Globalization and Medical Care

A EUROPEAN PERSPECTIVE ON MEDICAL TOURISM: THE NEED FOR A KNOWLEDGE BASE

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Since the early 1990s, medical tourism, whereby individuals choose to travel across national borders or overseas to receive treatments, has been increasingly recognized in the United States and Asia. This article highlights the emergence of medical tourism in the European context. It examines the drivers for such developments and situates medical tourism within the broader context of health globalization and forms of patient mobility in the European Union. In outlining the developments of medical tourism in Europe, the authors distinguish between two types of medical tourist: the *citizen* and the *consumer*. The discussion explores the need for greater empirical research on medical tourism in Europe and argues that such research will contribute toward knowledge of patient mobility and the broader theorization of medical tourism. The authors make suggestions about the content of this research agenda, including understanding the development of medical tourist markets, the nature of choice, equity implications, the role of brokers and intermediaries, and general issues for health management.

Health policy and health care organization and delivery have traditionally been seen as bounded by the nation-state. Within the United Kingdom, for example, the establishment of the National Health Service in 1948 signaled services funded by (mainly) public taxation and delivered to the national population. Health care provision forms part of debates around wider citizenship rights, which themselves are about establishing criteria of inclusion and exclusion (1). In recent decades, significant economic, social, and political changes have encouraged a more transnational, international, and global focus for health policy and management. These national interconnections (political, economic, social, and technical) include the movement of people, products, capital, and ideas, and this has presented new opportunities and challenges for health care systems. The

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implications for health policy and delivery are wide-ranging: moves toward a global health agenda, greater professional mobility, corporate multinational health providers, e-health innovations, and increased patient mobility. Within Europe, such issues are played out against a backdrop of the enlargement of the European Union and a deepening of its regulatory reach.

One dimension of increased mobility has been the growing trade in health-related goods and services, including cross-border supply, foreign direct investment and commercial presence, temporary movement of service providers, and consumption abroad (2–5). Some forms of service mobility have received attention, notably the migration of health professionals, with ongoing debates on the ethics and implications of qualified staff moving from emerging economies to advanced economies (e.g., 6–8). Trends in consumption of services abroad have been a lesser focus of academic attention, perhaps because instances are still relatively unusual when set alongside mainstream national consumption of health care. Flash Eurobarometer (9) reported in 2007 that 4 percent of E.U. citizens had received treatment in another E.U. member state, while for the United Kingdom this was 3 percent and for Luxembourg 20 percent. Increased media coverage and anecdotal evidence, however, point to newly emerging forms of patient or consumer mobility across health services, with services available to individuals outside their country of residence. These developments raise a number of questions about choice and equity and emerging issues at the European level.

Consumption of health services abroad has some historical antecedents—travel across Europe to enjoy the health benefits of spas was well established for 19th century elites "taking the waters abroad," along with the recuperative effects of landscape as a motivation to travel (10, 11). Similarly, in recent decades, individuals from all continents have traveled abroad for surgery—whether to avoid waiting lists or to access state-of-the-art medical techniques and receive better aftercare. With the rise of lower-cost cross-border travel and developments in technology, including surgical techniques and information and communication technologies (IT), these transactions have burgeoned to serve, potentially, a more mass market. As one writer suggests: "whatever the motivation, medical tourists are on the move and on the rise" (12, p. 194).

Since the early 1990s, health tourism and medical tourism, whereby individuals choose to travel across national borders or overseas to receive treatments, have been recognized, but calls to establish a robust evidence and knowledge base (cf. 13, 14) have not been addressed. Medical tourism has emerged from the broader notion of health tourism, but with an emphasis on clinical, surgical, and hospital provision (see Figure 1) (3, 15).[1] Some writers have considered health

[1] In earlier usage, health "tourism" was used as a pejorative to signal the United Kingdom as a welfare magnet in much the same way as benefit tourists were said to defraud the U.K. social security system (cf. 16).

