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# 1. The shaping of contemporary medical tourism and patient mobility

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## 1.1 INTRODUCTION

A broad range of drivers have facilitated the emergence of contemporary medical tourism and patient mobility including transformations of economic production and trade, regional political and trade cooperation, technological shifts, migratory flows, and socio-cultural trends and developments. The suites of available treatments encompass forms of bio-ethical interventions such as fertility treatment, transplantation and stem cell therapy, as well as dental, cosmetic and a full range of elective surgeries. There are diverse approaches to choosing, providing and delivering these treatments and differing patient motivations (for example perceived quality, familiarity, affordability, availability), and different funding types (those with cover and those with no cover) (Glinos et al., 2010). Added to destinations, source countries, patient characteristics and system context, the picture becomes one of overwhelming complexity. Not surprisingly, to present a history of medical tourism and patient mobility necessarily embraces a range of medical *tourisms* and different forms of patient mobility (see Bertinato et al., 2005; Glinos et al., 2010; Lunt et al., 2011; Connell, 2013a).

Common to all definitions is the notion of travelling to receive healthcare – variously expressed as travel to a foreign land, abroad and, more recently, cross-border and ‘out of jurisdiction’ travel. Taken together, such a phenomenon has a long ancestry and ‘travel in search of healing is present throughout history’ (Howze, 2007: 9). Pursuing health benefits dates back many thousands of years to at least the Ancient Greeks and Egyptians who travelled for the therapeutic benefits of hot springs and baths (Snyder et al., 2011; Hall, 2012). Travel for health benefits pre-dates the rise of modern medicine and the existence of passports, harking back to porous borders and less institutionalized medicine, and with travel patterns punctuated by developments of road, steam and rail (Bruce, 2013).

Nineteenth-century Europe witnessed a fashion for the growing middle classes to travel to spa towns situated around mineral springs to ‘take the waters’, which were believed to have health-enhancing qualities. Across Europe, the health benefits of spas were widely accepted and resorts such as Bath in England, Aachen and Baden Baden in Germany were popular destinations for wealthy travellers (Goodrich and Goodrich, 1987; Hall, 2012; Bruce, 2013). In this era ‘spas and keeping away from doctors may have been the better of real evils so long as the individual had ample wealth . . . if the bourgeois consumer was not too ill, spas afforded great pleasure and delights . . .’ (Bruce, 2013: 27). Spas continued their popularity and Budapest was the centre of international spa promotion in the years leading up to the Second World War (Bender et al., 2002). Further, the recuperative effects of ‘landscape’ and ‘getting away from it all’ as a motivation to

travel is well documented (Hembry, 1990), as is the role of longer visits to convalesce for chronic disease and illness such as tuberculosis (Shorter, 1992; Smyth, 2005; Hall, 2012).

### **The Rise of Modern Medicine**

Alongside change in travel technology, scientific and surgical developments – internal medicine, surgical techniques and biochemistry – encouraged patient mobility for these more medicalized experiences (Temkin, 1951; Tilney, 2011; Gawande, 2012). Surgery in the nineteenth century ‘. . . remained a limited profession. Pain and the always looming problem of infection restricted the extent of a surgeons reach’ (Gawande, 2012: 1717). Progress within general anaesthesia and anti-sepsis were particularly significant in widening the reach of surgery. Combined with research in bacteriology, biochemistry, immunology, techniques including endoscopy, chemotherapy, and microsurgery broadened medical horizons. Surgery now began to deal with the internal as well as external human body on a more routine basis. There ensued a process of specialization and professionalization, for example the further development of dedicated training programmes for surgical specialities, and more recent sub-specialization (Rutkow, 1998; Toledo-Pereyra, 2007).

During the twentieth century, wealthy people from less developed areas of the world travelled to developed nations to access better facilities and highly trained clinicians, drawn by innovation and reputation. Movement of patients was also evident amongst Western health systems, including diagnosis, surgery, and to obtain ‘alternative’ forms of treatment that were not evidenced or legal within their home country (Howze, 2007). This was elite mobility and the destinations were promoted less by advertising and marketing and more through clinical networks where contacts and reputational capital were the main currency. Travel of celebrities, politicians and sports stars overseas for medical treatment occurred from the 1950s, pre-dating the recent consolidation of celebrity culture (Jackson et al., 2013).

