



Medical sociology as a heuristic instrument for medical tourism and cross-border healthcare

Comment on “International patients on operation vacation – perspectives of patients travelling to Hungary for orthopedic treatments”

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Abstract

In this commentary, we establish a relationship between medical sociology and the study of medical tourism and cross-border healthcare by introducing Ronald Andersen's behavioral model of healthcare use, and linking this model to the recent empirical study of Kovacs *et al.* on patients travelling to Hungary for orthopedic treatment. Finally, we plead for more measurement in the field of patient mobility.

Keywords: Cross-border Healthcare, Behavioral Model of Health Services, Medical Tourism

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Citation: Mainil T. Medical sociology as a heuristic instrument for medical tourism and cross-border healthcare: Comment on “International patients on operation vacation – perspectives of patients travelling to Hungary for orthopedic treatments”. *Int J Health Policy Manag* 2015; 4: 243–244. doi: 10.15171/ijhpm.2015.37

Article History:

Received: 2 February 2015

Accepted: 18 February 2015

ePublished: 20 February 2015

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Kovacs *et al.* (1) presented an empirical account of patient mobility in the European Union (EU). They offered insight on a particular form of patient mobility: cross-border healthcare (89% in the sample were Romanian patients, crossing the border to Hungary), seen as a good – but challenging – practice of patient mobility within cross-border regions in the EU (2). This issue could also be related to a broader context of medical tourism. In many regions, patients originate from surrounding neighboring countries (3), such as in the case of Malaysia (4), of South-Africa (5) and of patient mobility between the US and Mexico (6). In other words, cross-border healthcare and medical tourism seem to build on the same foundations. One could state that they are differently framed: in the EU, cross-border healthcare is historically the preferred practice and definition. In the Asian context, patient mobility is often framed as medical tourism and associated with market development. Furthermore, the authors shed a light on the decision-making behavior of the patients: 93% planned the treatment on their own, which could indicate that the role of a medical tourism facilitator in a European cross-border region setting is less logical or necessary.

In establishing a relation between medical sociology and medical tourism/cross-border healthcare, we introduce the behavioral model of health services use of Ronald Andersen. He developed the model with his peers in the 1960s and revisited the model in a famous paper in 1995. We are now in early 2015, and it would be a valuable methodological exercise to lay this model beside current patient mobility dynamics. Is this heuristic model also applicable to cross-border patients and medical tourists? The model makes a distinction between contextual (such as demographic/health policy/environmental) and individual characteristics (such as demographic/financing). These characteristics lead

to health behaviors (personal health practices/process of medical care/use of personal health services) which then lead to outcomes (perceived health/evaluated health/consumer satisfaction) (7,8).

Applying this model to the case study of Kovacs *et al.* (1) suggests that the Romanian health system as a contextual/environmental factor is urging patients to go abroad whereas the Hungarian health system is perceived as offering greater quality of care (58.7% in the sample) as well as attractive individual characteristics, such as financial situation and demographic status (83% is middle class in the sample). Such characteristics lead to transnational health behaviors in which patients travel across the border to receive healthcare in a border region hospital. The process of medical care in the case of patient mobility is coupled with the process of travelling, which could be translated into geographical distance, cultural distance, and organizational distance (e.g. making the necessary arrangements to travel abroad, such as lodging and transport) (9). Finally, these processes lead to outcomes such as customer satisfaction: in the study of Kovacs *et al.* (1) 99% of the patients reported being satisfied with the treatment process in the case of orthopedic care in Hungary. Although this establishing of the relationship between patient mobility and Andersen's behavioral model of healthcare use is limited, it allows identifying several variables which are present in the model: Do contextual characteristics such as specific health system policies influence citizens to travel abroad for healthcare? And do these citizens possess certain individual characteristics which make them travel? Do these characteristics influence the ways they use medical services in another country, and does this lead to certain levels of perceived health and/or satisfaction?

Measurement is crucial for the healthcare model of Andersen. The model has long been a guiding principle for

the National Health surveys in the US (8). A reasonable scale of measurement is still lacking in cross-border healthcare and medical tourism. The study of Kovacs *et al.* (1) could be seen as a pilot study in examining the factors/variables in Andersen's model. Further empirical research could unravel the mobile health system and its transnational health users using measurement and longitudinal research designs. Although still low numbers of patient mobility are estimated, given increasing migration patterns throughout the world (10), different types of patient mobility will only become more important in the future.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

TM is the single author of the manuscript.

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