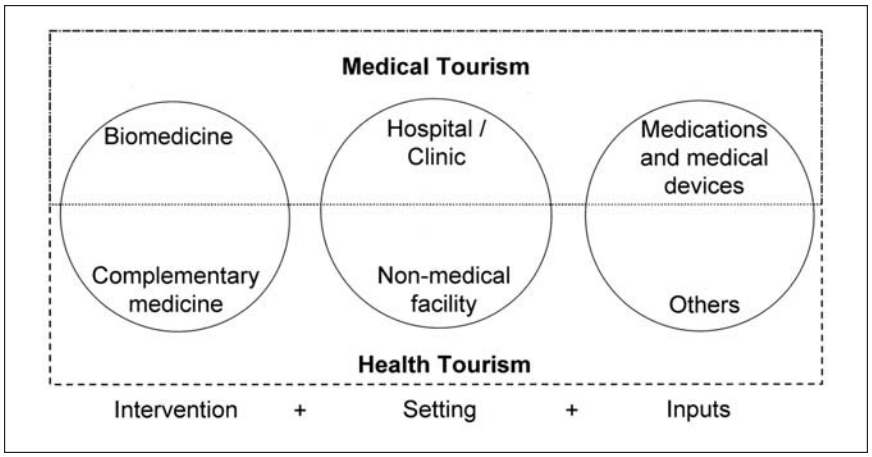

Figure 1. A conceptualization of medical tourism. *Source*: Carrera (15).

and medical tourism as a combined phenomenon with different emphases. Carrera and Bridges identify *health tourism* as "the organised travel outside one's local environment for the maintenance, enhancement or restoration of an individual's well-being in mind and body." It encompasses *medical tourism*, which is delimited by "organised travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through medical intervention" (11, p. 449).

THE CONCEPT OF MEDICAL TOURISM

Although there has always been overseas travel to receive some specialist treatments, given their possible illegality and unavailability in particular home countries, medical tourism involves a quantitative and qualitative shift—not only in the type and scale of treatment but also in the emergence of a number of stakeholders and interests in this field. As Connell writes: "Medical tourism as a niche has emerged from the rapid growth of what has become an *industry*, where people travel often long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense" (17, p. 1094, emphasis added).

There is a gap in our knowledge of medical tourism, with little detailed empirical work and disagreement on the scale and scope for development. Some estimates have put the number of medical tourists globally at 500,000, and some "medical cartographers" (18–20) point to a map of provision that includes Asia (India, Malaysia, Singapore, Thailand, and the Philippines), Africa (particularly South Africa), South and Central America (including Argentina, Brazil, Costa

Rica, Cuba, and Mexico), and the Middle East (particularly Dubai), offering procedures such as elective surgery, cosmetic surgery, dentistry, and IVF (in vitro fertilization) treatments.[2] A more sober assessment of a recent McKinsey report (22) put the number at between 60,000 and 85,000.

Writing in the field of medical tourism has two particular limitations for the European observer. First, the emerging scholarship is focused on the U.S. experience (23–27). Second, the discussion is on the role of Asian countries in meeting the demand for forms of lower-cost elective and cosmetic surgery (28–30). Furthermore, the price factor or cost of treatment abroad vis-à-vis costs at home serves as the catalyst for medical tourists to seek medical "refuge" overseas (26). These are valuable contributions, although a dearth of empirical work remains. At the European level, relatively little has been written to date about the development and experience of medical tourism.

European issues and experience of medical tourism share some similarities with the United States, and U.K. residents may choose to travel to Asia for medical treatment. But arguably there is also a distinctive European medical tourist market, specialist brokers and activities that are bounded by European initiatives, national policy of European countries, and particular cultural mores and preferences, and these require attention.

Beyond sharing common drivers (e.g., consumer preferences for immediate treatment, a willingness to travel, or a desire for privacy in receiving cosmetic care), Britain and the United States have different systems of health services funding and organization: in the English and Scottish National Health Services, access to health care is based on need, whereas (the majority of) Americans secure access based on their ability to pay (with the exception of emergency care, for which there is universal coverage). Issues of underinsurance, service eligibility, and length of waiting lists shape the decisions of those considering obtaining treatment, and these vary across nations (11, 19). National policy has external effects, such as in stimulating markets for particular groups and treatments. As Milstein and Smith suggest of the United States: "These patients are not 'medical tourists' seeking low-cost aesthetic enhancement. They are middle-income Americans evading impoverishment by expensive, medically necessary operations" (26, p. 1637). With 45 million people lacking health insurance, a figure set to skyrocket as a result of the global financial crisis, a particular series of drivers is apparent for the United States (31, 32).

In a consideration of medical tourism, sensitivity to social context and legislation is important, as are issues of culture and history. Medical tourism may be a

[2] To be sure, medical tourism also occurs between developed countries, including Canada and the United States, Netherlands and Germany, and the United Kingdom and Belgium, particularly for services that may involve forms of outsourcing and be less available in a patient's home country due to (various forms of) rationing (11, 21).

global phenomenon, but there is no global perspective on medical tourism. Is there a European one?

