to cross-border healthcare have been increasingly extended. In late 2003, Member States began debating the issue, but not much was achieved. National governments are reluctant to let go of control over this sensitive sector of healthcare. In 2006, the consequential epic failure was the removal of healthcare services from the 2006 Services Directive. The current attempt by the Commission based on the accumulated rulings of the Court of Justice over a decade has been pushed again through the process of elimination, the Member States' pick-and-choose; the Directive on the Application of Patients' Rights to Cross-Border Healthcare was subjected to internal fights and numerous re-drafting before surfacing and submitted to the European Council and European Parliament for consideration in July 2008.

On July 2, 2008, the proposal for the Directive was adopted by the Commission and transmitted to the European Council and European. It is important to mention that after the submission of the proposal the Commission has no further role in the proposed Directive's progress, unless there the Council and the Parliament could not reach a common decision. The Commission can only answer question posed by the two institutions.

On December 16, 2008, the Council held a public policy debate on the proposal for a Directive on the application of patients' rights in cross-border healthcare. Reservations were expressed in the areas of quality and safety of healthcare and prior authorization. The rights of patients and of Member States should be balanced. Mandatory reimbursement by a Member State should not exceed the level provided for

by its own system. A number of changes were made to the Commission's proposed prior authorization mechanism. Other concerned issues include the management of patient inflow, the definition of healthcare and the quality of care.

On March 31, 2009, the Parliament's Committee on the Environment, Public Health and Food Safety adopted the report by John Bowis amending the proposal under the first reading co-decision procedure. The main amendments are as follows:

- **Aim:** The aim of the Directive should be the clarification of patients' rights not the harmonisation of healthcare. The directive should respect national competencies in healthcare.
- **Scope:** The Directive shall not apply to long-term care health services, including services provided over an extended period of time as in daily routine care. This Directive shall not apply to organ transplantation.
- **Safety and quality:** The committee inserted a clause stating that nothing in the Directive requires healthcare providers to accept for planned treatment.
- **Definition of hospital care:** The committee states that the definition provided by the Commission does not correspond to the real nature of the services provided in the Member States. It does not, for example, take account of outpatient surgery. The definition of hospital care should refer to the definition in force in the patient's Member State of affiliation. Extended coverage of hospital care through References to a specific list was deleted.
- **Prior authorisation:** The Committee deleted the Commissions proposals on prior authorisation with regard to the financial balance of the Member State's social security system and hospital overcapacity. Member States should be able to decide the circumstances in which prior authorisation systems are mandatory for patients seeking healthcare abroad, provided these systems meet criteria such as transparency and proportionality, are simple and straightforward, and provide timely responses to requests.
- **Patient inflow:** The Member State of treatment may take appropriate measures to address the inflow of patients. The Member State of treatment shall refrain from discriminating. Measures restricting free movement shall be limited to what is necessary and proportionate.
- **Prior notification:** A new clause states that Member States may offer voluntarily a system of prior notification whereby the patient shall receive a

written confirmation of the maximum amount that will be paid. With this confirmation, reimbursement can be made directly to the hospital providing treatment.

- **European Patients Ombudsman:** a new clause makes provision for the Commission to present a legislative proposal to establish a European Patients Ombudsman within 18 months after the Directive comes into force. The European Patients Ombudsman will deal with patient complaints with regard to prior authorisation, reimbursement of costs or harm.

On April 23, 2009, the European Parliament adopted by 297 votes to 120, with 152 abstentions, a legislative resolution amending the proposal under the first reading of the co-decision procedure. The main amendments are as follows:

- **Scope:** This Directive shall also not apply to organ transplantation; due to their specific nature, they will be regulated by a separate Directive. The Directive does not address the assumption of costs of healthcare, which become necessary on medical grounds during a temporary stay of insured persons in another Member State. Nor does the Directive affect patients' rights to be granted an authorisation for treatment in another Member State where the conditions provided for by the regulations on coordination of social security schemes, in particular Regulation (EEC) No 1408/71, are met.
- **Responsibilities of Member State of treatment:** This Directive shall not oblige healthcare providers in a Member State either to provide healthcare to an insured person from another Member State or to prioritise the provision of healthcare to an insured person from another Member State to the detriment of a person who has similar health needs and is an insured person of the Member State of treatment.
- **Responsibilities of Member State of affiliation:** If a Member State of affiliation rejects the reimbursement, the Member State has to give a medical justification for that. Parliament added that Patients with rare diseases should have the right to access healthcare in another Member State and to get reimbursement even if the treatment in question is not among the benefits provided for by the legislation of the Member State of affiliation.
- **Prior authorisation**: Prior authorisation system shall not obstruct the freedom of movement of patients. The Member State of affiliation, therefore,

shall ensure that patients are expected to pay only upfront any costs that they would be expected to pay as if the care were provided in the health system where they are insured. Funds should be transferred directly to the care providers.

On June 9, 2009, the Council held a discussion on the progress of the proposed Directive under the direction of the Czech Presidency. The main emphasis of the discussion is to reach the right balance between the patients' freedom to receive cross-border healthcare in another Member States and the sustainability of the Member States' health systems as well as their rights or control of their systems. Many ministers wanted to exclude long-term care from the scope of the Directive. They also opposed the use of comitology procedures, which refers to the delegation of power to the central authority to work out details of the legislation. The body will be delegated with this power is the Committee on safe, high-quality and efficient cross-border healthcare, which is composed of representatives from Member States and presided over by a Commission representative. This would render Member States less control over the details of the Directive.

On December 1, 2009, the Council's (Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) could not reach an agreement on the Directive, particularly the scope of and the definitions in the Directive. Reimbursement of costs regarding non-contractual healthcare providers is one of the most discussed issues here.[78] [79] [80]

At a meeting of European health ministers, Spain managed to gain the support from other European countries such as Greece, Lithuania, Poland, Portugal and Romania to block agreement on the Directive. These countries that oppose the legislation have reservation regarding the burden of costs incurred on their national system as high as €2 Billion annually. Spain, for instance, is concerned that the directive would not guarantee quality health care to patients. During the Swedish Presidency, the second half of 2009, the Presidency was able to present several compromises in key

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[78] European Public Health Alliance, **Update** Directive on Patients' Rights in Cross-border Healthcare – European Public Health Alliance [online], 10 April 2010. Available from: http://www.epha.org/a/2878

[79] Europa, Prelex, COM (2008) 414 [online], 10 April 2010. Available from: http://ec.europa.eu/prelex/detail_dossier_real.cfm?CL=en&DosID=197193

[80] European Parliament, Legislative Observatory: Procedure file, legislative dossier – European Parliament, COD/2008/0142 [online], 10 January 2010. Available from: http://www.europarl.europa.eu/oeil/file.jsp?id=5661632

issues swaying toward more control on healthcare such as control of patient outflow through prior authorization and inflow of patients through the less restrictive criteria for denial. Most of the discussion at the European Council focused on the reimbursement of costs with regard to non-contractual healthcare providers and the definition of the member state of affiliation. As a result of the differences among Member States, the proposed Directive was not supported by the Council of Ministers which consists of representatives of Member States' ministers. As Spain is taking EU Presidency in the first half of the 2010, hindrances and obstacles could be multiplied[81] [82]

In an interview with the International Medical Travel Journal, Dr. Constantine Constantinides of healthcare cybernetics expressed that Spain and other countries that oppose the Directive are "being rightly fearful of the potential logistical nightmare that would come about as a result of a poorly thought out system." There are many elements missing from the Directive, which should be addressed before the Directive can be ratified. Dr. Constantinides believe that "bureaucrats and academics who drafted the Directive failed to do their homework and therefore failed to address the issues of concern and in doing so failed to provide practical and universally acceptable solutions that could make this work." He believes that many countries are "paying lip services to Brussels" as it is politically correct.

Healthcare cybernetics identified three major areas in which the original Directive should have covered: financial and administrative management of imbalanced patient flow; financial responsibility and reimbursement; and patient safety.

The first area of concern is the financial and administrative management of imbalanced patient flow. Due to the popularity of some destinations, some countries will be flooded with inbound patients. Without system to manage the flow of patients, both short and long-term implications could jeopardize the stability of the healthcare system.

Secondly is the financial responsibility and reimbursement, which refer to the common pricing and e-billing structure. While all countries have adopted these principles, few have actually implemented them in practice. Without harmonisation in

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[81] Assembly of European Regions Cross-border healthcare services [online], 5 January 2010. Available from: http://www.aer.eu/main-issues/health/cross-border-healthcare-services.html

[82] European Cancer Patient Coalition, 12/2009: Cross-Border Healthcare: Failure to reach political agreement on draft directive [online], 5 January 2010. Available from: http://www.ecpc-online.org/newsletter/member-updates/252-122009-crossborder.html

coding system, the creation of E-billing and the EU-wide interoperable electronic health information system, reimbursement could become a big hurdle.

The last concern is patient safety, which includes the Member States' responsibility in the areas such as cross-border patient, hospital accreditation, safety records and doctor qualifications. It is imperative that the Member States collaborate to create infrastructure that allow patients to safe cross-border healthcare.

In a similar International Medical Travel Journal interview with Dr. Bertinato of Veneto Health Region, Italy, the issue of flooding inbound patients arise. Dr. Bernito stated "We understand the preoccupation of the Spanish authorities which is linked to the economic sustainability of the impact of the huge number of pensioners traveling to southern Spain for long periods in the winter season, who make extensive use of local health facilities with additional services, but without acquiring prior authorization. Reimbursement of their costs can only be made with great difficulty and is subject to a lot of red tape."[83] The issue to be addressed here goes along with that stated by Dr. Constantinides. The survey by Techniker Krankenkasse also reflect the popular holidays destinations such as Spain, Austria and Italy being preferred by cross-border patients.[84] Without a system to regulate the flow of patients, the host country could be faced with problem of overcapacity.

In June 2008, the Observer reported that the inactive British would no longer be eligible for access to free healthcare in Costa Blanca, Spain, unless they are qualified for British pension. The inactive refers to those who neither work in the current country they are residing nor are old enough to qualify for healthcare for the retired. The government of Valencia had given this group of people along with expatriates the 2002 access to local healthcare through coverage extension. It is estimated that the cost of care for this group of people, which constitutes over 500,000 British and other expatriates, exceeded €1 billion per year. For the economic situation and this reason, the coverage was therefore curtailed. In spite of that, the British who are qualified for British pensions could transfer their pension benefits through the E-121 social security benefits transfer

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[83] nternational Medical Travel Journal, European Directive on cross-border healthcare encounters opposition [online], 5 January 2010. Available from: http://www.imtjonline.com/articles/2009/european-directive-on-cross-border-healthcare-30031

[84] Techniker Krankenkasse, TK in Europe: TK Analysis of EU Cross-Border Healthcare in 2007 [online], 20 March 2010. Available from: http://www.tk-online.de/centaurus/servlet/contentblob/48308/Datei/1695/TK_in_Europe.pdf, 8.

scheme are eligible for healthcare as their pension benefits will pay for the healthcare cost abroad.

With the reduction of the number of patients, the system could then be able to sustain itself financially. It must be mentioned that in case of Spain the current success and sustainability stems from their citizens' utilisation of both private and public systems. If the public system were flooded with foreign patients, Spanish citizens using the public healthcare would experience a more crowded, lower quality healthcare provision. Some might be pushed to use the private system, which costs more than the public ones. Inequality and inaccessibility could become a problem.

Dr. Bertinato also proposed that the development of bilateral agreement with healthcare insurers could be a viable method during this time when the Directive has not yet come into effect. For example, a direct link with German health insurance companies could facilitate the use of health services in Veneto of German tourist visiting the region.[85]

It is expected that if the Directive were not to face much opposition or to get stuck in controversy, the Directive would be effective by the end of 2010. However, as demonstrated by the progress listed about, the strength of the Directive has been tremendously weakened. "The Commission are particularly unhappy with the Council as they are trying to remove any mention of Quality and Safety standards and, as they see it, restrict free movement by ensuring prior authorisation across the board."[86] As the Commission has no further power to amend the Directive during this process, the Commission continued to support the original position as well as the original draft Directive. Commented by Francis and Francis, "The EU does not have as (sic) its disposal the requisite agencies to implement its understanding of healthcare but must continue to work to induce and cajole member states to do its bidding in often convoluted negotiations that takes an extended period of time."[87]

[85] Ibid.
[86] European Public Health Alliance, op. cit.
[87] Francis and Francis, op. cit., 27.

CHAPTER V
PUSH AND PULL: EU AND THAILAND

The push and pull factors will be analyzed as to identified the possible effect of the Directive. The push factors refer to the factors that drive people to receive healthcare outside of the European Union. The change in the push factors is based on the changes in cross-border healthcare and the provision of care because of the Directive. The pull factors refer to the factors of Thailand that attracts patients from the European Union to receive treatment in Thailand. The push factors are discussed in chapter 5.1 and the pull factors in chapter 5.2. After the discussion on the two factors, the relevant changes will be discussed and analyzed as to deriving the effect on Thai medical tourism industry in chapter 5.3.

5.1 Push Factors: the Analysis of European Cross-Border healthcare

5.1.1 Strengths and Weaknesses of European Healthcare and Cross-Border Healthcare after the implementation of the Directive

In discussing the strengths and weaknesses of European Cross-Border Healthcare, there are a number of elements to be considered. Here the change in the strengths and weaknesses induced by the directive will be analyzed. The discussion of strengths and weaknesses will be a basis for the derivation of the push factors

It must be established that players exist in many levels: patients themselves, public and private hospitals in a country, many countries in the European Union and groups of countries supporting and opposing cross-border healthcare. That European states group together as a Union involves political and legal aspects in the analysis equation. Without overstating the role of the European Union, inherent healthcare elements in the national level such as the capability, accessibility as well as cultural aspect should be considered. This analysis of strengths and weaknesses of the European cross-border healthcare will lay a framework for the analysis of push factors. By looking specifically at the strengths, weaknesses and the impact of the directive, both positive and negative, the analysis on the subject will yield a more definite and conclusive result on the push factors for citizens of the Union to utilize healthcare outside of the Union.

5.1.1.1 Strengths

- **Ability to provide high quality healthcare:** in general the quality level of healthcare in Western Europe is high. Before the current rise of global medical tourism, Europe has long been the destination of patients in need of specialized or high quality healthcare from around the world. This gives them experience needed to succeed in cross-border healthcare. Despite the enlargement, which adds a number of Central and Eastern European countries, whose healthcare systems are not in a good shape, the cross-border healthcare scheme does not lower the high level of care. Instead, the enlargement brought about the healthcare integration required as part of the accession criteria and therefore raise the level of care and stability in these countries. At the same, the window of opportunities was opened for patients in these countries to have access to foreign healthcare under the public scheme compensating for the lack of ability such as in treating some highly specialized care and rare diseases. These countries are such as Cyprus and Malta. The economy of scale could be utilized to the transnational level. The cross-border scheme such as the E112 scheme under Regulation 1498/71 scheme allows patients to receive care in another Member States. Without the strength of the former Member States to provide extra care, the inclusion of Central and Eastern European states could result in healthcare apocalypse throughout the region and of course could withstand the cross-border healthcare required in facilitating the smooth operation of the internal market.
- **Proximity:** one factor that makes cross-border healthcare or medical tourism a success is the proximity factor. Europeans generally prefer to receive medical care close to home as much as possible for that there is a family support. The notion of foreign doctors and nurses not being able to comprehend what patients are talking or there is no government of theirs to provide help in case of malpractice could make medical tourism a dreadful nightmare. Furthermore, in case the destination is far away, patients in certain conditions might not be able to travel. For patients who are able to travel, they have to pay for the cost of travelling as well

as losing the chance to work, which might be a good trade-off in case of medical tourism. Therefore, with the feeling of being close to home, proximity plays a significant role in reducing physical and psychological barriers.

