



# Magic Mountains and multi-disciplines in international medical mobilities

## Comment on “Patient mobility in the global marketplace: a multidisciplinary perspective”

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### Abstract

Medical mobilities offer both opportunities and challenges. This tension follows the same ratio as many other historic fora, but offers at the same time a sustainable equilibrium. Multi-disciplines are, therefore, the key to the medical lifeworld for the global health and well-being of transnational health users around the globe.

**Keywords:** Global Health, Transnational Healthcare, Medical Mobilities, Well-being, Regionalism, Citizenship

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**Citation:** Mainil T, Meulemans H. Magic Mountains and multi-disciplines in international medical mobilities; Comment on “Patient mobility in the global marketplace: a multidisciplinary perspective”. *Int J Health Policy Manag* 2014; 3: 51–52. doi: 10.15171/ijhpm.2014.58

### Article History:

Received: 7 June 2014

Accepted: 23 June 2014

ePublished: 24 June 2014

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In *The Magic Mountain*, Thomas Mann uses a sanatorium in the Swiss Alps—a community devoted exclusively to sickness—as a microcosm for Europe on the eve of the First World War (1). To this hermetic yet intrigue-ridden world comes Hans Castorp, a young marine engineer from Hamburg who arrives in Davos and ends up staying in the sanatorium for seven years. Despite such stories, it is difficult to understand why people prefer a place far away from home for medical treatment. Even one century after *The Magic Mountain*, the reasons why people leave their familiar environment and are attracted by medical facilities far away are not totally understood. Neil Lunt and Russell Mannion state in their editorial that “the willingness of patients to seek medical services across international borders is not a new phenomenon—social elites have always travelled to be treated in more advanced healthcare systems” (2). Hans Castorp belonged to such an elite. In the 21<sup>st</sup> century seeking medical care abroad has become a commodity, accessible not to society at large but to large groups within society.

Medical sociology has paid a lot of attention to the determinants of health behaviour and illness behaviour. Almost fifty years ago, in 1966, Kasl and Cobb defined health behaviour as “any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage” (3). They defined illness behaviour as “any activity, undertaken by a person who feels ill, to define the state of his health and to discover a suitable remedy” (4). Travelling to foreign destinations for medical treatment is not only the result of a process of commodification. It also reflects a specific form of health behaviour or illness behaviour. The heuristic difference between health behaviour and illness behaviour is essential for the understanding of transnational healthcare and cross-border patient mobility. Healthy people can travel for the purpose of preventing

disease and thus develop healthy lifestyles; ill people can do the same to discover a suitable treatment and to recover. The decision to go abroad for consumption of care is dependent on six clusters of determinants: demographic, economic, psychological, cultural, triggers, and a cluster of supply-induced determinants (5). In the last decades of the 20<sup>th</sup> century many causal models were tested empirically with this typology of clusters and determinants in mind (6).

In their editorial Lunt and Mannion discuss the key challenges in relation to medical tourism under the six key disciplinary preoccupations of the Journal: epidemiology, health economics, health policy ethics, politics of health, health management, and health policy. From an epistemological point of view, it is obvious—and at the same time gratifying—that the disciplinary preoccupations of the Journal link up completely with the multidisciplinary form of the contemporary phenomenon of medical tourism, patient mobility, cross-border healthcare, transnational healthcare, and so on (7). Let us leave the coexistence of all these terms for a while out of the discussion. After all, it is evident that various terms exist at the same time, since they are building blocks of new, developing theories. Comparing the new disciplinary preoccupations of the Journal and the old clusters of behavioural determinants indicates that epidemiological, ethical, political, and managerial insights have gradually become cornerstones in our attempts to understand the complex phenomenon of medical tourism. Besides these new insights, the classical disciplines, in particular economy and psychology, continue to explain the variance of health and illness behaviour in the perspective of going *strange* and going *international* for medical reasons.

A word on the terms *international* and *global* used in the editorial is in order. Lunt and Mannion state that “key factors associated with the rise in the global movement of patients

across international borders include the growing globalisation and inter-connectedness of economic production and trade, new forms of political cooperation, technological developments, and a burgeoning international market in medical care and services provided by health professionals". The use of these terms is not neutral, as Farmer *et al.* explain (8). The term *international* refers to "the nation-state as the base unit of comparison and implies a focus on relationships among states". The term *global* should more accurately encapsulate "the role of non-state institutions, including international NGOs, private philanthropists, and community-based organizations" (9). In the editorial many organisations involved in medical tourism are listed. Providers and insurance companies as well as stakeholders who are responsible for Internet marketing, registration, accreditation, and data create a complex configuration transcending the borders of states. Medical tourism will not lose its international dimension in the near future, but it is quite clear that its natural habitat is the global marketplace. Transnational healthcare/medical tourism should not become a "magic mountain", but should be carefully constructed as sustaining network, with benefits for both citizens as health passengers on route.

#### Ethical issues

Not applicable.

#### Competing interests

Authors declares that they have no competing interests.

#### Authors' contributions

TM and HM contributed equally to the drafting and revising of the manuscript and have read and approved the final version.

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