Taking one European example, within the United Kingdom, growing media attention has been paid to medical travel for dentistry (33, 34), hip replacement (35), and cosmetic surgery (36, 37). A publicly funded system such as the U.K. health service will have its own distinctive drivers and dilemmas in terms of equity and context that must be understood. Bearing in mind that the funding, organization, and delivery of health care are deemed to be within the purview of individual member states under E.U. law, one has to be cognizant of the particularities of health policy across E.U. member states and particular national cultures and developments. For example, particular forms of medical tourism such as dental care may develop in response to national policy changes, a growing national familiarity with overseas provision, and the opening of new low-cost travel routes from within particular countries.

The purpose of this article is to review "medical tourism" through a European lens and to attempt five broad tasks:

- Distinguish sources of mobility
- Outline some broad developments of medical tourism
- Begin to situate medical tourism within broader policy debates
- Locate medical tourism within a European context, using the exemplar of the United Kingdom
- Argue for a research agenda on European medical tourism that will contribute to knowledge of patient mobility and broader theorization around medical tourism

PATIENT MOBILITY IN EUROPE

Medical tourism is one part of a wider phenomenon of mobility and, in particular, a subset of patient mobility. Patient mobility in Europe has some parallels to patients' travel from the United States, but there are also key differences that distinguish the European experience. Bertinato and coauthors (38) identify five categories of patient mobility (see also 39).

First, there are the *temporary visitors abroad*. Greater mobility has meant a sharp increase in short-term tourist flows. People vacationing abroad use health services as a result of accident or illness. Europeans may make use of the European Health Insurance Card for occasional or emergency treatment. Tourists may receive health services funded variously by private insurance and private contributions. Tourists are distinguishable from medical tourists in that they do not specifically travel abroad to receive medical treatment (11, 15).

Second is the category of *long-term residents*. Increased wealth, open borders, and lower cost and ease of travel contribute to mid-life worker mobility and later-life mobility known as "retirement migration." There are increased flows

of E.U. citizens choosing to retire elsewhere within the European Union (39), as well as examples of increased European exchanges of working-age citizens. For the United Kingdom, for example, traditional "seaside" retirement is being joined by forms of "sunset retirement" (40). Besides long-term residents there are also those living between places, so-called shuttlers, who may choose to retain access to services in their countries of origin (cf. 41). Such residents may receive health services funded variously by the country of residence, the country of origin, private insurance, and private contributions.

Countries that share *common borders* may collaborate in providing public funding for health services from service providers across borders (39). For example, frequent cross-border flows take place between Belgium and neighboring countries, and there are collaborations among Estonia, Finland, and Latvia (42).

People being *sent* (or *outsourced*) abroad for treatment form a fourth category of patient mobility. Such outsourcing is an organizational purchasing initiative, driven by waiting lists and a lack of available specialists and specialist equipment in particular countries. Some countries' health agencies contract overseas authorities to deliver services to patients, who then travel abroad. Patients typically travel relatively short cross-national distances, and contracted services are subject to robust safety audits, quality assurance, and tight monitoring. Examples include the Pilot Project at Guy's and St Thomas' Hospital as part of the broader London Patient Choice, and initiatives that have given patients living in the southeast of England opportunities to receive treatment in Brussels, France, and Germany (43–45). Under these arrangements, services are bought by public funders from both public and private providers.[3]

Finally, some patients are mobile on *their own initiative* (39), a category of patient mobility that is said to raise issues about quality, access, equity, and financial sustainability.

Within the European context, although we should not overstate the importance of medical tourism, it remains our assertion that the topic still deserves greater attention than it has received thus far. The following discussion attempts to sketch a conceptual framework and a research agenda around medical tourism within the European context. Improved standards of care and technological developments are increasing the range of countries offering complex procedures. The identified characteristics of medical tourism are those of individual choice, tailoring of services and travel packages, and the requirement that individuals travel across borders from their home countries.

[3] The English National Health Service provides patients on the waiting list for elective treatment the choice of treatment within the European Economic Area (European Union plus Norway, Liechtenstein, and Iceland), with the qualification that air travel to the provider should not be more than three hours (45).

EUROPEAN MEDICAL TOURISTS: CITIZEN AND CONSUMER

In the European context, medical tourists may be conceptualized in two ways. First, they may use their European citizenship rights to avail themselves of medically necessary surgery in another E.U. member state and seek to have their national purchaser reimburse the costs of the treatment. A second group of European medical tourists may be seen as consumers, because they use purchasing power expressed through the market to access a range of dental, cosmetic, and elective surgeries. These dual roles of citizen and consumer—and the attendant guarantees to *claim* and *choice* of such roles—set Europe apart from the U.S. circumstances, where the medical tourist is more accurately described as a consumer rather than citizen.