- **Continuous Care:** along the same argument with proximity, the relative locational closeness allow healthcare to be done over an extended period of time. For example, if a patient needs a monthly care or a followed check-up, the patient will be more comfortable visiting the doctors again as the location is not so far away. Thus continuous care can be achieved. Furthermore, with the innovation of telemedicine, it is possible for patients to contact their doctors and receive further consultation or instruction for their treatment.
- **Being EU:** being EU means a lot to cross-border healthcare. Firstly, the EU as an internal market obligates that cross-border healthcare must happen. Therefore, there is an impetus for all the countries as well as the Union to improve the cross-border healthcare. The issue cannot be neglected or avoided, regardless of the resistance and the delay. Secondly, the EU has the Commission, which has the duty to work for the citizens of the Union. For the cross-border being one of the Union's priorities, the EU has someone working solely on this issue. This is contrast to cross-border healthcare in other regions whereby governments whose goals are to protect or increase national benefits and may not pay attention to this issue. Thirdly, for the less financially endowed countries, the EU provides support through structural funds, which help levelling the play field by improving infrastructure and developing low-income regions.
- **Strong supporting industries and relating industries:** like medical tourism, European cross-border healthcare is not an isolated industry; rather, it is a complex one. Cross-border healthcare in Europe does not necessary focus solely on the medical aspect. Even though receiving healthcare in the public sector, the patients can take this opportunity to travel, to do sight seeing, to go shopping and many more. To completely segregate cross-border healthcare from medical tourism is unwise.

Recalling the typology of medical tourists, out of all five types, only one involves no travelling at all. European cross-border healthcare, despite constituting cross-border healthcare in border region, which can be just a few hours trip done in one day, is highly involved with other industries. Firstly, Europe has a number of strong supporting industries such as tourism and transportation. Copious tourist attractions can play a role in attracting patients. This is evident in case of retirees and expatriates living in other European countries such as in Italy and Spain. Inexpensive transportation also increases the facility to travel. If net costs were too high, a number of patients would receive care at home. Therefore, supporting industries must be attractive and cost-effective enough to induce cross-border healthcare. Secondly, European industries related to cross-border healthcare such as pharmaceuticals and health professional training allow healthcare to be traded efficiently. Europe is one of the largest producers and innovators in the field of pharmaceuticals and medical equipments. It also has a reputation of good health professionals training such as medical and nursing school. Both groups contribute to the operation of the healthcare industry and therefore cross-border healthcare.

- **Multiple cross-border healthcare schemes:** in this thesis, the spotlight has been cast on the European-wide scheme. However, there exist other forms of cross-border healthcare both public and private. For example, the agreement between Malta and the United Kingdom before 2004, discussed earlier. In terms of private ones, Techniker Krankenkasse, a leading health insurance company in Germany, have contracts with medical and health facilities in other EU Member States not only in the border regions but also relatively far away countries. Its policies covers over 70 clinics in Austria, Belgium, Italy and the Netherlands and over 26 spas in Austria, the Czech Republic, Hungary, Italy, Poland and even Slovakia. The openness of the insurance companies and many countries allow healthcare to be traded across border.[1] Not only could patients

[1] European Medical Travel Conference 2010, EMTC 2010 Insurance Partner [online], 18 April 2010. Available from: http://www.emtc2010.com/insurance.html

receive high-quality healthcare together with or during their vacations, the insurers also could receive higher profits to the contracts with good and cheap health facilities.

5.1.1.2 Weaknesses

- **Asymmetric flow of patients:** the intention of the cross-border healthcare besides facilitating healthcare provision in border regions and providing highly specialized care and care for rare diseases, which are to smoothen the care and eradicate the problem of lack of healthcare access, aims at making the internal market a real internal market by allow health services to be traded freely as if it is domestic trade of a country. In reality, neither the cross-border healthcare scheme of the European Union nor any other schemes could achieve real internal market due to the asymmetric flow of patients. Under the perfect or ideal economy, suppliers and demanders should be able to meet and give services without restriction, i.e. a real competition. Patients from various, however, form a specific pattern of trade. As concerned by Spain and many countries that oppose the Directive, the flow of patients might not be able to be retained and thus would cause damages and shake financial stability of their healthcare systems. While most workers receives healthcare within the countries they are working in, as in one goals of the internal market, a number of other patients receive care because they come to those particular countries for specific reasons such as for retirement, expatriation. While some countries with lower quality of healthcare such as those in Eastern Europe do not receive high level of patient inflow, the Mediterranean countries are flooded with patients from the north. Small countries such as Luxembourg have a very high level of cross-border healthcare utilisation, while other countries have a lower rate. As some countries have a system of gate keeping delaying the access to healthcare, these countries would not be so desirable as country of destination. With such asymmetric flow of patients, the scheme would not be easily formulated and hard to come to a conclusion, similar to the

situation of this Directive.*

- **Unequal access to the cross-border healthcare due difference in domestic healthcare systems:** under the Treaty and the proposed Directive, EU Member States retains the rights to provide domestic care. As the Directive's goal is to extend the rights to healthcare received domestically to cover the same benefits abroad, there is no extension of benefits. Only those eligible under the domestic systems are eligible under that Directive. Therefore, countries that have a large proportion of eligible population will have more chance to healthcare abroad. Citizens from the Beveridge countries would trump over the Bismarck countries in this case as the Beveridge system provides care to almost all citizens of the countries. It can therefore be said that this Directive does not provide universally the coverage for all EU citizens i.e. inequality of access to cross-border healthcare. From another perspective, the inequality also extends to the care they receive. Eligible citizens of countries that provide more benefits will receive more benefits than those providing less.
- **Diversion of health resources to foreign citizens:** while the scheme in this Directive does not result in the diversion of resources, such as human resources in terms of brain drain, from public to private sector and the market segmentation as in medical tourism of other regions, the Directive instead has an impact on resources diversion from domestic citizens to foreigners. However, due to the prior authorisation system of the sending countries and the ability to deny cases of the receiving countries, the impact could be controlled. Nevertheless, once accepted for treatment, patients must be treated under a non-discriminatory manner, which means that foreign citizens are treated as if they are national citizens.
- **Difference framework of operation:** due to the distinct differences in healthcare system, each country has their own ways of operation deep-rooted within the system. It is imperative that foreigners understand this operational difference or else this different can cause a barrier to trade or

* See Annex for the level the volume of cross-border healthcare in 2004 under the Regulation 1408/71 scheme.

even disrupt the possibility of the treatment being successful. In receiving cross-border healthcare, the patients benefit from non-discriminatory requirement; however, they are also subjected under the laws and regulations of that country. While they are treated non-discriminatory in terms of healthcare, they are not in other areas. If legal matters arise, they could be at a significant disadvantage.

- **Upfront costs:** upfront costs constitute an important barrier to cross-border healthcare. Under the Directive, upfront costs could be required if the citizens of that country are required to do so. Those without financial substance may not be to receive treatment and thus be subjected under inequality despite qualified to receive healthcare abroad under the cross-border healthcare scheme.

5.1.2 Evaluation of Cross-Border Healthcare Scheme in the EU: Impact of the Directive

The evaluation of the European Union's cross-border healthcare scheme in this thesis will emphasise only on its impact that will change the push factors for European patients to receive healthcare outside of the Union. The Directive on the Application of Patients' Rights in Cross-Border Healthcare, however, deals directly with cross-border healthcare within the Union only. In the impact assessment issued together with the draft Directive, the estimated impact is provided from the Community's point of view. As the Directive is meant for the creation of internal market, in other words a discrimination against non-member state, the viewpoint can be provincial or inward looking. It is therefore the attempt of this thesis to expand the scope of impact beyond that provided by the Commission as to cover the push factors.

In this section, the potential impact of the Directive according to the Commission will be selectively discussed as to understand choices and possible ramification in need for the determination of the push factors in the later section. The framework of analysis in this section will emphasise on the change in cross-border healthcare scheme due to the implementation of the Directive under option 3A. Specifically, the E112 scheme based on Regulation 1408/71 will remain in place and the cross-border healthcare scheme based on the free movement of services Article 49 will change to the scheme based on internal market Article 95. How would this change affect

the healthcare system as a whole as well as on medical tourism? While the former is a public scheme, the latter is private. Also recalling the scope the Directive, the Directive has three working areas: common principles in all EU health systems, a specific framework for cross-border healthcare and European co-operation on healthcare. The consideration should be kept open minded. This will lead to the consummate goal of understanding the prospective change in cross-border healthcare and medical tourism consumers' behaviour and the change in push factor driving European patients from utilizing public cross-border healthcare.

5.1.2.1 Impact of the Directive on the system as a whole

- **Level of impact:** according the Commission, the level impact of the Directive will be small because the cross-border healthcare constitutes only around 1% of public healthcare budgets. This would refer to the approximate financial amount of €9.7 Billion. Therefore, cross-border healthcare activities can be counted for only a few percent of all healthcare volume. Furthermore, the Commission states that the over level of unmet care is low. The domestic level of met care is over 90% on average.* The effect of the Directive on the overall system will therefore be limited.
- **Structure of healthcare system:** while the Directive itself focuses on the cross-border aspect, its implication goes beyond such focus. The main area in which there will be a change or a harmonisation is the quality and safety as elaborate in Chapter II of the Directive. Overall, the change is rather an improvement toward common standard. And as the Member States retain the rights to implementation, the effect will be minimal. Structure of overall healthcare system will be the mostly the same. The cooperation at the European level will however improve efficiency in dealing with cross-border healthcare as well as help spreading best practices. In some cases, cross-border healthcare scheme can serve as a scheme to improve the system performance or reduce the price. The open up of market, which increases the level of supply, will increase competition. For instance, the United Kingdom's National Health Services use

* See Annex for the level of unmet need.

cross-border contracts a way to increase its negotiating power in price reduction. Therefore, the higher volume of cross-border will lead to the improvement of healthcare services.[2]

- **Impact on the price elasticity of demand:** price in healthcare normally, has low elasticity of demand, which means that demand is not so sensitive to price. The commodification of healthcare gradually turns the service into products, which can be offered at various prices. Market segmentation with the specific purpose of creating price range makes patients more aware of price. The expansion of the scope of healthcare has included non-essential care such as cosmetic surgery, recuperative care and wellness & spa into the system. All of these increase the elasticity of demand. Patients will think more when it comes to prices and worthwhileness of receiving health treatment. Cross-border healthcare and medical tourism are solution to escape high prices offering a wider range of provider. With the Directive coming into place, there will be more selections of healthcare abroad, which comes at various prices depending on their offers as well as net costs as a result of the scheme.
- **Impact on sending countries:**

  To the sending countries, the out flux of patients can be interpreted as both positive and negative. Positively, the country with less capacity and capability to healthcare provision, such as the lack of technology, the lack of specialized care and the long waiting list, can utilize other Member States' resources without making further investment in healthcare. This might be justifiable for small countries with limited resources but might not be for the others. This might give carte blanche for countries emphasise on other areas instead. From the half-empty-cup perspective, the out flux of patients signifies the failure of the state to provide their citizens the care

[2] European Commission, COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/commsec_20082163_en.pdf, op. cit., 44..

needed. However, this could be used as an indication pinpointing the areas that need improvement.[3] Also must be taken into consideration is the supplier-induced demand. Supplier-induced demand refers to the increase of demand due to the increase in supply. In this case, the increase selection of healthcare facilities and the possibility of having healthcare in foreign countries lead patients to consider and choose cross-border healthcare. Generally, the association of public cross-border healthcare is less involved with travel and tourism as in the case of medical tourism. The concept of supplier-induced demand in the case of cross-border healthcare includes the notion of medical tourism as part of the factor inducing demand. On a side note, this increase in demand does not mean that more people becomes sick and need more health services. Rather, they are more open to receiving care due to the increasing availability and practicality of receiving healthcare treatment.

The healthcare sector of the sending countries could be damaged as a result of the open up of trade. For countries that contract private sector to provide public care such as through the insurance in the Bismarck system, the healthcare industries could suffer from the loss of profits. This is a direct hit on the sector that provides care under the system.

Trade diversion, an indirect blow to the private healthcare industry, also could happen as a consequence of the trade open-up. The notion of healthcare abroad as an alternative to public healthcare in the country is too narrow under the existing and upcoming arrangements of the EU cross-border healthcare. Under the current Article 49 scheme and the replacing Article 95 scheme, reimbursement will be made up to the same cost level of the procedure providing domestically under the public system. Prices in the private sector whether in the home country or the others are generally higher than that provided to the mass public. However, with the reimbursement patients can receive care in the private sector

[3] Ibid., 45.

at a lower price, but only in other Member States. This scheme can put the domestic healthcare sector at a serious disadvantage.

- **Impact on receiving countries:**

The worst-case scenario for the receiving countries or the countries treatment is the over-influx of foreign patients, which could result in the over-crowdedness of the healthcare capacity and financial instability. However, with the current volume of cross-border healthcare, it is unlikely that such situation will happen. Nevertheless, with the increased certainty in rights and the upgrade in cross-border healthcare, the volume of patients would naturally increase.

In general, this increase of patients, which is the increase in demand, could result in the crease in price, given that out flux of the receiving does not counterbalance the influx of foreign patients. Under fixed resources and fixed supply, the increase in demand would result in price. However, if price is fixed, the waiting time for country that has one will increase. Both domestic and foreign will experience a lower level of care provided. If the influx is massive, the crowdedness might reduce the quality of care.

Depending on the implemented scheme, the resources might be less diverted from the public sector. The current cross-border scheme, under the Article 49 scheme, includes both private and public healthcare facilities as part of the eligible institution. This creates the problem of resources diversion from the public to the private sector. The Article 49 scheme virtually functions as a subsidy for patients from abroad to utilise healthcare provision in the private sector. A result of which could be a boom in the private sector.

With the prospect of policy option 3A being implemented, hospital care in the private sector will continue to be included but under Article 95 on the internal market. On the contrary, if option 3B were implemented, the hospital care in the private sector will not be cut out as the regulation 1408/71 covers only healthcare facilities provided under the receiving countries' public healthcare system.

Therefore, the diversion would reduce. Under Article 95 scheme, the reduction in resources diversion might or might not happen depending on the actual prior-authorisation scheme and its implementation, which could vary from country to country.

On the bright side, the increase in incoming patients will result in the better utilisation of that provides economy of scale. This would justify the investment made to improve capability on healthcare.

- **Inequality between countries:** the inequalities gap between the usages of cross-border healthcare will be widen. Both the regulation 1408/71 scheme and the Article 95 scheme could lead the poor country not being able to have a high volume of cross-border healthcare. The regulation 1408/71 scheme guarantee that the reimbursement will cover total costs of treatment and it is the duty of the home state to pay. Therefore, the out flux of patients could lead to the financial instability of the healthcare system. Authorisation would be granted when the system is capable to only when necessity arises to avoid the envisaged financial disaster. The Article 95 scheme, similarly, does not give access to the poor due to the upfront costs and the level of reimbursement given. This is confirmed by the Eurobarometer's survey conducted by the Gallup Organization in 2007 that the citizens from the new Member States are deterred from receiving healthcare in another Member State because of the affordability problem.[4] This problem of Article 95 will be discussed in details in the following section on impact on patient: social inequality. Nevertheless, as it can be assumed that poor countries have a higher proportion of poor people, inequality between the rich and the poor country will be widened after the implementation of the care as the rich are able to gain access to cross-border healthcare, while in theory, rights are given equally.

[4] The Gallup Organization, "Cross-border health services in the EU," Flash Eurobarometer 210 [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/crossborder eurobaro_en.pdf, 5.