By the late twentieth century these elite flows were strongly shaped by the experience of history, including migration patterns and southern elites now being treated in the capital cities of their former colonial rulers, economic downturn, and the explosion of oil wealth. Some countries exploit long-standing historical ties, for example between Malta and the UK or the UK and Cyprus (Muscat et al., 2006). In the 1970s, up to 200 000 Arabs visited London each year as tourists and by the end of the 1980s between 250 000–500 000 Arabs lived in the UK for most or part of the year (Karmi, 1997). Within the UK, the Kuwait embassy helped up to 1000 patients annually – around one-third of whom were sponsored by the Kuwaiti Government. Similarly, Qatar sent up to 2000 patients each year to the UK (Raynor, 1986). The 1980s saw competition between Britain, France and Germany for Arabic patients (Roberts, 1991). Attempts to attract what were termed ‘international patients’ gathered pace during the economic downturn with private activity squeezed within domestic health markets and the public sector experiencing retrenchment. Significant interest was expressed from the United States’ healthcare providers in sourcing such international patients (Wagner, 1993; Zinn et al., 1994; Lagnado, 1996; Hutchins, 1998). Discussion ensued in 1990s Canada about plans to open a private facility to cater for American patients, and the benefits of international patients and an out-of-province programme within the public system (Blewett, 1988;

Cairney, 1996). Such patients brought economic benefits, although debates over foreign patients receiving organ transplants in developed countries (Prottas et al., 1986) and an 'economic elitism in which wealth and power appear to mean the difference between life and death, a kidney transplant or painful dialysis' (Gruson, 1985: 5) highlighted how some activity was mired in ethical and political controversy. Treatments could also reflect legal and moral restrictions in home countries; in 1981, one-third of abortions in the UK private sector were for patients from the Republic of Ireland or Europe.

Perceived centres of medical excellence to which patients gravitated included: Rochester, Boston, Paris, Hamburg, and London. Around a quarter to one-third of the turnover of private patients in London was from 'foreigners' (Raynor, 1986; also Mencher, 1968). But regional centres existed within the Middle East and from the 1960s and 1970s, 'Patients from the Gulf countries were sent to Beirut, Cairo, Paris, Germany . . . Beirut has the reputation of being the "hospital of the Orient" . . .' (Kronfol, 2012: 1235). Amman in Jordan has attracted patients since the 1970s from Yemen, Sudan, Bahrain, Syria and Libya (Glinos et al., 2010; see Kronfol, 2012).

Such flows, which continue into the twenty-first century, are both out-of-pocket and government supported. Government support may be a full-blown organizational purchasing initiative, driven by a lack of available specialists and specialist equipment in particular countries. Countries' health agencies contract overseas authorities to deliver services to patients who then travel overseas. Patients travel long distances as evidenced by Middle-East patients to Europe. For New Zealand and Australia there has been travel from the Pacific Islands for treatments supported by Pacific Island governments and bilateral country relationships (see Oliver et al., 2011; Park et al., 2011). Thus, travel to regional centres' 'backyards' (Connell, 2013a) under state-sponsored programmes is a well-established form of mobility.

In more recent developments such outsourcing is utilized by developed Western countries experiencing waiting lists for treatment provided within the public health system. Under these outsourcing initiatives patients travel relatively short cross-national distances and contracted services are subject to robust safety audits, quality assurance and tight monitoring. Examples include a pilot part of the broader London Patient Choice initiative which gave patients opportunities to receive treatment in Brussels, France and Germany. Under these arrangements services were bought by public funders from both public and private providers (Lowson et al., 2002; Glinos et al., 2006). Similar developments occurred within Denmark, the Republic of Ireland and Norway, allowing patients to travel elsewhere in Europe to avoid waiting lists and bottlenecks for some public sector treatments (Hervey, 2007; Legido-Quigley and McKee, 2007).

## 1.2 GLOBALIZATION AND THE INTERNATIONALIZATION OF HEALTHCARE

Sketching the current geography, activity and processes with regard to medical tourism and patient mobility highlights quantitative and qualitative differences compared with earlier forms of health-related travel. As Chapters 2 and 3 suggest numbers have increased over the past decade. The world map of medical tourism destinations would now include a range of competitive European destinations (Western, Scandinavian, Central and

Southern Europe, the Mediterranean); East and South Asia (India, Malaysia, Singapore, Korea and Thailand); South Africa; South and Central America (including Brazil, Costa Rica, Cuba and Mexico); and the Middle East (particularly Dubai and Jordan). It would appear that geographical proximity is an important, but not decisive, factor in shaping providers' marketing plans (Connell, 2013a).