Citizen as Medical Tourist

European citizens, under particular circumstances, may invoke rights to receive medical surgery and services out-of-country, as established by rulings of the European Court of Justice on private cases regarding consumption of health care in another E.U. member state and reimbursement thereof by the (national) purchasing body in the home country, brought before the institution for adjudication (11, 23, 38).[4] Around 1 percent of total health care expenses in Europe go into cross-border care, although this amount is variable and increasing (47). There has long been some confusion about patients' rights to travel out-of-country and their need for authorization, and a lack of clarity about the process and redress. The current European Commission's proposal for a Directive on Patients' Rights in Cross-border Health Care seeks to address the lingering confusion about how the broad principles resulting from the rulings of the European Court of Justice would be applied. Among a number of issues, the Directive advances two key notions in relation to citizen tourism. First, the insured "will not be prevented from receiving health care in another Member State . . . [And in the event of consumption of care from abroad] the Member State of affiliation shall reimburse the costs to the insured person, which would have been paid for by its statutory security system had the same or similar health care been provided in its territory" (47, pp. 36–37). Second, "Member States of treatment shall be responsible for organisation and the delivery of care" (p. 35).

The previous demand from some E.U. member states that patients should receive prior authorization for treatment was seen as an obstacle to free

[4] Judgment of the European Court of Justice, May 16, 2005, Case C-372/04 (the Watt case); also Case C-158/96 (the Kohll case, 1998); and Case C-120/95 (Decker case, 1998). This established that internal market provisions allowed citizens of E.U. member states to access health care in E.U. member countries (10, 46).

movement of patients, although there is still a recognition that such authorization would be required where evidence existed that cross-border treatment would threaten planning and where the evidence base for particular treatments was not established.

The Directive is currently under deliberation within the European Commission. However, its underlying thrust offers an interesting perspective on citizen tourism in that it may Europeanize a "patient choice" agenda. It effectively offers a form of voucher or shadow budget, and citizens may seek health care in another E.U. member state and be reimbursed up to the amount of the cost of the treatment within their home country. Such possibilities for greater choice prompt three key questions: Will there be growing interest in the relative costs of treatment and greater calls for comparisons? Will mediators and brokers for services become more prevalent? And what will be the profile (socioeconomic, gender, ethnicity, age, locality) of those seeking to take up such opportunities? Further, how will such options dovetail with national developments? Under the Patient Choice initiative in England, for example, a referred patient has the right to choose any hospital (public, private, independent) in England. What, if anything, acts as a break on such competition now including European providers?

Medical Tourist as Consumer

European patients may also be consumers—paying out-of-pocket or drawing on private voluntary health insurance. How services are funded raises questions about access to insurance, the portability of insurance, and whether public and voluntary insurance systems offer the choice of overseas services. Within the United States, for example, some domestic private insurers have looked toward purchasing services overseas, and in Europe there is likely to be a push toward the signing of agreements with out-of-country facilities to allow patients greater choice of services (42, 48, 49).

Some consumers make journeys to European and international medical tourist destinations, funding them out-of-pocket. Figures are sketchy, however, with the number in the United Kingdom estimated at about 50,000 in 2008, according to figures provided by industry, and said to be set to grow by 25 percent in the following 6 to 12 months (50). Of these 50,000 medical tourists, the estimates indicated 20,000 dental, 14,500 cosmetic, and 9,000 elective (including hip, knee, and eye surgery), with a further 5,000 undergoing fertility treatments.

The boundary between the citizen and the consumer is not stable but is subject to shifts and reshaped by policy developments and decisions around eligibility and waiting times. For example, for IVF services there are changes in what services will be funded and at what points in time; in dental care, waiting lists for treatment have emerged in the United Kingdom. High out-of-pocket payments for services at home will increase the demand for cross-border care, which in turn will magnify the challenge of weighing and balancing the risks and

opportunities of medical tourism at the macro level—for both patients going abroad for care and patients staying home (47).