- **Asymmetric flow of cross-border healthcare:** as discussed earlier in the weakness of EU cross-border healthcare, the cross-border healthcare does not and could reflect the real purpose of creating internal market. The proposed scheme will not help solving such asymmetric flow of patients nor will it change the flow direction. Patients would not change their behaviour in selecting their destination of care as the proposed merely codified the scheme and ensure that the flow of cross-border healthcare will be smooth. The only change might be in terms of volume, but still at a very low level. Patients will still be facing the same national systems whether it is co-payment, requirement for general practitioners' reference or the waiting time.
- **Impact on patient:** as part of the Directive, the clarification of rights on cross-border healthcare as well as the obligation to provide information on the scheme will empower the patients not only as in ascertaining their rights legally with a formal scheme but also in terms of strengthening psychological confidence. The real level of impact of the scheme manifesting will be varied according to the change in patients' behaviours. With time, this change will gradually incorporate itself into patients choosing to receive cross-border healthcare. Currently, according to the Eurobarometer, 54% of EU citizens are open to travel to seek healthcare in another EU country and 4% of all EU citizens received medical treatment in another EU state within the last 12 months.[5] Despite, such willingness, without enough motivation to travel such as the inability to pay for the care, the satisfied citizens do not need to travel for care. This manifests in the current low volume of cross-border healthcare.
- **Impact on patient: Social Inequality**

  Social inequality could be a result of how cross-border healthcare schemes are regulated. The coverage might result in certain group of people being excluded from the scheme, as they cannot afford the care. This section attempts to compare and analyse

[5] Ibid.

the impact on social inequality between the rich and the poor before and after the implementation of the Directive. Specifically, the Article 49 scheme currently used will be compared with option 3A. Comparison with option 3B will also be provided to demonstrate the difference in level of the scheme impact.

According to the Commission, the impact of a health scheme where all citizens are benefited from it is the increase in health literacy. However, unequal levels of knowledge about the options available for them such as the current cross-border healthcare scheme, which is very complex and arcane, can be a deterrent to equal access to healthcare. Mentioned in this impact assessment, the 2004 study by the OECD on the income-related inequality in use of medical care finds that the rich or the more educated are more likely and more frequent to visit a specialist or a dentist than the poor or the less educated.[6] It therefore can be assumed that the lack of information availability will increase the inequality.

At the same time, the inequality stemmed from the financial resources availability of the patients and the expectation to get reimbursement cannot be neglected and should be analysed according to the cross-border healthcare scheme. Under the regulation 1408/71 scheme, inequality is less significant a problem because the scheme will guarantee reimbursement of the additional costs. Only up-front costs demanded by the Member States providing care are the problem.

On the other hand, the scheme based on Article 49 as in the existing scheme and the schemes on Article 95 as in sub-options 3A and 3B discourage patients with limited or less resources from pursuing these option routes. Only those with sufficient funds can utilize the care and therefore create the problem of inequality. This is because not only they have to pay out of pocket; in some cases they

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[6] European Commission, "COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT," op. cit., 39.

might not get reimbursed. However, taking into consideration the difference in nature of cares and the costs incurred, hospital care should be given particular attention due to the higher costs of treatment. Comparing the two sub-options, 3B will have a lower impact on inequality as hospital care under this option is through the regulation 1408/71 scheme. Considering that the needed healthcare for the poor is provided under the 1408/71 scheme, option 3A can be justified. Not only does it give patients more access to healthcare, it also instigates the internal market for healthcare.

Supposed that option 3A is the actually implemented option, would the inequality gap be widened or narrowed? The comparison here is between the cross-border hospital care provided under the Article 95 scheme of option 3A and the Article 49 of the existing scheme. The pitfall of the Article 49 scheme is that authorisation for the hospital care maybe required and the reimbursement is not guaranteed. The actual situation varies by countries, as the scheme is not codified, rather it is merely an interpretation or the implication of the rulings of the European Court of Justice. There are many uncertainties in the scheme. The Article 95 scheme, on the other hand, will have a more defined structure for authorisation process, which could actually or not actually come into place. However, the Member States are very likely and very keen to have control over patients flow. Authorisation by way of derogation would probably be part of the Article 95 scheme. Even though the actual criteria of derogation have not yet surfaced, it can be assumed that authorisation will guarantee the reimbursement. The Article 95 scheme will give more opportunity of cross-border healthcare to those with sufficient funds, as both schemes require upfront payment and the Article 49 scheme do not guarantee reimbursement of cross-border hospital care. In conclusion, the inequality gap will be widened after the implementation of the Directive due to the Article 95 scheme under the sub-option 3A.

5.1.2.2 Impact of the Directive on medical tourism within the EU

Cross-border healthcare under the European Union does not confine itself solely within the public sphere. It is important to consider private cross-border healthcare, generally termed medical tourism because of the trade creation and the alternative solution to escaping constraints of domestic healthcare.

The increase in the flow of patients to another country is the trade creation in itself, regardless of their arrangement and the sphere in which they happen. The cross-border healthcare scheme based on internal market Article 95 represents the possibility to commercialise the healthcare sector under the notion of internal market, whereby trade can be done according to principles of the Union. Specifically, the scheme does not differentiate between private and public healthcare sector. In other words, such scheme incorporates the private into the public sphere through the non-discriminatory reimbursement, which is tantamount to actual costs but do not exceed the costs of same care provided under the home system.

The demand for private medical tourism under the scheme based on internal market, which specifically refers to hospital care in the private sectors of other Member States, is not easily determined. While this demand increases because of the trade creation and the reimbursement that acts as a subsidy, the demand also decreases because of the availability of cheaper healthcare. For example, a patient may receive the same level of care without paying anything by switching from foreign private sector under the Article 95 scheme to public sector of another EU Member State under the Regulation 1408/71 scheme. There are many factors that make demand so hard to analyse.

Looking at the nature of medical tourism, it is possible to segment medical tourists into: those who cannot afford domestic care, those who are not part of or eligible under public cross-border healthcare scheme, those who are eligible but do not have sufficient funds to do so and those who prefer to superior care. Each group receives distinct impact particular to their circumstances.

The first group is medical tourists that could not afford domestic care. In global medical tourism, this group constitutes an important portion of all patients. This group is in search of cheap good-quality medical care for that they could not afford the expensive domestic care. In general, this group of patients is very poor such that they are excluded from the system. The only option for them is to find cheaper care elsewhere. As they are not part of the system, they are not eligible for the EU cross-border healthcare scheme. Therefore, the scheme has no direct impact on them.

The second group, which is not part of or not eligible under public cross-border healthcare scheme, covers a wider group of citizens than the first group. This is because the reason for ineligibility can be a voluntary opt-out from the public system. For instance, the very rich can choose this option in some country. Similar, to the first group, as they are not part of the system, they are not eligible for the EU cross-border impact. Therefore, there will be no direct impact of the Directive on them.

On the contrary, there exists a group of eligible patients under the scheme that do not have sufficient funds to pursue cross-border healthcare option. Under the scheme based on regulation 1408/71, they may be able to receive care for free. Even though authorised and guaranteed for total reimbursement, they still could not pay for upfront costs and other costs that are parts of the travelling or not covered by the reimbursement. The Article 95 scheme would be less of a preferable option for them. Not only do they have to pay the whole upfront costs and other costs incurred, they might not receive reimbursement, depending on the to-be-worked-out details of the scheme. The introduction of this Directive would drive this disparity further, however does not mean that this group of patients will still be at the same disadvantageous position. With the clarity and the legal consolidation of the scheme, the information they have might make them decide to pursue the path of EU cross-border healthcare scheme as they can be surer of

their rights to reimbursement, especially in the case of Article 95 scheme, which will possibly replace the vague Article 49 scheme.

The last group is patients who prefer healthcare superior to that provided within the domestic system. It can be assumed that this group of patients is rather affluent in that they can pay for high quality care. However, if they are cost-concerned and understand the possibility of the scheme reducing their costs without balancing out with lower quality of care, they would opt for the EU scheme such as through Article 95 scheme, which allows costs of cross-border hospital care to be reimbursed. The difference in costs between care in private medical tourism and equivalent care under the EU scheme after reimbursement will determine the level of attractiveness to switch from one option to another. Thus, some of these patients may instead switch to the public scheme instead of the private option of medical tourism.

Due to the impact of the Directive, the existing demand for medical tourism may reduce. However, with the overall problem of healthcare system in the Central and Eastern Europe, the long waiting which may or may not be solved and the high cost of co-payment, the degree of medical tourism will probably remains high.

5.1.3 Inherent need for cross-border healthcare outside of the Union: Medical tourism attraction

Under the assumption that patients prefer to receive medical care as close to home as possible, cross-border healthcare or medical tourism would have happened if the healthcare at home is sufficient. While it is explained earlier the inherent need for cross-border healthcare, which are labour mobility and travel and tourism,[*] there are also inherent needs for medical tourism, which in this context refers to cross-border healthcare in countries other than within the EU. These inherent factors should be differentiated from the needs of healthcare arising from the incapability of the home countries or the Union to solve the problem of healthcare provision.

It can be said that medical tourism industry cannot exist without good quality healthcare treatment at a reasonable price. However, there are also other factors that

[*] Please refer to 4.2.1 Factor Mobility and the Inherent Need for Cross-Border Healthcare.

make patients come to utilize healthcare abroad: the inherent need for medical tourism. One reason is the convenience to receive healthcare abroad. Medical tourism is often a combination of medical treatment and tourism. In case of emergency or routine medical treatments, it is more convenient or sometimes necessary to receive healthcare abroad. In some cases, health treatment and check-up are offered as part of a travel package. Busy executives might prefer to have these options combined within their travel schedule. While their families are shopping and doing sightseeing, the busy executives may use this time to retreat from the works and have their health taken care of. An internationalist who travels the world might also have to resort to medical tourism out of convenience. Another reason is the exclusive availability of particular medical procedures, such as an experimental one not available in the first world country due to their safety. This is in case of, for example, the stem cell therapy.*

5.1.4 Push Factors

The whole chapter IV on the European Union, its healthcare integration and its cross-border healthcare scheme culminate in the reaching the consummate goal of identifying the push factors of the EU patients to choose healthcare abroad. The push factors in this thesis refer to the negative factors that drive citizens of the European Union to select healthcare outside of the Union, whether willingly or not. From one point of view, they may be traced back to the incapability of the EU and the Member States to provide healthcare to their citizens. From another point of view, they can be traced to the preference of the patients to receive healthcare abroad. The analysis of the push factors will be based on the current state of healthcare system and the potential impact of the Directive in changing the cross-border scheme and the structure of the system.

The distinct differences between the rich and the poor form the first group of the European push factors. The rich and the poor, whether they are in terms of countries or the citizens themselves, are subjected under circumstances that lead to different ability to make choices. While the rich have access to more choices, the choices of the poor are limited by their financial resources. Quality healthcare at a reasonable price as a solution to this limitation is therefore the *raison d'être* of medical tourism. The below factors are a

* Already discussed in 2.8 SWOT Analysis of the Thai Medical Tourism Industry.

result of the discussions on various topics in this chapter. They represent structural deficiency stemming from the lack of financial means.

- **Social exclusion through ineligibility under national healthcare scheme:** there is a group of citizens that are not eligible under national healthcare scheme. This group will not benefit from the EU cross-border healthcare scheme.
- **Limited coverage of treatment national healthcare scheme:** in order to sustain the financial stability of the healthcare system and to preserve the benefits for all citizens, necessary must come first. Not many countries can afford including preventive or non-necessary procedures in the national healthcare system. If the care is not available in the national system, it will not be available under the EU cross border healthcare scheme. If the country uses insurance premiums as a way to contain cost and give benefits to those who contribute more, the system clearly segregate citizens into levels. Those who pay less will receive fewer benefits.
- **Price in Europe:** costs of health treatment in Europe are generally high, especially in the private sector. Even though the costs in Central and Eastern Europe are lower, they are in general not lower enough to beat major tourism hub in Asia.
- **High co-payment rate:** co-payment rate is often used to keep the cost of subsidy under control. Even though, the system could pay for the costs incur, without co-payment, moral hazard as in over-utilisation could be a big problem. The higher the co-payment rate, the less the patients are willing to receive healthcare. Evidences show that upon the introduction of the co-payment in Germany, Slovakia and the Czech Republic, 10-20% of the visits primary care vanishes in the short run.[7]

According to Dr. Rosenmölller, an expert on patient mobility, "the primary weaknesses in Europe are of a truly elementary nature: patients do want to have themselves treated abroad, but they fail to overcome bureaucratic obstacles, language barriers or to understand the completely different problem."[8] Much has been conveyed within one sentence. One message is that cross-border healthcare within Europe will

[7] Health Consumer Powerhouse, "The Empowerment of the European Patient 2009 – options and implications Report." op. cit., 16.
[8] Ibid., 15.

have a tough time elevating itself to another level. Even though patients are willing to travel, they are stuck by many fundamental problems. According to the 2007 Eurobarometer, 70% of the EU population tends to believe that the costs of healthcare can be reimbursed by their home state and 54% are willing to travel to another EU to receive healthcare.[9] Nevertheless, the survey also shows that 86% and 83% of all EU citizens do not want to travel to another country to receive medical treatment because of the convenience of treatment at home and the satisfaction with the care received at home respectively.[10] The second group of push factors relates to the organisation and delivery of healthcare provision at national level. While the first group focuses on the structural deficiency, this group refers to the operational deficiency of the healthcare system, which also includes the provision of cross-border healthcare, as the Member States are the one responsible for it.

- **Mediocre quality of healthcare in the Central and Eastern Europe:** even though the quality of care in Western Europe is good, the level and quality of care are very restricted in Central and Eastern Europe. Only a number of procedures are offered and the quality of care is not up to the standard.
- **Bureaucracy:** bureaucracy can be an important to healthcare. When receiving care under the public sector, the services tend to be little of desirable. Such might increase the time before one can receive treatment or healthcare. On the other hand, bureaucracy exists to a much lesser extent in the private sector.
- **Language:** one of the most fundamental problems in any cross-border trade is the problem of communication. Different countries use different language. Even though most of the doctors can speak English, not all patients, nurses and hospital administrators can. In order to overcome this problem, hospitals often have a team of interpreters to facilitate the care. However, public hospitals do not have incentive to employ them as their main duty is to provide care to local population in the region. Furthermore, where would the money come from? They are not hospitals that emphasizing on medical tourism or cross-border healthcare. According to the Eurobarometer, 49% of all EU citizens do not want to travel to another EU

[9] The Gallup Organization. op. cit., 5.
[10] Ibid., 18.

country to receive healthcare because of language reasons.[11] Lost in translation!

- **General Practitioner (GP) referral requirement:** in some countries, general practitioner referral requirement is needed in order for patient to see a specialist. This requirement is similar to co-payment or cost-sharing scheme in that they are put in place to defy the problem of moral hazard. The additional benefit of the GP is to make sure that patients are rightly referred to and the specialists are not overwhelmed with patients coming to see them directly.
- **Long waiting list:** in many countries where healthcare treatment cannot be delivered immediately, their citizens are suffering from the waiting time. The reason of the waiting time can be such as the need to wait for transplant organ to be available, the over-congestion of the system or the lack of staff. Therefore, many patients in order to avoid excruciating pain decide to sacrifice their money for faster treatment, which could be through cross-border healthcare, medical tourism and informal payment.
- **Informal payment:** informal payment refers to payment to the doctors or hospital administrator in order to secure better care or expedite the treatment through skipping the waiting list. According to the European Consumer Powerhouse, this problem is rampant in more than half of the 31 European countries.[12]

The third group of the push factors concerns the EU cross-border healthcare schemes, both before and after the implementation of the Directive. This group represents the push factor in terms of how the cross-border healthcare is administered at the European level or specific to cross-border healthcare when it comes to national level. These factors include:

- **Prior authorisation system:** the system of prior-authorisation is introduced to control the outflow the cross-border healthcare. While it is good to be able to curb the unnecessary needs for cross-border healthcare, a number of Member States, however, have bad attitude toward cross-border healthcare. With the conditions for authorizing and refusing the cross-border healthcare

[11] The Gallup Organization. op. cit., 18.
[12] Health Consumer Powerhouse, "The Empowerment of the European Patient 2009 – options and implications Report." op. cit., 8.

not clearly established, those Member States can limit the flow of cross-border healthcare to their heart's content.