Globalization has been the pervasive undercurrent of contemporary medical travel, with economic, social and political shifts encouraging a more international, transnational and global focus for health policy and management. These include the movement of people, products, capital and ideas and this has presented new opportunities and challenges for healthcare systems, regulation and health trade. Across the globe, many domestic health systems continue to undergo significant challenges and strain – tightened eligibility criteria, waiting lists and shifting priorities for healthcare impact on consumer decision making. There is also the emergence of patient choice and forms of consumer consciousness in healthcare, including within countries that traditionally have had public-funded services. The implications for health policy and delivery are wide-ranging: moves towards a global health agenda, greater professional mobility, corporate multinational health providers, e-health innovations, and increased patient mobility. All of these have implications for supply- and demand-side developments within medical tourism and patient mobility.

### **Low- and Middle-income Countries as Stakeholders**

A first difference is the addition of flows from developed to less developed nations, more regional movements, and the emergence of a truly international market for patients. What we are seeing is a form of internationalization of private healthcare activity aimed at travelling patients which generates 'a more extensive geographical pattern of economic activity' (Dicken, 1998: 5, cited in Holden, 2002). Offering medical tourism services is no longer confined to a small number of countries in the developed West and regional centres, a far greater number of countries are now seeking to compete regionally and, to a lesser extent, more globally for travelling patients.

Just as previous forms of health and medical tourism developments emerged as an outcome of roads, railways and steam development, so contemporary medical travel has been enabled by travel innovation and particularly lower-cost air travel for long haul and the mushrooming of short-haul routes (Bruce, 2013). This has changed the nature of travellers and the direction of travel, opening up possibilities for a 'massification' of medical travel. As Burkett (2007: 226) suggests 'before the shift in global economics, medical tourism was an activity of the wealthy not the bargain shopper'.

Lower- and middle-income countries (LMIC) have sought to enter the medical tourism market-place since the mid-1990s marking a significant realignment of the supply side of medical services. Thailand, for example, increasingly focused on the provision of healthcare to overseas patients as a result of the 1997 Asian economic crisis, which resulted in underused capacity in its private health system because Thai nationals switched to using the publicly funded healthcare system (Burkett, 2007; Whittaker, 2008; Wibulpolprasert and Pachanee, 2008; Connell, 2011).

A number of countries, including Malaysia, India and South Korea, began seeking to attract medical tourist patients and their national governments funded the promotion

and development of medical tourism services and activities in the search for foreign exchange and to develop domestic high-tech industry. The diffusion of surgical techniques and patient safety knowledge, combined with the circulations of clinicians who have trained within, or have experienced, overseas systems facilitated the internationalization of techniques previously confined to Western nations. Whereas transplant abroad has existed since techniques were introduced in Western health systems, during the 1990s transplant tourism as an activity involving LMIC emerged and a concept of transplant tourism was born (Scheper-Hughes, 1998).

Particularly within Asia there has been the development of customer care strategies and corporate 5-star hotel-like facilities (Connell, 2013a). In part, the experience of many UK and American private patient hospitals and hospital wings for wealthy patients has informed the strategy of emergent medical tourism destinations with an emphasis on quality and customer service.

Looking to other regions, such as Latin America, travel to Brazil, Costa Rica and Argentina for cosmetic treatment and Mexico for prescriptions and dental treatment by Americans were not new developments (Parsiyar, 2009). However, these countries are now seeking to expand into additional treatment areas. For some regions such as the Caribbean previous developments around health tourism, drug and alcohol rehabilitation, cosmetic surgery and health resorts are seen as assisting the development of wider medical tourism services (Gonzales et al., 2001; Connell, 2013b).

### **Provider Developments**

At the international level there has been an expansion of private healthcare (Connell, 2013a, 2013b; Ormond, 2013) and medical tourism provision is dominated by the private sector and intensification of competition. As Porter identifies (1990: 247, cited in Holden, 2002), 'With rare exceptions, government-owned service organisations do not compete globally'. Within the wide picture of medical tourism as Ackerman (2010: 405) notes, there are 'cottage industries and transnational enterprises'. Within Europe for example, relatively small clinical providers may include solo practices or dual partnerships, offering a full range of treatments. Within Asia there are extremely large medical tourism facilities (e.g. Bumrungrad in Thailand, Raffles in Singapore, Yonsei Severance Hospital in South Korea) where clinical specialism is clearly evident. Hospitals may be part of large corporations (the Apollo Group for example has 51 hospitals within and outside India), and ownership itself may lie primarily in the higher-income countries from where patients mostly originate (see also Connell, 2013b). Countries seeking to develop medical tourism have the options of growing their own health service or inviting partnerships with large multinational players. To raise the profile of countries and their health facilities, approaches include seeking partnerships and oversight by overseas hospitals and universities, most often from the American private sector. Formalized linkages with widely recognized medical providers and educators (like Harvard Medical International, the Mayo Clinic, the Cleveland Clinic, Johns Hopkins Hospital) are becoming increasingly popular among hospitals catering for medical travellers. Within Dubai Health Care City, the Harvard Medical School Dubai Center, the Dubai Harvard Foundation for Medical Research and University Hospital comprise the Academic Medical Center (Khodr and Reiche, 2012).