EUROPEAN PROVISION: MARKETS AND DEVELOPMENT

Medical tourism is underpinned by private provision and individual demand for health care and stimulated by people's increased ability and willingness to travel. The debate about health/medical tourism is about commercialization and competition (cf. 2, 48), as much as it is about unmet need for health care at home (due to long waiting lists or on financial grounds) (11, 15, 23). Within the European setting, we know relatively little about the development of a European industry and markets in the provision of medical tourism. As noted in *Patient Mobility in the European Union*, from the Europe for Patients (e4p) project, there is a lack of information on mobility in general, but particularly in relation to the commercial sector (39, p. 6), and for medical tourism, research needs to gain a better understanding of, and access to, the private sector.

Countries receive patients from various source countries, with some travel routes well-established. For example, those using Hungarian services are Western European, and some countries play on longstanding historical ties such as those between Malta and the United Kingdom, or the United Kingdom and Cyprus (cf. 51), or take advantage of the growing familiarity with countries resulting from the opening up of Europe (e.g., the United Kingdom and Poland). However, we need to know far more about the actual and potential points of exchange, and we need more robust data.

Proximity is an important, but not a decisive, factor in shaping choices, given people's ability and seeming willingness to travel longer distances. The demand for services is also volatile (52, 53), with supply and demand for such services moving in line with both economic and external events, as well as with changing consumer preferences. Thus, monetary exchange fluctuations will make countries less or more attractive, and restrictions on travel and security concerns will prompt consumers to explore alternative markets. Moreover, considering that health care is a luxury good and that tourism spending is positively correlated with increased economic growth, a tightening or expansion of the economic situation inhibits or engenders medical tourism (54–56).

Some countries see significant economic development potential in the emerging field of medical tourism. The Hungarian, Polish, and Maltese governments have sought to promote the advantages of their countries as medical tourism destinations. As with Asian countries (India, Malaysia, Singapore, Thailand, and the Philippines), efforts are being made to engage a range of interested stakeholders and to promote activity, including promotion at large international trade fairs, advertising in the overseas press, and official support for activities as part of economic development and tourism policy. The industry is engaged in a

process of legitimating and marketing, with emphasis on promoting service quality and competitiveness. A series of unanswered questions remain about these activities, however, including: What strategies are used? To what extent are such strategies effective? And what are the implications for both domestic and overseas countries' health policy, especially in terms of access to care?

UNDERSTANDING CHOICE IN EUROPE

In the limited literature on the reasons for medical tourism, the suggested reasons include the costs of treatment at home and abroad, the speed of obtaining treatment, treatments not being available (or legal) within home countries, the desire for privacy, and the wish to combine traditional tourist attractions (hotels, climate, food, cultural visits) with medical procedures (57). Although choice is said to be rarely made on the basis of quality alone, quality is a major consideration in shaping the choice of destination. Glinos, Baeten, and Boffin (43) give five drivers for seeking medical health services out-of-country: familiarity, availability, cost, quality, and bioethical legislation (abortion tourism, fertility tourism, and euthanasia). The Flash Eurobarometer survey (9) lists unavailability of treatment at home, better quality of treatment abroad, provision of services by specialists, and faster treatment and affordability of care as among the factors that motivate citizens of E.U. member states to seek treatment outside their home country. However, there is little information beyond such cross-sectional data.

To date, relatively little is known about the patient/consumer profile of those seeking surgery abroad. Questions as yet unanswered include: What shapes individual decision-making in European settings? What types of information are used? Where is it sourced? What is most highly valued? And what is the role of technology? There are also issues around socioeconomic status as well as identity, and whether individuals see themselves as consumers, patients, or purchasers, and the implications for wider health systems (58–60). Konrad (61), writing about U.S. health care, notes that employers are encouraging employees to travel overseas, raising questions about the influence of other stakeholders within the European context—including insurers—on individuals' decision-making. We need to understand the "medical tourism paradox": that patients prefer local treatment, but are prepared to travel long distances under particular circumstances, with specific preferences and boundary conditions. It is imperative to understand the range of choices that are available for different sectors of the population, depending on education level, locality, and socioeconomic status. In effect, for some medical tourists the issue of choice may be little more than a Hobson's choice. As Baeten, McKee, and Rossenmöller note: "going abroad for treatment is almost never the first option, but is the result of specific circumstances" (62, p. 179).

What are the experiences and perspectives of individuals who are part of various European medical surgery markets? How do they conceptualize the

process, and how do they perceive and evaluate their experience? What have been the consequences and unintended consequences of their decisions? We know little beyond isolated, anecdotal reports. The U.K. consumer organization Which? suggests that the European Union should commission research on satisfaction, complaints, and redress (63). Further dilemmas include the extent to which medical tourists are aware of and understand the risks, and the extent to which this differs among patients (57).