- **Rights to deny reimbursement:** similar to the prior authorisation system is the rights to deny reimbursement. Under the free movement of services Article 49 scheme, reimbursement for hospital is not guaranteed. As part of the legal-political process of the Directive, the discussion of increasing the rights of Member States to deny reimbursement always resurfaces.
- **Upfront payment:** upfront payment stems from the requirement of the State providing care. However, it is categorized in this group because it is a specific problem to cross-border healthcare. As the reimbursement in many cases of cross-border healthcare has to be done later, high upfront costs might be a hindrance to cross-border healthcare. It might be better to go to countries that offer a more competitive price. The whole payment could be lower than the upfront cost.
- **Out-of-pocket:** out-of-pocket refers to the costs that the patients have to pay by themselves, which equals to total costs subtracted by the reimbursement. If the out-of-pocket is still very high, medical tourism might be a better option**.**

Lastly, the fourth group deals with behaviour and preference of the patients themselves.

- **Lack of confidence in healthcare at home and in Europe:** the October 2008 Eurobarometer on quality of life finds that four of five citizens perceive medical errors as an important problem in their country. A quarter of all the citizens are directly affected by medical error personally or in their family.[13] If this viewpoint is extended to other countries, healthcare in Europe is not trustable for them. This is confirmed by the surveys of Health Consumer Powerhouse that there is a "limited degree of trust in national authorities – and the EU level…."[14]
- **Medical tourism agents and access to information on medical tourism:** While the information on medical tourism through agents and the internet are readily available contributing to the promotion of medical tourism,

[13] Eurobarometer, quoted in ibid., 4.
[14] Ibid., 5.

information regarding internal healthcare with the EU is "a disaster area."[15] If they were not sure about the treatment, they would seek an alternative that could convince them. Even though the Directive aims to fix this problem, the results would vary, if not miserable, as Member States are responsible for all the arrangement. In fact, even the information on national-level patients' rights is not well publicized. Also during the amendment process, compromises have been made on restricting the information on the EU cross-border healthcare options.[16]

- **Insurance company with contract abroad:** a number of insurance companies have contracts with many health facilities outside of the Union. This contract not only facilitates the medical tourism, but also promotes it.

5.2 Pull factors

In this part the attention is brought back to Thailand and medical tourism after discovering in the earlier section the factors influencing European citizens to receive healthcare abroad. While it may be true that the changes in these push factors affect the consumers' behaviour in choosing to come to Thailand for medical treatment, however if the Thai pull factors are strong enough, the effect of the change in the push factors would be minimal. This chapter attempts to link these two factors together to derive the possible effect of the Directive.

The pull factors refer to the factors that attract foreigners to choose to come to receive medical treatment in Thailand. In this thesis, the pull factor aims specifically at the European patients. Therefore, in selecting the corresponding pull factors, the knowledge of the European healthcare system and its cross-border healthcare scheme are necessary. Unlike the push factors, the pull factors are not affected by the Directive as they are derived from the Thai industry; however, the European patients' respond to the pull factors can changed and therefore will be analyzed in the next sub-chapter.

Based on the SWOT analysis in the literature reviewed, chapter 2.8, the pull factors are identified through the results from the interview with key informants. These factors will be discussed in conjunction with the push factors and the Directive. As a basis for confirmation and through the method of deduction, the 2001 Eurobarometer

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[15] Ibid., 7.
[16] Ibid., 15.

#210 "Cross-border health services in the EU" will be used to substantiate the factors. However, the assumption must be made that preferences and behaviors of the consumers do not deviate much; EU patients made choices for healthcare within the EU under the same basis as making a choice for healthcare abroad or Thailand. This assumption is needed so that the results or the findings of the surveys can be extended to cover the issues discussed. Interview will be used to confirm the validity of the pull factors.

5.2.1 Pull Factors

As a result of the interviews, the main pull factors attracting European tourists to Thailand mentioned by the industry are: prices for quality, availability of treatment and information, reputation and tourism. The pull factors are directly related to the competitiveness of Thailand and therefore connected to the strengths and weaknesses of the Thai medical tourism industry. The related elements identified in the strength and weakness analysis are similar to those stated during the interviews. For complete results of the interview, please refer to Appendix A.

- **Prices:**

  Prices are an important factor in attracting medical tourists from countries with the cost of treatment so high. The result of the interview yields that prices as a factor are an important factor for medical tourists. The degree of importance, however, varies due to group of patients. For European medical tourists, whether prices are important or not depend on the treatment and their countries of origin.

  For the Beveridge countries, whose main problems are the long waiting list, prices are important when the treatments needed are not provided under the system. For those who want to skip the waiting list, prices are not of main issues, as prices in Thailand are much cheaper anyway. Theses countries include the UK and the Scandinavian countries.

  For the Bismarck countries, costs are more important as patients have to pay through insurance. For those that could not purchase premium insurance, not all treatments are covered and therefore they have to pay by themselves if they want those treatments, which often are dental treatments and cosmetic

surgeries. Medical tourism becomes a choice for them as the prices in the countries are so high and foreign prices are lower.

There are two ways of looking at this: first, in terms of high prices as a push factors; and second, in terms of low prices as a pull factors. It can undeniable that the two are interrelated. In this discussion, of the pull factors, we are trying to look specifically at the second viewpoint: low prices as a pull factor.

Of course, cheaper prices play a role but only when it is accompanied by good quality. For Europeans, quality are important and must not be neglected when they considers receiving healthcare abroad. Low prices, therefore, are not of-utmost-important pull factors for European medical tourists.

- **Availability of Treatment:**

Availability of treatment can be interpreted as the availability of a treatment that is not provided or does not exist in the home country; and the immediate availability of treatment. As the European healthcare systems are mostly advanced, the first viewpoint is not of concern for this group of medical tourists. Only people from less medically advanced countries falls into this category. For the European patients, specifically countries with long waiting list, immediate availability of treatment are concerned. While the lack of immediate availability is the push factor for them, the abundance of supply that results in the immediate availability of treatment in Thailand is the pull factor.

- **Information Availability**

At the crux of the success of the medical tourism industry is how information is distributed. European patients preferred to be informed of their rights and understand what is going to happen to their bodies. Hence, confidence is a key to their consideration of choosing to receive healthcare abroad. It is important that information is available. Nowadays with the Internet, information flows fast making healthcare abroad very accessible and understandable. On the contrary is the reflective push factor of unavailability of information about rights, which the Directive aims to solve.

- **Reputation**

Thailand is well known for cosmetic surgeries, especially gender reassignment surgery. This is a manifestation of expertise accumulated as well as the economy of scale. Quality is assured with the Thai hospitals being

internationally accredited and their medical staffs' abroad experience. Thailand is also well known for its reputation as a tourist destination, which renders good image of the country. Nevertheless, it must be recognized that this factor is in conjunction of the information availability, which allows patients to have more confidence in receiving care abroad.

- **Tourism**

Lastly, European medical tourists come to Thailand not only to receive treatment but also to travel and enjoy their vacation here. European medical tourists are in contrast to other groups of medical tourists such as those from nearby countries and the Middle East. European tourists are very open to travelling exotic destinations. They love sun, beaches, nature and culture. Thai food is a delicacy for them. With strong tourism industries, tourism is a strong pull factor of Thailand.

5.2.2 Responses of European patients to the pull factors

The discussed pull factors are that of the Thai industry. However, in measuring its effectiveness, there is a need to connect them with the viewpoints of European patients as well as their responsiveness to the factors. In this section, the factors are attached with the level of importance, which could be changed because of the Directive as it will change the cross-border healthcare and the provision of care. There are many pull factors; however not all of them are relevant to the discussion in this section, as they have no relation with the Directive and the affected push factors. This is for example the agent in EU that could increase the number of patients coming to Thailand substantially but as it has nothing to do with Directive, it is not eligible under this analysis.

Provided below are the factors motivating and discouraging EU citizens to obtain treatment in another Member State according to the Eurobarometer on Cross-border health services.[17] The number in the bracket refers to the percentage of the people stating that the factors are relevant to them. This information will be used in discussing each pull factors.

[17] The Gallup Organization. op. cit.

Motivating factors:

- To *reduce the waiting time* for medical treatment [64%]
- To receive *cheaper* medical treatment [48%]
- To receive a treatment of *better quality* [78%]
- To receive treatment from a *renowned specialist* [69%]
- To receive *treatment that is not available at home* [91%]

Discouraging factors:

- It is *more convenient* to be treated near home [86%]
- Already *satisfied* with treatment at home [83%]
- *Lack of information* about the medical treatment available abroad [61%]
- Because of *language reasons* [49%]
- Medical treatment abroad is *not affordable* [47%]

- **Availability of healthcare not available in the home country**

Stated as an important motivation factor to choose healthcare in another Member State with the rate as high as 91%, to receive the healthcare treatment that is not available at home could be an important factor for EU patients to go outside to receive this healthcare in Thailand also. According the discussion of the push factor on accessibility and coverage, the Directive does not change the coverage as the Member States have the rights to choose which services to provide to their citizens. If the treatment is not available and deemed necessary, the system might extend the benefits for the patient to receive this treatment abroad. However, this would be a rare case as the duty of the government is to provide healthcare that will guarantee fundamental health rights of its citizens. Therefore, it is very likely that if there is a lack of treatment provided at home and it is available in Thailand, they are likely to choose to come to Thailand. To improve their convenience, hospitals in the tourist town such as Chiang Mai and Phuket could be an option for them.

- **Convenience**

86% of the EU citizens feel that it is more convenient to be treated at home. This factor, overall, is not affected by the Directive as its concern is on cross-border healthcare. In other words, it is inconvenient for them to waste time and money to travel abroad to receive care. Therefore, it is imperative that

coming to Thailand is convenient for them. This might sound illogical, but it can be made happen. Without the need for treatment, people would not travel to Thailand. However, if they need the treatment, they have to come to Thailand. When they come to Thailand if they have other things to do at the same time, the level of convenience will increase. If they come to receive treatment and have their families with them, the level of convenience will even more increase. This is because there are other activities for them to do to convince them that travelling is a waste of time. And if the net cost is cheaper, the worthwhileness will make everything more convenient. This pull factor corresponds to medical tourism attraction.

- **Satisfaction**

83% of the EU population states that if they are satisfied with the treatment at home, they will not travel to another EU country to receive healthcare. The Directive does not have the main goal of improving national care, rather it demands that the care should be of certain standard to guarantee that the care provided to citizens of other countries are of guaranteed European standard. Therefore, for countries with already high standard, there is no need to improve the standard of care. Only those with lower standard needs to reinvent their system. As a result, the Directive will partially improved the satisfaction rate of the country through European standard. To make this statement relevant and applicable to the pull factor of Thailand, the statement must be extended to the European level. If they are satisfied with the European cross-border scheme and the care provided, they will not go abroad. The corresponding push factor could be a high co-payment rate, a long waiting list, bureaucracy, language and many more. As there are many factors involved and the outcome undetermined, it cannot be concluded that the impact Directive will have a positive or negative effect on the satisfaction rate. Considering the Thai side, if patients are satisfied with the services, they could come back again.

- **Better Quality**

Of all EU citizens, 78% of them are motivated to travel to another country to receive better quality of care. Similar to the earlier factor, the Directive if implemented will lead to the harmonisation and the improvement of the quality of care so that it will be up to standard. This means that this pull factor of

Thailand will be affected as the Directive has an impact thwarting the effect of the pull factor.

- **Reputation**

69% of all EU citizens are motivated to receive care in another EU state to receive treatment from renowned specialist. The Directive does not change the amount of renowned specialist; therefore, it must be assume that the Directive through the cross-border healthcare scheme will allow more people to gain more access to them. Therefore, the Directive will reduce the effect of this pull factor. However, the subjected must be changed to suit the pull factor of Thailand, as Thailand does not have a world-renowned specialist. Rather, reputation of Thailand and the hospitals can supplement that. This is, for example, the case of gender reassignment surgery.

- **Waiting time reduction or immediate availability of care**

64% of the EU citizens are willing to travel to another EU Member State to reduce the waiting time for medical treatment. While the Directive does not actually solve the problem of waiting time intrinsically, the Directive consolidates the rights for patients to receive care faster through the cross-border healthcare scheme. Therefore, if the volume of movement increases, this pull factor of Thailand will reduce in its effect. However, as patients can almost always receive treatment within an immediate timeframe, Thailand has an advantage over this category.

- **Availability of Information**

The lack of information discourages 61% of the EU citizens from going to another EU Member State to receive healthcare. Hence, if the Directive induces the better level of information distribution, the pull factor of Thailand in terms data availability will be less effective in attracting patients from EU to choose Thailand. However, whether the Directive will achieve in distributing data or not remain questionable, as Member States are the one responsible for this. Because Member States are cautious about letting their citizens know about rights in healthcare, the success would be rather bleak. On the other hand, if Thailand provides clear information whether it is about rights, costs of care or miscellaneous things such as travel plan, the pull will be stronger.

- **Language**

49% of the EU citizens are not willing to travel to another EU country for medical care because of language reasons. As the Directive has nothing to do with language, there will not be an impact on this factor. As long as Thailand is equipped with proficient interpreter, the industry should be fine.

- **Cheaper Costs**

Surprisingly, only 48% of all citizens of the EU are willing to travel to another EU Member State because of cheaper costs. The cross-border scheme involves with reimbursement, which acts as cost reduction. The Directive may help with boosting the level of activities in cross-border healthcare. From another perspective, does this imply that European patients coming to Thailand does not have cheaper costs as their reasons for coming here or anywhere else. Only 48% of them believe in cost-reduction. This implies that price war might not be a good strategy for attracting EU patients.

- **Affordability**

Lastly, 47% of all EU citizens do not go to another Member State to receive care because they believe they could not afford the costs there. Again, the problem of affordability could be solved with the Regulation 1408/71 scheme or the reimbursement. Therefore, if the citizens know about these possibilities, they may be able to afford the care. Along the same thinking, if EU patients are assured that they can be the costs or there is a level of certainty in terms of what the treatment costs might incurred, they may be more comfortable choosing to come to Thailand to receive medical treatment.

5.3 Push and Pull Factors: Effect on Thai Medical Tourism Industry

In this section, the possible changes in the push factors as well as the change in responsiveness to the Thai pull factors after the Directive has been implemented will be evaluated as an effect on the Thai industry. So far each push and pull factors are investigated as a single items variously affected by each of the three main working areas of the Directive. However, the question here will be that how would all of what we have been discussed so far affect the Thai industry? In other words, would there be a change in a number of medical tourists from the European Union.

As stated in chapter 3 on methodology and data collection, this research is a qualitative research due to the limited availability of data. Quantitative measures can be given only in terms of broad movement, either increasing or decreasing. Overall movement also cannot be predicted as the changes induced by the Directive results in both the increase and decrease in the number of the European patients choosing to receive healthcare outside of the community. Furthermore, the effect can be specific to or varied among countries and groups of patients. And since the effect of the Directive will go through the push factors, the changes in the push factors will be analyzed in yielding the change in number of patients. Only relevant factors that will be affected by the Directive will be included here.