There is some limited public sector exceptionalism: since the 1980s Cuba has promoted health spa and medical tourism to fee-paying foreigners, particularly those travelling from North America but also from within Latin America (Goodrich, 1993), including ophthalmic, cardiac and cosmetic specialties, using the income generated to cross-subsidize the domestic public health system (Simon, 1995; Charatan, 2001). Specialist NHS facilities in Britain have a long tradition of treating international patients, and private services are offered to patients from abroad within both integrated and stand-alone facilities. Integrated facilities utilizing shared theatres and treatments arise because of the need to co-locate activities for reasons of intensive care units and specialist supports. For some treatments there may be dedicated facilities with private operating theatre space and ward facilities. Types of treatment centre on complex tertiary procedures (including paediatrics and heart surgery), and also include maternity services and ophthalmic surgery. These public sector providers compete within more crowded environments (with domestic private sector providers and new country entrants) and public sector marketing strategies are being unveiled. With these forms of public sector activity some aspects of 'health diplomacy' are evident (Kickbusch, 2011). Cuba has long used its health investment and medical system as a leitmotif of Cuban equality; the NHS has strong historical, geo-political and colonial relationships with source countries and maintains training and consultancy relationships.

For most countries seeking to develop medical tourism, prospective providers are private sector; but some countries attempt to reorientate an ailing public sector system. However, these attempts to utilize excess public sector capacity have achieved little success. Such sectors experience more restrictions and inflexibilities (commercial and political) and have less experience with marketing and targeted advertising than the private sector. Success within these settings requires public sector providers to negotiate political context, manage internal stakeholders and show commercial acumen (Currie et al., 2008).

### **Commodification**

In what is predominantly a private sector there has been dramatic commodification of health and medical treatments. From marketing materials, particularly web-based, the full range of *life saving* and *life changing* treatments available abroad are priced and promoted, becoming services that are bought and sold as with any other (Whittaker and Speier, 2010; Connell, 2013a; Epstein and Danovitch, 2013). At the heart of the growth in medical tourism lies commercialization and in some part this is premised on the availability of web-based resources to furnish the consumer with information, imagery and market destinations, and to connect consumers with an array of healthcare providers and brokers.

At the wider shores of medical tourism are countries offering treatments targeted at conditions and treatments for which there are no clinical trials to support efficacy, for example some stem cell therapy, and internal mud-pack therapies for internal gynaecological and fertility interventions. Whilst arguably ethical and legal issues arise for all surgical treatments, forms of medical tourism including 'fertility tourism', 'transplant tourism', 'stem cell tourism' and even 'euthanasia tourism' raise ever more fundamental questions. Under a regime of commercialization and commodification, relationships are governed by commercial regulation (tort and contract) rather than professional ethics.

Commodities are also seen as fungible, impacting on the role and place of patients and clinicians (Pellegrino, 1999). The dangers of the increasing commercialization and commodification of healthcare are that 'physicians no longer look on patients as "theirs" in the sense that they feel a continuing responsibility for a given patient's welfare' (Pellegrino, 1999: 253).

### **National Government Interests**

Distinct from earlier forms of medical travel is the strategic role of governments in supporting and promoting national interests. National government agencies and initiatives have sought to stimulate and promote domestic medical tourism, identifying economic development potential from health and related non-health activities. The Thai, Indian, Singaporean, Malaysian, Hungarian and Polish governments have promoted their comparative advantage as medical tourism destinations at large international trade fairs, via advertising within the overseas press, and official support for activities as part of their economic development and tourism policy (Mudur, 2004; Chee, 2007; Whittaker, 2008; Reisman, 2010). Since 2003, SingaporeMedicine, a multi-agency government-industry partnership promoted Singapore as a medical hub and a destination for advanced patient care. Led by the Ministry of Health, it had the support of the Development Board, International Enterprise Singapore, and the Singapore Tourism Board (see also Chapter 29 for Rupa Chanda's discussion on India in this collection). In Malaysia, the National Committee for the Promotion of Medical and Health Tourism was formed by the Ministry of Health in 1998. It developed a strategic plan and networked both domestically and overseas with relevant interests. Tax incentives were provided for buildings, equipment, training, advertising and IT (Chee, 2007).

