Knowledge gap nr 2. **Trans-border health care**

The geographical reconfiguration of healthcare arenas is gaining speed, placing new challenges to politicians, donors and service providers. In fact, in many settings health needs, demand and supply trespass borders, encompassing multi-country clusters and even acquiring global dimensions. Trans-border health care can occur locally, in interlinked peripheries, or by connecting cities in long-range networks. The Ebola epidemic in West Africa has dramatically drawn attention to such world-wide trend. In the African Great Lakes, the Horn of Africa, or in the Middle East, healthcare provision can no more be conceived as confined to single countries. Forced displacement boosts an ongoing trend, due to the increased mobility of healthcare seekers.

Health workers, medicines and germs move across borders, with hubs of healthcare provision serving trans-national markets. Lebanon, Jordan, India and Thailand are major exporters of health care. Informal providers become themselves itinerant to satisfy the healthcare demand of nomadic or displaced populations. Disease occurrence, the vulnerability of the affected communities, and health service delivery are all transformed in the process. Tracking communicable diseases – and related drug resistance - worldwide gives the measure of trans-national interactions. The traditional concept of national health systems serving settled populations within official borders is increasingly obsolete.

The international health architecture – by definition state-centric – faces global health issues, which must be addressed in novel ways (Kennedy and Michailidou, 2016). Statistics assembled to reflect recognised countries mask trans-border healthcare provision, which requires devoted studies to be understood. The usual neglect of this phenomenon leads to serious analytical mistakes in relation to service uptake, coverages, costs and effectiveness, with obvious policy and operational implications. Dewachi et al. (2014) have made a compelling case for adopting *"..new transnational methods of inquiry so that we can begin to understand, before we are able to provide answers to, health problems of populations enduring protracted and long-term conflicts"*.

Questions

Q. Which alternative options can be considered to engage in such trans-national healthcare arenas? Were they already tested in troubled contexts? Which lessons can be drawn from such experiences?

Q. Which implications would they have if adopted? Which undesirable effects might they have?

Q. Which studies / pilots could be carried out to appraise the merits of the proposed options?

References

Dewachi, O. Skelton, M. Nguyen, V.-K. Fouad, F.M. Abu Sitta, G. Maasri, Z. Giacaman, R. (2014) Changing therapeutic geographies of the Iraqi and Syrian wars. *Lancet*. Published online January 20, 2014 http://dx.doi.org/10.1016/S0140-6736(13)62299-0.

Kennedy, J. and Michailidou, D. (2016) Civil war, contested sovereignty and the limits of global health partnerships: a case study of the Syrian polio outbreak in 2013. *Health Policy and Planning*. 1–9.