In the first group of the push factors, the differences between the rich and the poor, the problem of high prices as a result of the co-payment scheme can be partially solved as patients can go to receive care in another country whereby the prices are lower. Therefore, patients opting for healthcare outside of the community may decide to travel to another Member State instead.

The second group, the organisation and delivery of healthcare provision at national level, on the other hand, factors are more affected by the Directive. For countries with mediocre quality of healthcare as in the Central and Eastern Europe, patients can go to the Western European countries to receive high quality care while being subsidized by their home system. The problem of bureaucracy will be partially solved as the Directive includes European co-operation as one of the working areas. The process of cross-border healthcare will be easier as for example through better personal information transfer. For countries with long waiting time, i.e. the lack of capacity to treat patients without undue delay, patients can be sent to another Member States instead as to reduce the crowdedness of the system. However, a number of countries have already resorted to this option. The Directive would not have much impact in this respect.

The EU cross-border scheme, as the third group of the push factors, has a direct impact on the change in the flow of EU patients. Overall, the harmonization and the consolidation of the scheme will make it easier for one to receive care abroad with scheme in place and the rules and criteria for authorization clearer. However, when looking deeply, there are a number of aspects that need to be considered. The change in the scheme as in from that of Article 49 to 95 will allow Member States to use prior-

authorization by way of derogation, which will result in a more restricted flow of patients than under Article 49. As the actual criteria for derogation is not clear, Member States will likely want to minimize the flows as to be necessary as much as possible. In other words, the change in the scheme will give more rights for the Member States to deny reimbursement. The flow of patients will probably decrease than before because of the denial but increase because of the harmonization of the scheme. Without actual details, it is impossible to predict the overall change.

Last but not least are the behaviour and preference of the patients. By establishing a standard for European healthcare, certain level of confidence can be assured. Improvement in quality of care in the Central and Eastern European countries will be seen; however, probably not that of the Western European countries due to their already high standard. For people that travel to the Central and Eastern European countries for healthcare, confidence would be boosted. Systems of the Western countries, even though good, are still suffering and will continue to suffer from the bad reputation. With confidence that they will receive better care and that they have rights to cross-border healthcare, the flow would probably increase.

So far, the change in the level of patient movement has been analyzed in terms of internal movement. The flow of patient to Thailand needs further discussion. Before proceeding with the discussion of the possible change, it must be established that most of the EU medical tourists coming to Thailand are from the Western countries according to Table 5, page 31. The number of patients from Eastern Europe is negligible. While the UK, Germany, France and the Scandinavian countries rank high on the chart; it must be taken into consideration the size of their populations. According to the author's calculation, approximately 0.174% of the UK population utilizes health services in Thailand. For Germany and France, the rates are similar at 0.053% and 0.055% respectively. For Scandinavian countries, the rate is 0.092%.[*] This implies countries with the Beveridge system comes to Thailand more and hence it can be said the problems existing in the Beveridge system, which is mainly the long waiting time, are the main

[*] It must be recognized that the percentage provided is the proportion between patients receiving care in Thailand and total population. It does not differentiate among expatriates, tourists, and medical tourists. However, according to the interview with the industry, rules of thumb can be applied that 50% of all European patients are medical tourists. Also important to note is that the number of population of other European countries are smaller and therefore despite the high percentage of patients coming to Thailand, the number would not show. However, it still can be generalized that the patients under the Beveridge system needs to come out of the countries more than the Bismarck.

push factors. According to the European Union Statistics on Income and Living Conditions (EU-SILC)*, the Western European countries are Italy, Finland, Germany, and the UK, which indicates that the Directive might have wide impact especially for these countries.

From the earlier analyses of both the push and the pull factors and the identification of the long waiting time as an important reason for European countries, specifically those with Beveridge system, to come to receive care in Thailand. As the waiting time involved with both the push and pull factors, the impact will be more pronounced for Thailand in case of the patients from the Beveridge countries and patients from the countries with the problem of waiting time. Specifically, patients from Germany, the UK and the Scandinavia will be probably come to receive care in Thailand less than before as the Directive would allow for better flow and partially solve the problem of waiting time by sending patients to other Member States. Patients from countries with the Bismarck system will still come to Thailand, as the Directive does not solve the problem of high price as much.

* See Table 18 - Main reasons for unmet need for medical examination and treatment (2005) in Appendix C.

CHAPTER VI
CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

There would not be an easier or a more effective way to end this thesis than to re-answer the stated research questions and to look at how the objectives of this research have been fulfilled.

The main research question on the effects of the European Union's Cross-Border Healthcare Initiative on the Thai medical tourism industry is a universal yet conclusive question. To answer this question, three questions are posed to elaborate and focus on separate elements of the questions. The first question is on the push factor, the second on the pull factor and the third on the Thai medical tourism industry:

Q1: How would the Directive induce or detract European Union public healthcare service receivers from selecting healthcare service outside of the community i.e. the push factor?

There is no easy way to answer this question, as there are a number of push factors affected by the Directive. It is impossible to state that overall the Directive induce or detract EU patients from receiving healthcare in another Member State. The scope of the Directive has been limited, while the Member States retains the rights to implement the Directive in their own way. Uncertainty abounds along the legal process and the details need to be worked out in the comitology level. Nevertheless, looking at the change in the cross-border healthcare scheme and four groups of push factors can give a zoom-in viewpoint to the impact.

In terms of the cross-border healthcare scheme, the change in the scheme will be the change from the free movement of services Article 49 scheme to the internal market Article 95 scheme. While the Article 95 scheme will be more consolidated in terms of rules and method of implementation, Article 49 has a wider coverage and flexibility. The impact will depend on the worked out details and the actual implementation of each Member States

The first group of impacts is on social inequality. While the Directive gives clarity to rights and the scheme, it does not fix the problem of social inequality being it a result of the exclusion from the scheme, the limited coverage posed by the Member State and the problem of price and the high co-payment rate.

The second group of the push factors is the operational deficiency of the healthcare system. Again, due to the limited competence of the Union and the limited scope of the Directive, operational deficiency such as the problem of healthcare quality in the Central and Eastern Europe, red tape, informal payment, language, the referral system and most notorious of all the long waiting list. While patients can escape some of these problems by receiving care in another Member State, the Directive will not fix the problem from its roots with the exception of the quality. The EU's structural funds have been injected into the region to improve their system. And if the Directive does not lose its strength in defining level of quality and safety in the legal process, there will be an obligation of the Member States to make sure their system is up to the defined level of standard.

Administration of the cross-border healthcare scheme at the EU level is the third group of the push factors. Overall the prior-authorisation system, the rights to deny reimbursement, the upfront payment and the out-of pocket will remain despite the attempt of the Directive to get rid of them as much as possible as they are hindrance to the efficiency and create the problem of inaccessibility.

The last group of push factors is the behaviour and preferences of the patients themselves. There is a lack of confidence in European healthcare system. Information deficit, which is one of the areas the Directive would tackle, remains the problem. The easier access to information on medical tourism and the contract of insurance companies with private facilities both inside and outside of the system allure people to leave the public system if they can.

To conclude, many of the problems will remain. Some will be fixed. But right down to the root of the problem is the resistance of the Member States to retain the control over healthcare. If the Member States understand the need of cross-border healthcare and are committed to it, the problem will be much more alleviated.

Q2: Are the Thai pull factors of medical tourism susceptible to such effects?

This question also is not easy to answer, as the basis for the pull factors eligible under the scope of this thesis must be related to the Directive and therefore the push factors. However, the responsiveness to the Thai pull factors can be used in determining the degree of the effect. Identified from the interviews and based on the SWOT analysis of the Thai medical tourism industry, five main pull factors of the Thai industry are identified The improvement in European healthcare as well as the cross-border healthcare scheme will change the receptiveness of the European tourists to the Thai pull factors as follows:

- Prices as a pull factor will remain the same, as there is no change in prices within the EU. EU patients will still come to Thailand, as the costs in the Union are so high.
- The availability of treatment in the EU due to the better cross-border healthcare after the implementation of the Directive will reduce the need, i.e. the responsiveness, of the Europeans to come to Thailand. And as the important group of people coming to Thailand for treatment is patients from the Beveridge countries, particularly the UK and the Scandinavian countries, as well as the non-Beveridge with the problem of waiting time, the blow can be rather direct.
- Information availability will remain a problem in the EU despite the central attempt because of the protectionist attitude of the Member States. The Thai industry will still able to tap into the market because of this problem.
- Reputation of Thailand is irrelevant in this case.
- Tourism will remains a strong pull of Thailand as European medical tourists come to Thailand for both treatment and tourism.

Overall, it can be said that the Thai medical tourism will continue to attract European medical tourists. Europeans still need to come to Thailand as the Directive will bring about a higher level of patients movement, but does not solve the other problems that would result in the change in European medical tourist's response to the Thai factors. Problems inherent to the system will remain intact; EU cross-border healthcare can only help alleviate some aspects of the problems.

Q3: Should the Thai industry react to the Directive? If so, on which area should the Thai medical tourism industry focus in order to attract more medical tourists from the European Union?

Even though the Directive indirectly affects Thai medical industry, there is nothing specific that the industry should do as demonstrated by the limited linkages of the pull factors to the European medical tourists. Only one pull factor will be hit by the Directive. If the Directive will be successful, it can be estimated that Thailand will lose patients from the Beveridge countries, whose main countries are the UK and the Scandinavia. Patients from the Bismarck countries that do not have the problem of waiting time such as France will remain relatively unaffected. The industry itself is a robust and innovative industry. All the existing marketing campaigns and the services offered can be considered effective. The second part of the question, however, is a recommendation and, therefore, will be in the following section.

In summary, the effects of the European Union's Cross-Border Healthcare Initiative on the Thai medical tourism industry is minor due to the expected level of EU cross-border healthcare to remain low and the protectionist attitudes of the Member States. Push factors will remain mostly intact. European medical tourists will still come to Thailand, as demonstrated by the pull factors remaining relatively unscathed. However, in long run, with the improvement and the changes in the healthcare provision and cross-border healthcare scheme, the effect will be more pronounced; more EU patients will be able to receive healthcare in other Member States with reimbursement assured.

To evaluate the success of this thesis, the objectives shall also be revisited. The first objective of this research is to assess the effects of the European Union' Cross-Border Healthcare Initiative based on the existing European healthcare system and the cross-border healthcare schemes on the push factors. In Chapter IV, the elaborate build-up of information, whether political, legal or economic, leads to the in-depth analysis of the European healthcare system, the existing cross-border healthcare scheme, the Directive and its ramification on the system. At the end of the chapter, the push factors are identified in accordance with the prospective change that would be cause by the implementation of the Directive. The second objective, which is to make a link between European medical tourists through the push factors with the Thai medical tourism

industry through the pull factors, is reflected in the first and second already. European medical tourists coming to Thailand are identified in terms of their reasoning and their countries of origin. Hence, the two objective of this thesis are fulfilled.

6.2 Recommendations

- **Recommendations for the Hospitals and the Industry**

As the Directive does not have a direct impact on the Thai medical tourism industry, the impact rather channels through the changes in the push factors and the changes in the responsiveness of the European medical tourists to the pull factors. The hospitals and the industry therefore cannot respond to the Directive, but respond to the change in behaviours of the European patients caused by the Directive. Based on the current rate of cross-border healthcare activities and the European Commission's prediction, the level of impact will be low. However, once the full effect of the Directive takes place, which means that patients acknowledge their rights to cross-border healthcare, the situation will be totally different. By that time, the healthcare system will be up to common standard as directed by the Directive. This will intensify the internal market through the higher level of cross-border healthcare. Despite the strong support from the tourism industry, the amount of European medical tourists will decrease, especially those from Germany, the UK and the Scandinavian countries as the Directive will solve the problem of the waiting time.

It is necessary for the Thai industry to make a pre-emptive move to secure the confidence of the European consumers. This can be done through various marketing campaign, which is the core and the success of Thai medical tourism industry. It is important to emphasize the strong link between the tourism and the medical tourism industries since most European patients come to Thailand for both travel and treatment. If the campaign could penetrate EU-wide, there will be a bigger market for the industry. Tourism also should be emphasised as they form one of the elements differentiating Thailand from the rest. As a number of patients are returned patients, it is possible to retain some of the patients that could no longer come to Thailand and instead resort to the care provided within the Union. To do so, the hospital must maintain a relationship with these patients. The already established scheme such as health check-up or extra cosmetic surgery can be used here. Long-term connection with the European market

such as through wellness and medical tourism agency and private insurance companies will also secure the consumer base.

There is also a possibility of penetrating into a new market: the Central and Eastern European countries. Despite the relatively cheap costs compared to the Western European countries and the improvement of the systems as a result of the Directive, Thailand still has comparative advantage in terms of prices. As the reason to come here is not as strong as that of the Western European countries in terms of price, it is necessary to give them motivation to come to Thailand. Tourism can be used. However, it must be considered that in embracing this market, the Thai industry must evolve as well. The hospital must expand the interpreter team to include Eastern European languages, establish a presence in the region and form a new network of agents.

Regardless of the campaign used, the strategy should be based on the question: how to make them get out of the region and come to Thailand

- **Recommendations for the Thai Medical Tourism Industry**

According to the findings, prices, even though important as a factor, are low enough that there is no need to compete in terms of prices with other countries. European comes to Thailand because of quality and tourism; as long as prices are reasonable medical tourists will continue to come to Thailand. The industry should not use price as a strategy. Rather, the industry should come together and create a common understanding that the hospitals will not compete against each other in terms of price

Currently, the effort to do marketing in the European Union has been done on an individual basis. It is necessary the industry form a coalition such through a new organization having all hospitals with foreign patients as a target group to come together in addition to the existing, yet not-specific-to-the-issue, the Private Hospital Association, Thailand. By joining as a group, the industry will have a better presence in the world as well as a power to instigate the government to give support to the industry.

- **Recommendations for the Government and Supporting Institutions**

Despite the 2004 Medical Hub policy of the government, actual implement has been put into a freezer. Nothing has been achieved. While the industry receive support from the Tourism Authority of Thailand, the Department of Export Promotion and the Thai Chamber of Commerce, the supports given concentrate in terms of promotion such as in terms of road show and exhibition. The hospitals are struggling to survive on their owns in practical reality. The Ministry of Public Health should reconsider the position of

the industry within the Thai healthcare community. Is the industry really causing a negative impact on the overall healthcare performance? Is the problem of brain drain really caused by the industry?

To boost the confidence of the European tourist, the government must eradicate the problem of legal uncertainty and bureaucracy. Overall the level of consumer protection is very low, especially that of foreign patients. There should be a legal guarantee if there is a problem going on, the patients will beappropriately protected.

The government should establish a centre to deal with medical tourism as Singapore does and be a chairman in leading the industry. As there is a only a limited number of players in the industry, an organization with a neutral position such as the government should step in and create unity through its presence and support.

- **Recommendation for further study**

The thesis has intensively focused on the European side for the reason that there is no focused study on the topic. To further the study of the first part of this thesis on the push factors, it is recommended that analysis should be made using the detailed Directive and method of implementation, which will take shape after the legislative adoption by the Council and the Parliament. This means that the analysis can be done with less ambiguity.

Studies on the Thai medical tourism, on the contrary, are abundant. However, there is no study with an emphasis on the European market. It is recommended that the study on the synergic link between Thailand and Europe on the subject be made. This is so that the Thai industry can use this information to develop tailored marketing strategy targeting at the European market. For instance, the link can be investigated in terms of countries as a target group.