Brokers and Intermediaries for Europeans

Discussions of medical tourism have undergone a shift from emphasizing individuals organizing their own travel arrangements overseas for a procedure, to an intermediary helping to arrange treatment (a so-called concierge or broker) and national agencies and policy frameworks seeking to stimulate and promote surgical treatments within their countries. There has been a steady rise in the number of companies and consultancies offering brokerage arrangements for services and providing web-based information for prospective patients on available services and choices, which can be attributed to the transaction costs associated with medical tourism that patients would want to contain. Typically, brokers and their websites tailor surgical packages to individual requirements: flights, treatment, hotel, and recuperation. Some brokers or concierges offer medical screening. Websites present a range of comparisons in terms of treatment costs, and some sites specialize in certain procedures (such as dentistry or cosmetic surgery) or destination countries (e.g., Poland, Hungary). A series of interrelated issues exist around the precise role of these intermediaries in arranging overseas surgery: how organizations determine their market and how they source information, choose providers, and subsequently determine what the most appropriate advice is. These matters require investigation in the European context.

Health Management

A wide range of organizational dimensions exists, and a dearth of understanding about them, including issues of quality in patient care, patient safety and data, and legal issues around harm and liability. These are not necessarily unique to medical tourism, in that all health care is rife with information asymmetries, but they are made pronounced by the element of "distance," including jurisdiction. What attempts are being made to regulate the industries, by national governments or the organizations themselves? What use is being made of international health care accreditation in European settings, such as the International Organization for Standardisation and the Joint Commission International?

Ideally, a common platform should serve as the basis for assessing quality of care to allow for comparisons of indicators, as facilitated by international accreditation and certification. It should be emphasized that when medical treatment is

sought abroad, the continuum of care is interrupted. A positive treatment outcome is important not least because the patient's local health care system takes on the responsibility for post-operative care, including treatment for complications and side effects (11, 64–66). In the event of an adverse outcome, it should be made clear whether, and to what extent, the patient has recourse for redress.

For information flows, further important questions are the use of IT information by professionals and how patient information flows across national boundaries. Continuity of care can be facilitated by the sharing of patients' records, but data protection regulations among countries, even within the European Union, complicate ease of access to medical records. The European Health Card may well serve as a first step toward better information flows, but at present this is difficult to know.

SUMMARY

Significant economic, social, legal, and political changes, occurring in recent decades, are presenting new challenges and opportunities for health care systems. Medical tourism, or the consumption of health services from abroad, is one example of such a development, which has received media mileage but has so far been unexplored by academics. This is particularly true when comparing the U.S. and European perspectives, which is unfortunate considering the politico-economic construction of the European Union. This article contributes to the knowledge base on medical tourism in general and European medical tourism in particular.

Medical tourism in the European context is but one part of the wider phenomenon of patient mobility, which includes both the short-term, temporary movement of individuals and the long-term relocation of individuals abroad. It also involves the shared delivery of health care to the populations of border areas of national territories and the outsourcing of patients from one country to another, even distant country, through organized purchasing arrangements between health authorities. Finally, there is the movement of patients of their own volition for reasons of access, financial or otherwise. Medical tourism concerns the latter.

In the European context, medical tourism is a function not merely of consumerism but also of citizenship. Indeed, European medical tourists, in seeking health care abroad, invoke both their purchasing power and citizenship rights, thereby setting them apart from their American counterparts, who in the main exercise their consumer sovereignty rights.

Concerning the factors that fuel medical tourism, the "medical tourism paradox"—that patients prefer treatment at home but are prepared to travel abroad under particular circumstances, with specific preferences and boundary conditions—remains to be as fully explored in Europe as in the United States. The price, speed of obtaining, or availability of treatment and the quality of care have been proffered as main considerations for patients seeking treatment abroad.

With the rise of a medical tourism industry, the role played by intermediaries has also waxed. The increasing number of companies and consultancies offering brokerage arrangements, linking medical tourists and health care providers, is a response to patients' need for better information to guide their decision-making, given the information asymmetry. Such activity is also reflected in the debate on the proper regulatory mechanism to govern enterprises engaged in medical tourism to ensure quality of care and redress in the event of malpractice, as well as invasion of privacy.

The special nature of health care—and the object of its consumption—makes medical tourism a critical issue on medical, sociocultural, and politico-economic grounds. The consumption of care abroad need not, and should not, entail *caveat emptor*, given its monetary and non-monetary impact at the level of the individual patient and health care system.

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