Some destinations market themselves as a healthcare or bio-medical city. Singapore, for example, was promoted as a centre for bio-medical and bio-technological activities (Cyranoski, 2001). The last ten years has seen the emergence of the Dubai Health Care City (Connell, 2006; Crone, 2008; Lunt et al., 2011), established with the purpose of becoming 'the internationally recognized location of choice for quality health care, and an integrated centre of excellence for clinical and wellness services, medical education, and research' (Khodr and Reiche, 2012: 162).

Toyota (2011) suggests that the medical tourism markets of both Singapore and Dubai, alongside those of India, Thailand and Malaysia, should be considered as the 'first wave' of Asian medical tourism. She points to the post-2008 expansion of both the Japanese and the South Korean medical tourism markets as representing a second wave, one marked by increasing state involvement. Both the Japanese and South Korean governments have declared publically the desire to place medical tourism at the heart of plans for future economic growth (Sang-Hun, 2008; Hall, 2009; ITTimes, 2009; Kester, 2011) and both have matched this commitment with a relaxation of visa laws, making inbound travel easier.

As well as individual out-of-pocket payments for treatment, a potentially more lucrative source of income would be the private and workplace insurance systems. To date there has been relatively limited success by medical tourist providers in tapping these potential revenue streams. Examples of more institutionalized arrangements do exist but are rare.

## **Information and Service Access**

Helping to redraw the cartography of medical tourism are processes of informationization, and access to wider ancillary services. A key driver in the commercialization of medical tourism is the platform provided by the internet for gaining access to healthcare information and advertising. The internet provides multiple functionalities and formats including discussion forums, file sharing, posting information and sharing experiences, member-only pages, advertisements and online tours. As well as options for accessing information relating to diagnosis, purchase and aftercare, sites provide information on commerce allied to medical tourism: cost comparison sites and financial advice sites list medical tourism as a product, and travel insurance products are available for medical tourism trips. The openness of information encourages the development of diverse providers competing on quality and price, and catering for niche or more generic markets.

Individuals may put together their own package of services using the internet and other networks of friends, family and online support networks. Thus a UK patient seeking treatment in Europe could potentially have a pre-consultation in the UK and utilize products – financial, insurance, hotel services, translation, treatment and aftercare – that are each arranged individually by the patient. Alternatively, a prospective patient may access a single provider who offers all of these in a single supply chain. Services may be more loosely or fully integrated and can include those that emphasize upstream integration of getting the surgery arranged (finance, pre-consultation, travel), and/or downstream integration following surgery (recuperation, aftercare, follow-up).

A notable feature of the latest wave of medical tourism is the role of the third-party intermediary as aside from a clinical referral or a recommendation from a personal network. Healthcare brokers themselves are not new. A 1909 inquiry on patient trade reported on middlemen being paid by patients to arrange consultations for Russian patients visiting Berlin's clinicians (Maehle, 2010), but their role has developed. Most remain small, and there is a plethora of independent traders for some treatments such as cosmetic services (Connell, 2013a). Brokers may source treatments, advise, arrange, accompany, translate and troubleshoot.

The establishment of 'outposts' – local offices overseas organized by providers or government agencies – is a more recent development. For example the Korean KHIDI has offices in the US, Singapore, China, the UK, UAE and Kazakhstan. Some London specialist hospitals have an overseas presence in the Middle East, such as Great Ormond Street Hospital's regional office in Dubai Health Care City.