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APPENDICES

APPENDIX A
INTERVIEW

I. Interview Questions

Part I – Basic Information

1.) Information on the hospital:
- What is your overall strategy and focus of the hospital?
- How many patients do you receive per year, both in- and outpatients?
- How many beds do you have available?
- Is your hospital part of a chain or affiliated with other hospitals?

2.) Information on foreign patients:
- What is the proportion between Thai and foreign patients?
- What is the composition of foreign patients by region?
- How much do they contribute to your revenue?
- Do you differentiate between expatriates, planned and unplanned medical tourists?
- Which kinds of treatment and which departments do foreign patients often utilized, OP and IP?
- Do you offer relating services such as immigration services, city tour and extra accommodation?
- Do you have restriction on giving services to foreign patients?
- What are the main reasons that people travel to Thailand to receive medical treatment?

3.) Information on European patients:
- What is the composition of European patients by countries?
- How much do they contribute to your revenue?
  - Medical revenue
  - Non-Medical revenue
- Which kinds of treatment and which departments do European patients often use?

  Are they different from those of foreign patients in general?
- Is there a sub-group of European patients? If yes, which group?
- Does your hospital have European patients as a specific target group?

- Is there a specific campaign aiming at European patients? What are they?
- Do you have an office in Europe or a connection with European medical tourism agency? How important is their role?

4.) What are your strong points or advantage over other hospitals in attracting foreign patients especially planned medical tourists from Europe?

5.) What is the vision of your hospital toward global medical tourism industry?

Part II – Cross-Border Healthcare

1.) Are you aware of the European Commissions' proposal of the Directive on the Application of Patients' Rights in Cross-border Healthcare?

2.) If the Directive were implemented, what do you think would be the impact on the medical tourism industry in Thailand? What about the number of European patients using your services? How?

3.) What is your opinion on national healthcare system and public health insurance scheme not including payment for medical services or cross-border healthcare outside of the European Union?

4.) Private insurance increasingly includes the foreign medical services. What is your opinion regarding this?

5.) What do you think make medical tourists come to Thailand in particular besides the medical aspects of it? In other words, do you think that supporting industries and Thailand itself play an important role in attracting medical tourist to use your services?

6.) What is the payment mechanism? Is it mostly out-of-pocket or part of coverage by travel insurance?

Part III – Medical Tourism and Healthcare in Thailand

1.) Do you receive support from the Tourism Authority of Thailand and Ministry of Public Health or any other government agency in promoting medical tourism?

2.) Is there a sanction or a regulation by the government in treating foreign patients?

3.) What is your position on brain drain within the Thai medical community?

4.) What do you think is the effect of Thai medical tourism on Thai medical system?

II. Executive Summary

In 2008, the European Commission proposed a law regarding the functioning of cross-border healthcare within the European Union. Currently, it is within the legislative process, subjected to much debate and a number of compromises. Three main objectives of this draft Directive are as follows:

1. To outline common principles of how healthcare should be delivered in the EU member states to ensure safety and quality of the care;
2. To set a specific framework for patients' rights to seek healthcare in another member state; and
3. To provide a framework for cooperation between healthcare systems of the Member States in areas such as e-health and health technology.

Despite the wide coverage of the Directive, the important portion that potentially has effect on medical tourism in Thailand is the planned cross-border healthcare. Patient safety and quality of care provided also are included. According to the original draft proposal, public planned cross-border healthcare within the EU will be regulated accordingly:

- Who is eligible? – EU patients can receive reimbursement of the costs of treatment incurred in another EU Member State provided that the patients are entitled to public care in their home countries.
- Who pays? – Patients have to pay the costs upfront and receive later the reimbursement. The home country will provide reimbursement up to the costs of similar care provided within the country.
- How much? – The patients have to pay the exceeding costs by themselves. Reimbursement will not cover travel, accommodation and other expenses that would not incurred if the patients are treated in the home country.

- What Service? – Not all services are eligible for reimbursement; only the home system has the rights to decide if such services are available for their citizens or not through the prior-authorization system
- How to do it? – Patients have to make a request for treatment abroad before they can receive such treatment. Two criteria governing the prior-authorization system are that:
    a. the treatment must require an overnight stay in a hospital; and
    b. the outflow of patients does not pose serious risk of undermining the planning or financial balance of the system.
- When would it be effective? – The Directive will be effective immediately after it is passed. However, it allows 5-year period of transition before the system come into place. If the Directive were to be effective this year, the system should be functioning at the latest in 2015.

Despite this laid-out scheme, it is uncertain if the actual system will be as intended or even take shape. Healthcare is a very sensitive issue. The Directive has gone through numerous amendments withdrawing it strength. The effective scheme and thus its effect could be minimal.

III. Interview Summary

The following sectors summarize the results of the interviews conducted on key informants by the author. For the sake of confidentiality, results of the interview will be concluded into categories representing the interplay of opinions among interviewees according to the view of the author. As respondents are not aware of the Directive, the discussion on this will be excluded. Extensive discussions on the subjects as well as elaborated details are added to clarify the subject matters and to link with the content of the thesis.

Foreign patients and medical tourists in Thailand

In Thailand, there are a limited number of players in treating foreigners. Theses hospitals must be equipped with ability in terms of language and should be linked with international insurance company to facilitate their patients. For Thailand, foreign patients can be divided into four categories: border patients, expatriates, tourists and medical tourists.

The first group of patients is the border patients who need to come to cross-border to Thailand to receive treatment in the area. Most of the activities are around the border regions and do not spread to the Bangkok or big cities. In general, these patients come to Thailand in order to seek better care the level of care provided in Thailand is higher, despite being in the border regions where quality is often lower than that provided within the main cities. The volume and contribution of revenue to the medical tourism industry are insignificant. Activities are thus very limited in both scope and scale. It must be noted that for wealthy patients from nearby countries are under the fourth categories: medical tourists.

The second group is the expatriates living in Thailand and nearby countries. This group of patients is important to the medical tourism industry in that they often utilize the same facilities and services provided in the medical tourism industry. In other words, they are the constant group of patients that will utilize the services regularly. While domestic Thai patients can receive healthcare anywhere, expatriates often choose to receive care in hospitals where their needs in terms of language can be satisfy, which are the hospitals that provide care to international patients and medical tourists. Due to the

relative advancement and the relatively high level of care in Thailand, expatriates living in neighboring countries also come to Thailand for treatment.

Similarly, tourists, who are the third group of patients, prefer that the needs in terms of language be satisfied. However, the difference between the groups are that tourists can hardly be counted constant as the number of tourists fluctuates according to the traveling season and the medical attentions needed are often emergency or unplanned care.

Lastly are the medical tourists, whose purpose of visiting Thailand is to receive medical treatment. This group of patients receives the spotlight in this thesis. As a rule of thumb, half of all foreign patients in Thailand are expatriate, the other half tourists and medical tourists. Despite the same number of patients, the volumes of revenue generated are different. Medical tourists generate the highest rate of profits of all customer groups because of the nature of care they come to receive.

In spite of this categorization, in providing treatment, the hospitals perceive all foreigners as a single group. Same services are provided to all foreigners. This is to contrast with domestic Thai patients, which requires fewer services and therefore less investment and lower operating costs. While there is no distinction in terms of services provided among expatriates, tourists and medical tourists, the difference is instead in terms of marketing. While tourists require no marketing at all, marketing is very important for medical tourists. The setting up of offices in foreign countries can boost the confidence of foreign patients as well as to facilitate the cross-border process. For example, Bangkok Hospitals have offices in Bangladesh, Cambodia, Myanmar and Vietnam and representatives in Europe, Australia and North America.

In catering foreign and medical tourists, Thai hospitals often divided them into language groups, which often reflect cultural groups also. The groups are Asian, Middle Eastern and Western. Each group has a distinct trait and character of its own. The compositions of patients are also different and they also change over the years.

The first group of patients is Asian. In Thailand, the number one foreign patients are Japanese, however they are mostly expatriates. Chinese patients are increasing. They are often rich medical tourists coming to Thailand for special treatment such as assisted reproductive procedures. Patients from nearby countries, on the other hand, come here for the reason of better care as well as unavailable care in the country. Similarly are patients from South Asia. Increasingly, governments from countries such as Bhutan,

Maldives and Nepal have direct contracts with Thai hospitals. This allows more flows of patients to the industry. Regarding their characters, the hospital regards them as understanding. Like Thai patients, this group of patients respects doctors as well as the institution. There is not much problem with this group.

The Middle Eastern, on the other hand, are more problematic, but that depends on where they are from. In general, the Middle Eastern are used to being a VIP and they expect to be treated that way. Specialized cares as to accommodate their religions call for the higher costs of operation. While a large portion of them are capable of paying, due to the crisis, the payment quality may not be so good for some. The risks are high as they pay out of the pocket and often do not have insurance. Nevertheless, they often come as a large family renting an apartment and stay for a long time. Relating and supporting industries receive high income, which is good overall.

Lastly is the Western group, which constitutes Europe, North America, Australia and New Zealand. In general, this group of patients is quality patients. Most of them have insurances, which eliminate a number of payment risks. One significant character is that they are aware of their rights and demand them, which is on the contrary with the first group. In general, the group demands high quality care, but are easy to take care as they can often speak English, which eliminate the costs of extra or specialized interpreters. For Thailand, the highest number of patients from this group is America, followed by the UK, Germany, Australia, France, Scandinavia and Canada. It is commented by hospitals that the market has almost reached full rate of saturation in that it is hard to gain more customers. While it is undeniable that there are relatively unexplored markets such as countries in Eastern Europe, the investment and operation costs as well as the market size do not seem to worth exploring. Agents and representative are more appropriate as costs involved are low and they help screening the patients. The focus will remain to be on major countries.

European medical tourists in Thailand

Europe is an important for Thailand in that it constitutes an important number of constant medical tourists visiting Thailand. Not only are they quality patients, their payments are also good and often guaranteed because of insurance. However, in order to satisfy this group of customers, high standards must be achieved. In dealing with

insurance companies, high level of regulations as well as a number of conditions must be met.

In terms of marketing, the European Union as a market does not exist. Language group is instead used. This is for that first the treatments and need for services are similar for the whole group. As in dividing the EU into main countries, the hospitals believe that the market size is too small to be divided.

For American and European, treatment provided by the hospitals can be divided into two groups: disease and elective. For the disease group, top areas are dental, cardio, and bone and joints. For elective, most of the treatments are cosmetic surgery.

In choosing to come to Thailand, there are two groups of European patients: ones with self-initiative to receive treatment in Thailand and ones through insurance companies. The first groups with self-initiatives rely on the Internet and agents. Normally, the patients will contact the hospitals regarding the costs, quality and the process through their websites. Price quotation will be answered and then proceed on from there if the patients opt for the hospital. While the Internet provides and facilitates direct contact with the hospitals, the influx of information can be overwhelming as well as eliminating the problem of asymmetric information. Patients nowadays are very vigilant and always look for the best options for themselves. Price and quality comparisons are unavoidable. Agents come in helpful for this reason. The functions of agents and representatives are that they give suggestions to the patients. Normally, an agent represents a few hospitals at once. They will present the patients with the most suitable option as to tailor to the needs and preferences of the patients as much as possible. They can give price quotation for less complicated procedures or some procedures such as cosmetic surgeries, which can be a course over a period of time. For example, patient will fly in five times over the period of two years for full body cosmetic surgery. In case of complex procedures, the agents will be a middleman contacting the hospital or refer the patients to local doctors for prior diagnosis or screening. They can help facilitating the process. The payment can be arranged according to the patients' preference which could be through insurance reimbursement or out-of-pocket. Most of the hospitals have contact with major insurance companies and therefore allow more patients to receive treatment here.

The second group of patients, on the other hand, comes to Thailand because of the option of treatment abroad presented before them by their insurance companies. IN

this case, insurance companies and the hospitals have contract with each other. Everything must be detailed. Rules and regulations must be passed. Careful scrutiny must be done before the contract can be signed. Generally, contracts are single-timed and focus on a single type of treatment. For example, a contract may include ten patients receiving hip replacement all at once. The patients will come together as a group accompanied by a doctor appointed by the insurance company to observe and authorize the treatment. The payment will be according to the contract. In case of complications or necessity for extra treatment, the accompanying doctors will authorize the care. The costs as well need to be decided in advance. It is therefore important that agreements are conclusive. The response from the companies and the accompanying doctors are positive. They are satisfied with the quality of care, services as well as the prices. The hospitals also have good payment per head.

Most European patients do not come to Thailand for the sole purpose of treatment. They come for both treatment and travel. According to the hospitals, the patients come to Thailand for three main reasons: availability of care and quality of care, high prices in their home countries and travel.

The availability of care can be interpreted into two ways: unavailability of the treatment resulted from the incapability to provide the care and unavailability resulted from the ability to provide the care within timely manner. The first one is less relevant here as there are only a few operations not available in Europe. More pertained is the second reason: the long waiting list. In this case, patients have to pay out-of-pocket in order to receive the care faster. However, in order for them to come here, quality must be up to standard. Quality of Thai treatment is undeniable as the hospitals are internationally accredited and the medical staffs often graduated from abroad, mostly America. The quality of services provided is also more than what they can receive in their countries. In Europe, patients do not receive the same level of care and attention from nurses as in Thailand.

Second are prices as a reason. Prices come into spotlight when the treatments demanded are not covered by the insurance such as, but not necessarily, dental, cosmetic and pregnancy. As demonstrated by the price comparison in Appendix D, prices in Thailand are much cheaper than those in the Western countries. While the prices in Thailand can be as low as 30-70% lower than those of Europe, those of Thailand can be as low as 50-80% lower than those of the US. Prices are, therefore, important factors.

However, two points of view can be derived: first, the prices in Europe are so high that they have to escape abroad; or, second, the prices in Thailand are so cheap that they would like to save expenses. It is confirmed from both the hospitals and the Eurobarometer's survey that the first is the right reason. This reflects the facts that patients still prefer to receive care as close to home as possible.

The last reason is that European people come to Thailand for both treatment and travel. Specific to this group are lifestyle services such as spa, meditation, and culture. European patients are generally more open to travel and culture. This is reflected in the same group of patients and tourists coming to Thailand. The major countries are the UK, Germany and Scandinavia. However, whether the relationship is correlated or not deserve further investigation. For this reason, hospitals often refer to this group as a constant group; they will come no matter what. Other countries being regarded so are America, Australia and Japan. The hospitals therefore need not engage themselves too much in marketing within these countries. Efforts are therefore put into emerging and less-saturated markets such as China. The number of European patients has been stable with no rise or fall. The synergy between the hospital industry and the tourism industry contribute to the strength at drawing the European patients to Thailand.

Furthermore, there are also informal ways to draw in patients. Word of mouth is mentioned as an effective way to spread the cult of medical tourism as well as the legend of the hospital themselves. It is a very effective way of reaching patients as well as securing their confidence. However, this implies that the patients are satisfied with the services. If they were satisfied, not only would they spread the news, they could also return again. According to the hospitals, a number of the patients return for more treatments.

Marketing of Thai Medical Tourists and Current Trend

In general, the Thai medical tourism operates on an impromptu basis. There is no long-termed plan. While this may not sound good, it actually reflects the volatility of the industry and a good solution to problem solving. The medical tourism industry is a relatively new and fresh industry. Its beginning in Thailand dates back to only after the collapse of the Thai economy in the 1997-1998 Asian economic crisis. The birth of the industry itself begins from the need to fill in the empty hospital beds that used to be filled with the domestic patient. Foreign patients were only substitutes until the benefits

of having them begin to show. Adaptation as well as progress is made to fulfill the arising need of the patients. The number of treatments expands as to fulfill such needs. Once demand increase, expansion ensues as to increase supply. Constant adjustment appears to be the method to go for the industry. Furthermore, profit margin from medical tourists can be higher as they come here often for high-level treatment. Still, it is commented that the market has almost reached saturation; it is hard to grow further.

In terms of marketing, the industry is in a very unique situation unlike other industry. Overall, the industry must maintain its quality. Price strategy could be used in introducing or promoting new services, but should not be used in a long run as it has an adverse effect on the industry. Healthcare is matter of life and death, prices should not always come as a decision factors. Furthermore, price strategy could create a disturbance to the market, as price in the market should be kept rather constant to allow patients to make immediate decision in receiving treatment.

In positioning oneself as a hospital that provides services for foreign patients, there are a number of elements to differentiate oneself from the rest. While language and staff are evident as to be able to give services to foreign patients, location is also a very important factor. This is especially true for expatriate for the sake of convenience as demonstrated by the fact that a number of these hospitals situate in the areas where there are a lot of foreigners. Foreign patients will feel more at home if there are a lot of foreigners nearby.

While hospitals with advantage of location can attract more foreigners and expats in the area, Thai patients still remain important group of patients. In recent years, there is a self-realization of self-sufficiency: one should not depend too much on variable and neglect the constant. One reason for this is the unpleasant situation and conditions in the recent years, which includes epidemic and constant political unrest in the country. Medical tourists as well as tourists in general are deterred from coming to Thailand as they are afraid of possible danger that may arise. Most of the hospitals have been affected by it. In a number of websites on medical tourism, the situation has been put on notice. A number of prospective patients show signs of concern over the issue and decide to delay the treatment here. If not necessary or of possible, they would prefer to delay the treatment. In case of necessary, other countries may be a solution. The recent economic crisis results in mostly a hesitation and a delay, but not a change of mind in the end. In fact, with the crisis it might even more tempting to escape the high-priced

treatment to come to Thailand instead. Nevertheless, the level of overall spending, which includes spending on tourism, might be lower.

Retrospection and consideration of self-sufficiency as a result of economic reality and unexpected deterrence as in epidemic and political instability lead to the questioning of this industry: Does it really worth it? Marginal costs in treating Thai patients are lower than that of foreign patients. This implies that the risk will be higher. While the increase in Thai patients does not require much accommodation, that of foreign patients require interpreters and special services particular for that patient. The profit margin might not be attractive enough. It is commented that profit margins from each group of patients differ. For example, the profit margin received from the Japanese are almost the same as that received from Thai patients. If one can choose, would not it be better to serve Thai patients as the profits received are similar, while the work done are less.

Still, the current competition in the Thai hospital industry is fierce. Private hospitals as well as some public hospitals have been competing for the same customer groups. In recent years, the trend in Thai hospital industry has been the setting up of specialist center such as the cancer or heart center. For example, public hospitals such as Chulalongkorn Hospital and Siriraj Hospital, which are university hospitals, have invested in modern technology and provided dedicated services for these centers. With their reputation as a university hospital and the undoubted quality of doctors and professors, the competitiveness of the hospitals has stepped up. Some of the Thai patients that use private hospitals, which include those that serve foreign patients, have switched to public hospitals. The environment has changed: Thai patients might not be a constant anymore. The outlook of the private hospitals therefore should be to attract both groups of customers as to maintain the number of patients.

Position of Thailand in Global Medical Tourism Industry and Lessons from abroad

Global medical tourism has been on the rise, within the region, the major important players are Thailand, Singapore and India. Each country has its own unique position attracting different group of patients.

When comparing major players under the same price range, Thailand and India often comes a pair. Singapore is left out for its relatively more expensive price. While Thailand is better in terms of tourism, India has an advantage in terms of scale. In

general, Thailand can attract tourists better with its tourism and better image of the country. India, on the other hand, suffers from the lack of good environment for the patients to feel that they are sanitized. Nevertheless, the size of the Indian industry is much larger than that of Thailand. The number of heart operations in a major hospital in one day exceeds that of all Thai hospitals combined for a week. Experience and expertise are different. Still, Thai doctors working in the industry are of top-notched. Many patients come to Thailand for specific reputed treatment such as cardio-operation and sex change operation.

On the other hand, India is more successful in incorporating traditional medicines, medical practices and lifestyles into the industry. Ayurveda, or the science of life, is accepted as alternative medicine. Indian herbs, massage and yoga are well known and added to the already established western practices in India. Thailand, while well known for Thai massage, still leaves traditional and herbal medicine behind. Modernity and tradition remains detached. In order to conjoin the two, which means that traditional practices are accepted in the community, proven results through research must be achieved. The current rate of research does not suffice. A number of Thai herbs are researched and licensed in foreign countries by foreigners as clinically proven herbs with medicinal benefits. Thailand is defeated in this arena.

Singapore, unlike the two, positions itself as high-tech. In trying to create synergy in terms technology, the Singaporean government gives full unrelenting support to the industry. It establishes a dedicated bureau for medical tourism, which is much needed in Thailand. Technology, which extends to cover medical technology, pharmaceutical and biotechnology, will not only be imported, but also produced and invented within the country. For instance, the government pays for foreign firms to invest here or the government makes the investment itself and privatize later. In doing so, Singapore will always be on the top of the game. They can get familiarized with the technology first as well as might be able to control the spread of technology through licensing and selective selling. However, Singapore also does not have a lot of tourist attractions favorable by patients who would love to combine the treatment and traveling together. Still, with its location and proximity to a number of tourist destinations, medical tourists can fly to other countries, but this might not be as convenient and attractive. Overall, Singapore is suitable for patients coming with a specific aim of receiving very high quality and more expensive treatment.

Another aspect that needs consideration is the supply of medical staffs. Singapore needs to import doctors, as it could not keep up with the outflow of doctors and the small number of doctor produced. Nevertheless, the problem is not as grave as in Malaysia and the Philippines, where the problem of brain drain leads to the shortage of doctors. In case of Malaysia, a number of doctors with Chinese descents are not satisfied with the problem of discrimination in their country. In the Philippines, the living conditions are not so fortunate. These doctors prefer better living conditions, which cannot be provided within their countries. Therefore, emigration has become their choice. This is contrary to Thailand, whereby doctors that left the country in the past have come back to Thailand. Most of the young doctors prefer to come back after their studying abroad. Nevertheless, in the long there is a possibility of brain drain in case of Thailand as the level of legal protection given to the doctors is low. The number of patients suing doctors and hospitals has increased and the laws do not righteously protect the doctors enough. In long run, this problem might heighten the level of brain drain of doctors to other countries.

Brain Drain and Mismanagement of Public Healthcare System in Thailand

In Thailand, brain drain has been claimed as a negative effect of the medical tourism. Good and high-level doctors such as specialists might be drained from the public sector into the private sector, whereby salaries are higher. The scarcity of specialists and high-level doctors could lead to the overall level of care in the country being lower. It is often estimated that the ratio of doctors per population as well as the rate of doctor production are too low. Therefore, with the drain, the lack of doctors could be serious. However, this notion should be reconsidered.

Doctors are not universal. They are individual; their expertises are different. Not all are of the same level. The university doctors and the doctors working in the medical tourism industry are of high caliber. Both the university hospitals and the hospitals in the medical tourism industry continue to attract more and more doctors no matter what due to the prestige and the money received from working there. In Thailand, hospital can be divided into four groups: that under the ministry of public health; that under the military and police control; that as part of the university; and that operating privately. In all hospitals except that by the ministry of public health, doctors are sufficient. And within these hospitals, those in rural areas are the one that really in need of more doctors.

However, there are reasons for this: The salaries are too low. Prof. Dr. Somsak Lohlekha, the president of the medical council, recommends that the salary should be comparable to that in the private sector, which is tantamount to at least 80% of that in the private sector. If the salaries cannot be raised, there are other ways to reduce the workload of the hospitals as well as to re-manage the system to increase efficiency. Currently, most of hospitals are under-equipped with doctors because there are too many hospitals spreading around the country. And by hospital, it means a hospital fully equipped with doctors, nurses and necessary medical staffs. Currently, most of these hospitals do not have enough staffs and therefore the staffs have to overwork to keep the hospitals ready for upcoming events. While this seems good, it does not reflect the actual need of the population. Nowadays with transportation available, there is no for hospitals to be available everywhere. Only major hospitals are needed in the big cities. The unnecessary hospitals can be downsized into clinic with only a few staffs needed as in private clinics. If the patients require operation, they can be sent to the main hospitals, which could be only a few hours away. This will increase the efficiency of the system as well as reducing the number of doctors needed.

On the other side of the equation, the medical tourism industry employs a very small number of doctors. Only the selected few are in the industry. The movement of doctors is that of very high-level expertise. These doctors are often university professors or doctors already working in private hospitals. The brain drain therefore does not affect the hospitals under the management of the ministry of public health that lack doctors. The more relevant are university hospitals. However, there is no such problem of doctor shortage. Brain drain does not disturb the operation of these hospitals. Many doctors want to have prestigious job and therefore there is a large supply of doctors for these hospitals. For some hospitals, the synergy between university hospitals and private hospitals exist. University doctors regularly work or visit private hospitals, while keeping their prestigious job at the university hospitals. All of this implies the insignificance of brain drain as well as the incorrectness of using brain drain as a reason for not supporting the medical tourism industry.

ASEAN and Healthcare Integration

In 2015, the Association of Southeast Asian Nation aims to integrate similarly to the model of the European Union. Healthcare is one of the sectors that will go through the integration process. The integration aims to bring about the free movement of services as well as professionals. Nevertheless, most interviewees believe that the integration will remain low due to the protectionist measures and regulations together with the structural differences. It is basically impossible to harmonize the social security system within the framework. It takes tremendous efforts and time to transform, harmonize and integrate the systems. The main concern is money and reimbursement. To reach an agreeable rate of reimbursement and to come up with a common way to measure the costs of care against those in other countries will be problematic as the community is so diverse.

The industry expects that the level of cross-border patients and health professionals will be low. In the region, most of the quality care is provided by private hospitals. Therefore, citizens living in another community member will be the main group using the scheme. The integration also will not induce more movement in the private sector, as the scheme will remain only in the public sector. In terms of the movement of health professionals, the regulations as a result of protecting the national healthcare system remain a problem as in the problem of non-tariff barrier. For instance, in order for a doctor to receive a license in Thailand whether a foreign or a Thai doctor, one has to pass a required exam, which is in Thai. While this may seem as a protectionist measure, it is to protect healthcare delivery in Thailand to be effective as doctors in Thailand have to give care to Thai people, who do not necessarily can speak English. The inflow of foreign health professional will be low. The out flow, however, may be different, as Thai law does no give enough protection to doctors. If they are of high-level and can speak English well, they have the chance to work in foreign countries, which do not necessary mean within ASEAN.

APPENDIX B

EXPENDITURE ON HEALTH

Table 16 – Health expenditure in 2005 in European region

	Total expenditure on health as percentage of gross domestic product	General government expenditure on health as percentage of total expenditure on health	Private expenditure on health as percentage of total expenditure on health	Private prepaid plans as percentage of private expenditure on health	Out-of-pocket expenditure as Percentage of private expenditure on health
Albania	6.5	40.3	59.7	0	97
Andorra	6.3	70.5	29.5	26.3	71.5
Armenia	5.4	32.9	67.1	0.1	89.2
Austria	10.2	75.7	24.3	21.3	67.4
Azerbaijan	3.9	24.8	75.2	0.3	84.6
Belarus	6.6	75.8	24.2	0.1	69
Belgium	9.6	71.4	28.6	18.7	78.7
Bosnia and Herzegovina	8.8	58.7	41.3	-	100
Bulgaria	7.7	60.6	39.4	0.7	96.3
Croatia	7.4	81.3	18.7	6.4	93.6
Cyprus	6	42.3	57.7	8.8	89.7
Czech Rep.	7.1	88.6	11.4	2.2	95.3
Denmark	9.1	84.1	15.9	9.5	90.1
Estonia	5	76.9	23.1	1.2	88.7
Finland	7.5	77.8	22.2	10.2	80
France	11.2	79.9	20.1	63	33.2
Georgia	8.6	19.5	80.5	0.9	95.6
Germany	10.7	76.9	23.1	39.8	56.8
Greece	10.1	42.8	57.2	2.8	62
Hungary	7.8	70.8	29.2	4.1	86.8
Iceland	9.5	82.5	17.5	0	100
Ireland	8.2	79.5	20.5	33.3	59.3
Israel	7.8	66.5	33.5	23.8	69.5
Italy	8.9	76.6	23.4	3.9	86.6
Kazakhstan	3.9	64.2	35.8	-	100
Kyrgyzstan	6	39.5	60.5	-	95
Latvia	6.4	60.5	39.5	2.3	97.7
Lithuania	5.9	67.3	32.7	1.1	98.6
Luxembourg	7.7	90.7	9.3	19	70.5

Source: WHO, (2005).[1]

[1] World Health Organization, WHO Statistics Information System (WHOSIS) [online], 15 April 2010. Available from: http://www.who.int/whosis

Table 16 (cont.) – European Health expenditure in 2005 in European region

	Total expenditure on health as percentage of gross domestic product	General government expenditure on health as percentage of total expenditure on health	Private expenditure on health as percentage of total expenditure on health	Private prepaid plans as percentage of private expenditure on health	Out-of-pocket expenditure as Percentage of private expenditure on health
Malta	8.4	77.4	22.6	8.1	89.4
Monaco	4.6	74.9	25.1	16.2	83.8
Netherlands	9.2	64.9	35.1	55.5	21.9
Norway	9	83.6	16.4	0	95.3
Poland	6.2	69.3	30.7	1.8	85.1
Portugal	10.2	72.3	27.7	7.3	79.8
Moldova	7.5	55.5	44.5	0.8	96.4
Romania	5.5	70.3	29.7	14.1	85
Russia	5.2	62	38	8.2	82.4
San Marino	7.3	85.7	14.3	4.5	95.5
Serbia	8	71.9	28.1	0	86.7
Slovakia	7	74.4	25.6	47	88.1
Slovenia	8.5	72.4	27.6	22.6	45
Spain	8.2	71.4	28.6	1.6	73.1
Sweden	9.2	81.7	18.3	21.9	88.5
Switzerland	11.4	59.7	40.3	0	75.7
Tajikistan	5	22.8	77.2	12.8	96.6
Macedonia	7.8	70.4	29.6	0	100
Turkey	5.7	71.4	28.6	1.1	69.5
Turkmenistan	4.8	66.7	33.3	7.9	100
Ukraine	7	52.8	47.2	0	84.8
UK	8.2	87.1	12.9	0	92.1
Uzbekistan	5	47.7	52.3	1.8	97.1

APPENDIX C

EUROPEAN CROSS-BORDER HEALTHCARE

Table 17 – Claims for/on countries under Council Regulation (EEC) No.1408/71 in €, % of total and € per capita for 2004

Country	Claims from other countries (debt)			Claims on other countries (credit)		
	€ (1000)	%	€ / capita	€ (1000)	%	€ / capita
Austria	24321	1.99	2.96	72255	5.92	8.80
Belgium	112084	9.19	10.73	66564	5.46	8.37
Switzerland	12321	1.01	1.66	73514	6.02	9.91
Cyprus	0	0	0	0	0	0
Czech Rep	174	0.01	0.02	0	0	0
Denmark	6440	0.53	1.19	1634	0.13	0.30
Estonia	1	0	0	0	0	0
Finland	9802	0.80	1.87	3173	0.26	0.61
France	103927	8.52	1.72	345235	28.38	5.72
Germany	295232	24.20	3.58	154068	12.63	1.87
Greece	63067	5.17	5.69	8693	0.71	0.78
Hungary	14	0	0	0	0	0
Iceland	569	0.05	1.94	750	0.06	2.55
Ireland	6303	0.52	1.53	0	0	0
Italy	157961	12.95	2.70	130452	10.69	2.23
Lithuania	5	0	0	0	0	0
Luxembourg	73537	6.03	161.62	5848	4.81	128.90
Latvia	2	0	0	0	0	0
Malta	0	0	0	115	0	0
Netherlands	74006	6.07	4.54	42651	3.50	2.62
Norway	11161	0.91	2.42	1191	0.10	0.26
Poland	131	0.01	0	218	0.02	0.01
Portugal	58552	4.80	5.56	40182	3.29	3.82
Sweden	9482	0.78	1.05	17179	1.41	1.91
Spain	37649	3.06	0.87	155772	12.77	3.62
Slovenia	281	0.02	0.14	1989	0.16	1.00
Slovakia	52	0	0.01	0	0	0
UK	163001	13.35	2.72	45011	3.69	0.75
Total	1220194	100	2.59	1220194	100	2.56

Source: Administrative Commission, (2005).[2]

[2] European Commission, COMMISSION STAFF WORKING DOCUMENT Accompanying document to the Proposal for a DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the application of patients' rights in cross-border healthcare -IMPACT ASSESSMENT [online], 3 October 2009. Available from: http://ec.europa.eu/health-eu/doc/commsec_20082163_en.pdf, 70.