## **Multiple Forms of Governance**

Much of healthcare history is a history of regulation: professions, state and supranational. Medical tourism presents new challenges to regulation through market expansion and wider commodification. Within Europe such issues are played out against a backdrop of the enlargement of the European Union (EU) and a deepening of its regulatory reach. Developments in regional governance include attempts to codify, offer guidance and develop cohesive policies including EU cross-border healthcare. As Bertinato et al. (2005: 1) note: 'Until the establishment of EU mechanism for cross-border care, anyone requiring health care abroad would have considered this to be a private matter.' The

long-standing situation of confusion around patients' rights to travel overseas, their need for authorisation, and a lack of clarity about the process and redress was addressed by the European Commission's Directive on Patients' Rights in Cross-border Health Care. The Directive was the result of a number of high profile rulings of the European Court of Justice (Case C-372/04 [the Watt case, 2005]; also Case C-158/96 [the Kohll Case, 1998]; and Case C-120/95 [the Decker Case, 1998]) (European Court of Justice, 1998a, 1998b, 2005) which established that internal market provisions allowed citizens of EU member states to access health in EU member countries (Greer, 2008). Under this Directive, which came into force in 2013, EU patients are able to access healthcare across borders as a right – under certain conditions. Healthcare that falls outside of the Directive includes: long-term care; organ transplants; vaccination programmes.

Whole country strategies and individual provider marketing have identified accreditation from international programmes for clinical and sector development. Within Malaysia, providers were encouraged to pursue accreditation with an emphasis on quality (Chee, 2007). The Joint Commission International was established in 1994 to provide education and consulting services to international clients, publishing its international quality standards for hospitals in 2000. There are a range of competing accreditation organizations, including Accreditation Canada and the Australian Council for Healthcare Standards International. The International Society for Quality in Health Care (ISQua) is an umbrella body for these organizations offering international healthcare accreditation. In 2005 the World Health Organization (WHO) designated the Joint Commission and Joint Commission International as the WHO Collaborating Centre for Patient Safety Solutions. Industry-led initiatives have also developed a number of competing associations and bodies offering badges and certification for facilitators and providers.

### **Changeability and Volatility**

The presence of advertising, wide country interest and treatment diversity all contribute to fervour around medical tourism. Given the veneer of country promotion strategies, provider rhetoric and industry grandstanding it is difficult to distinguish aspiration from reality. Attempts to normalize consumption abroad through 'boosterism' and 'propagating myths' (Connell, 2013a, 2013b; Lunt et al., 2014) are clear. With hyped projections of medical tourist numbers and a tendency to overlook failed ventures, the bandwagon is rolled elsewhere to focus on the next emerging location (see Connell, 2013a; Lunt et al., 2014).

Wider economic and external factors introduce volatility (economic recession and shifting geo-politics) (MacReady, 2007; Gray and Poland, 2008). Exchange-rate fluctuations may also make countries more or less financially attractive, and restrictions on travel and security concerns prompt consumers to explore alternative markets. Medical tourism is no simple upward curve: travel to particular countries may also be volatile, reflecting their own political, climatic and economic events, as well as shifting consumer preferences and exchange rates (e.g. Helmy and Travers, 2009; Connell, 2013b: 128). Following the events of 9/11, patients from the Middle East were less willing to travel to the US (see Lee and Davis, 2008) and were sent instead to Europe, Thailand, Singapore and Malaysia (Kronfol, 2012). A ratcheting of competition results in providers and

national governments seeking to usurp existing suppliers and destinations, for example in the development of Latin American fertility clinics (Smith et al., 2010; Connell, 2013b). Medical tourist facilities may be targeted at particular cultural groups, for example the growing wealth of the emerging middle class and elites from Mongolia and Russia is identified as a lucrative opportunity within Asia, but it is unclear whether current travel to Asia will continue or whether Russian medical travellers will increasingly turn towards Europe (Furmanov et al., 2012).

### 1.3 CONCLUSION

Under contemporary forms of medical travel, greater numbers of people are travelling for treatment and there is a shift towards patients from richer, more developed nations travelling to less developed countries to access health services, largely driven by the low-cost treatments and helped by cheap flights and internet sources of information and imagery. The private healthcare sector and national governments in both developed and developing nations are instrumental in promoting medical tourism as a potentially lucrative source of foreign revenue. Such developments are *international* with most countries involved and raise trans-national considerations of governance for safety, regulation and funding. Developments have been *encouraged by globalization* – greater national interconnections that are political, economic, social and technical. The outcome however is not the globalization of medical travel – ‘the functional integration of such internationally dispersed activities’ (see Holden, 2002). Nor has there been any global patterning with developments better understood as strongly regional (e.g. Connell, 2013a; Ormond, 2013). The technological capacity for globalized healthcare clearly does exist – and alongside a globalized medical tourism imagery and aspiration may further fuel commercialization and commodification. Whether this form will include greater functional integration and global patterning is a question to be addressed in subsequent histories of the field.

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