Table 18 – Main reasons for unmet need for medical examination and treatment (2005)

Country	Could not afford (too expensive)	Too far to travel / no transportation	waiting list	other*	no unmet need
Austria	0.23%**	#	#	1.57%	98.04%
Belgium	0.68%	#	#	0.24%**	99.04%
Cyprus	2.95%	#	#	2.76%	94.13%
Czech Rep	0.32%**	0.47%**	0.40%**	5.95%	92.86%
Germany	6.69%	0.14%**	1.74%	7.93%	83.49%
Denmark	#	#	#	0.81%**	98.94%
Estonia	2.74%	0.81%	2.15%	2.55%	91.75%
Spain	0.41%	0.19%	0.70%	4.87%	93.84%
Finland	1.41%	#	0.98%	09.3%	96.62%
France	1.24%	#	0.21%**	2.10%	96.42%
Greece	3.44%	0.45%	0.62%	1.66%	93.83%
Hungary	2.44%	0.37%	0.73%	12.56%	983.90%
Ireland	1.06%	#	0.65%	0.51%	97.67%
Italy	3.14%	0.09%**	1.36%	2.11%	93.30%
Lithuania	3.65%	0.39%**	2.32%	2.89%	90.75%
Luxembourg	0.35%**	#	#	4.30%	95.25%
Latvia	17.01%	0.62%	1.72%	10.27%	70.38%
Malta	1.01%	#	0.50%**	2.12%	96.35%
Netherlands	#	#	0.28%**	0.97%	98.57%
Poland	7.13%	0.44%	2.26%	6.32%	83.85%
Portugal	3.77%	#	0.77%	0.77%	94.565%
Sweden	0.50%	#	2.02%	12.38%	85.00%
Slovenia	#	#	#	0.19%**	99.48%
Slovakia	2.52%	0.19%	0.34%**	4.80%	92.15%
UK	#	#	2.14%	2.96%	94.77%

Source: EU-SILC (2007); *"Other" includes: (1) Could not make time because of work, care for children or for others; (2) Fear of doctors/hospitals/examinations/examination/ treatment; (3) Wanted to wait and see if problem got better on its own; (4) did not know any good doctor or specialist; and (5) Other reasons. ** unreliable due to small N (20<n<50); # omitted due to very small N.[3]

[3] Ibid., 68.

APPENDIX D
PRICES

Table 19 - Major medical procedure with average total medical/hospital cost in a werstern-level hospital ($US)

Procedure	Countries (Cost as a % to U.S.)				
	U.S.	India	Thailand	Singapore	Malaysia
Heart bypass	130,000	10,000 (8%)	11,000 (8%)	18,500 (14%)	9,000 (7%)
Heart valve replacement	160,000	9,000 (6%)	10,000 (6%)	12,500 (8%)	9,000 (6%)
Angioplasty	57,000	11,000 (19%)	13,000 (23%)	13,000 (23%)	11,000 (19%)
Hip replacement	43,000	9,000 (21%)	12,000 (28%)	12,000 (28%)	10,000 (23%)
Hysterectomy	20,000	3,000 (15%)	4,000 (23%)	6,000 (30%)	8,000 (15%)
Knee replacement	40,000	8,500 (21%)	10,000 (15%)	13,000 (33%)	8,000 (20%)
Spinal fusion	62,000	5,500 (9%)	7,000 (11%)	9,000 (15%)	6,000 (10%)

Sources: Woodman, Josef "Patient Beyond Border."[4]

Remarks: The above costs are for surgery, including hospital stay. Costs assumption taken for India (20%); Malaysia (25%); Thailand (30%); Singapore (35%).

[4] Woodman, Josef, Patient Beyond Border [online], 5 April 2010. Available from: http://www.abilitymagazine.com/pbb.html

Table 20 – Calculation of foreign prices in US dollars

Country	Knee Antroplasty	Shoulder Arthroplasty	TURP	Tubal ligation	Hernia repair	Excision of skin lesions	Adult Tonsillectomy	Hysterectomy	Travel Cost
Barbados							1,478	2,599	401
Belgium	1,927	2,637	3,424	2,008	2,282	736	845	4,594	380
Brazil	5,088	5,627	5,638		2,763	1,931	2,717	5,198	961
Chile	3,733	4,966	4,825	2,755	3,071	1,607	1,965	5,524	857
Costa Rica			3,819			192	1,145	3,022	342
Dominican Republic	1,240								265
Egypt	2,738	1,734	1,734		1,062	573	363	2,298	715
France	1,645	2,172	4,148	1,251	2,200	763	663	3,998	336
Germany	3,133	3,619	4,505	982	2,787	929	994	5,096	337
Hungary	637				1,317			354	415
India	662		1,263	113	701	512	175	1,260	1,008
Jamaica								3,145	
Jordan	4,564		4,719		1,387	874	419	1,939	810
Mexico	4,706	7,773	1,768		3,686	3,086	3,288	6,106	410
Peru	2,390				2,719	184	315	3,795	638
Phillippines	2,312	2,492			1,667	748	1,122	2,475	1,204
Poland	3,672	1,213			2,499		898		441
Singapore	5,281				3,913	4,515	3,967	6,781	808
Thailand	2,860	3,874	2,551		1,715	750	1,194	3,071	793
Trinida and Tobago	2,249	2,249	1,928	803	884	578	884	2,490	500
UK	4,955	6,199	7,190		3,158	2,334	3,090	11,036	307

Source: Vanbreda International, and Expedia. 2004.[5]

[5] Mattoo, Aaditya and Rathindran, Randeep, Does Health Insurance Impede Trade in Health Care Services? [online], 20 March 2010. Available from: http://www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/07/19/000016406_20050719140725/Rendered/PDF/wps3667.pdf, 32-33.

Table 20 (cont.) – Calculation of foreign prices

Country	Hemorrhoid procedures	Rhinoplasty	Bunion removals	Cataract procedures	Vericose vein stripping	Glaucoma procedures	Tympanoplasty	Travel Cost
Barbados	2,143							401
Belgium	1,895	2,135	2,859	1,982	1,240	784	4,271	380
Brazil	1,941	3,266		1,832	3,923			961
Chile	2,359	3,432	2,972	2,426	2,439	1,232	3,741	857
Costa Rica				1,090				342
Dominican Republic	166	1,727			875			265
Egypt	738	1,677		1,096				715
France	1,550	1,874	2,337	1,821	2,025	2,474	1,730	336
Germany	1,402	3,709	3,426	1,970	2,555	618	2,818	337
Hungary	80						293	415
India	489	792		396		240	469	1,008
Jamaica				1,064				
Jordan	1,570	1,562	440	1,367	1,116	734		810
Mexico	5,747	3,930	3,307	1,827	3,175			410
Peru	1,381	1,287	594	1,067		934		638
Phillippines	1,082	2,939		864	1,165	331	1,947	1,204
Poland				490	977			441
Singapore	3,996			2,376	4,707	1,274		808
Thailand	1,201		2,405	1,022	2,570	140	806	793
Trinida and Tobago	916	2,249	1,478	2,892	1,124	1,478	1,928	500
UK	3,152	4,565	3,982	4,426	4,681	1,779		307

APPENDIX E

MEDICAL TOURISM IN THAILAND

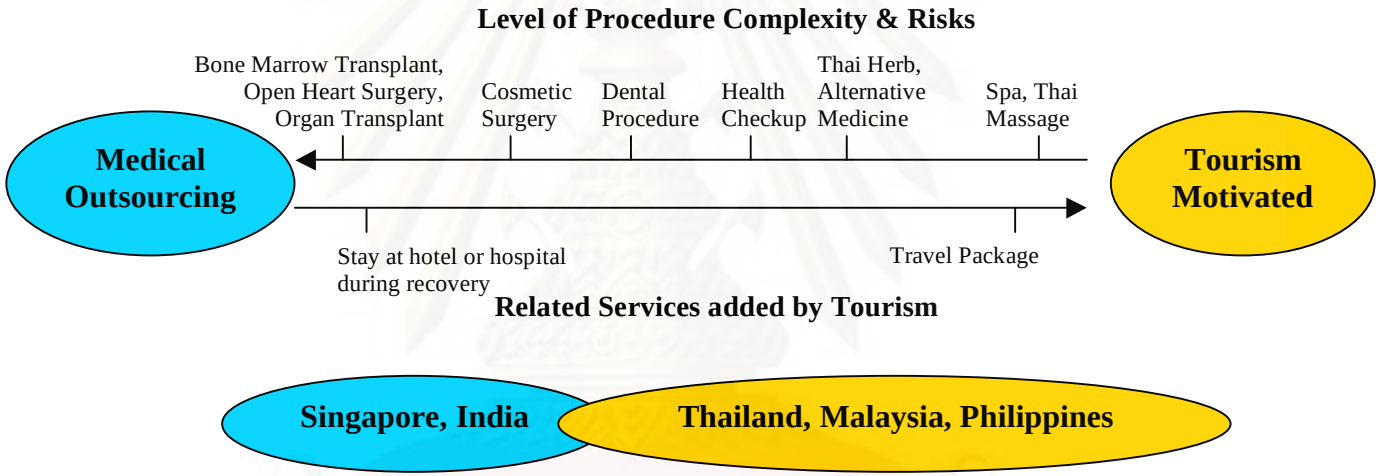

Figure 7 – Model of Medical Tourism[6]

[6] Harryono, Monica, Yu-Feng (Tom) Huang, et al. Thailand Medical Tourism Cluster [online], 10 January 2010. Available from: http://www.isc.hbs.edu/pdf/Student_Projects/Thailand_Medical_Tourism_2006.pdf

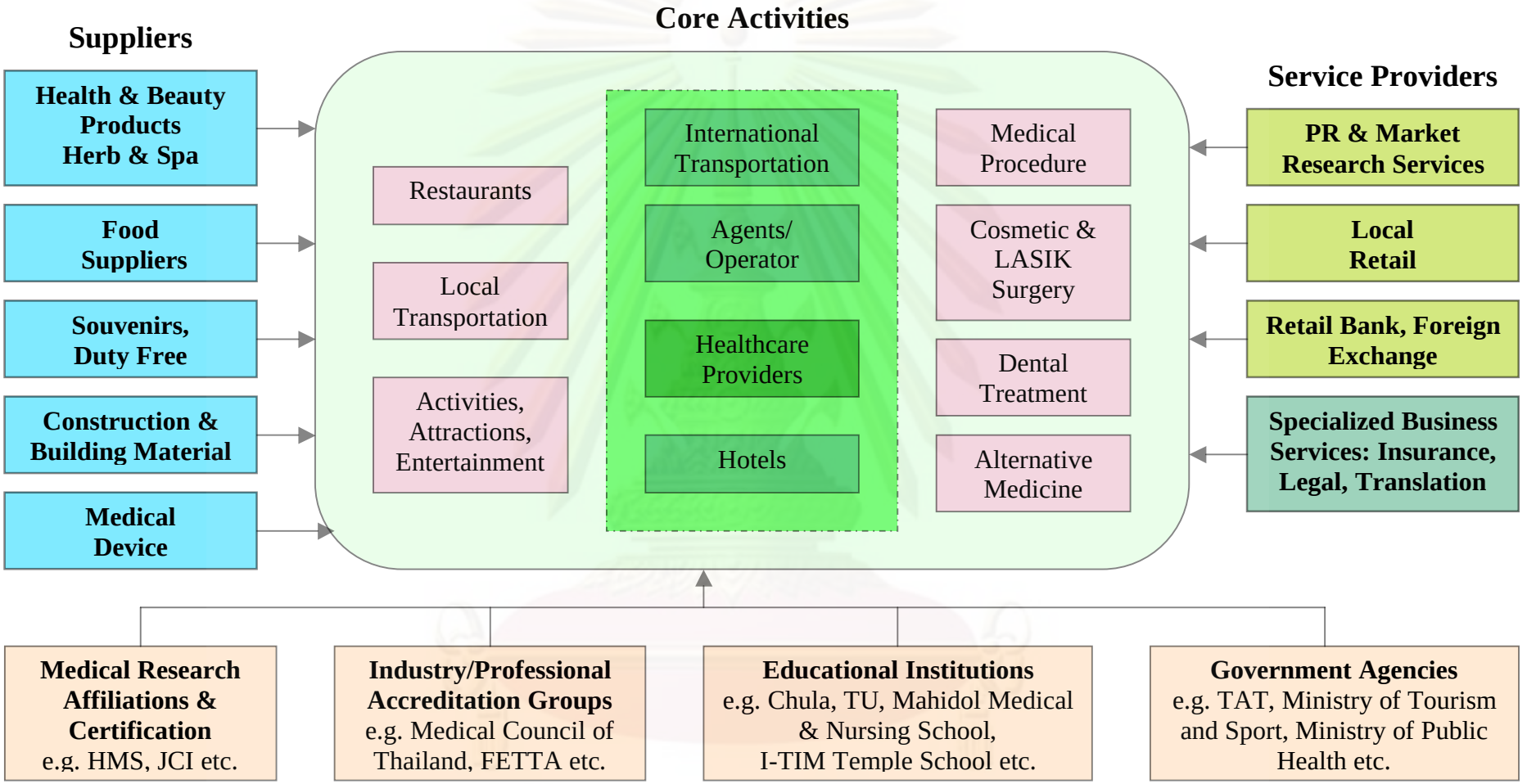

Figure 8 – Medical Tourism Cluster Map[7]

[7] Ibid.

BIOGRAPHY

Sakda Chantanavanich was born in Bangkok on December 16, 1986. After graduated from Bodindecha (Singh Singhaseni) School, Sakda went on to study at Haverford College, Pennsylvania, USA, for three years, early graduation. His diverse interests led him to majoring in Music and minoring in Economics. His undergraduate coursework culminated in composition of an avant-garde contrapuntal string quartet, "Ricerca Ubriaca." Other researches include Arts of Improvisation in Late Renaissance Music, Evolution of Japanese Kingship and Comparative Analysis of Private Healthcare Sector in China and India. After graduation, Sakda moved back to Thailand and has since taught piano, composition and music theory privately. In 2009, Sakda commenced his study in European Studies at Chulalongkorn University. This thesis "The Effect of the European Union's Patients' Rights in Cross-Border Healthcare Initiative on Medical Tourism in Thailand" is part of the requirements for the degree.