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From medical tourism to transnational health care? An epilogue for the future

1. Introduction

In the past two decades, medical tourism has seemed to define cross-border travel for medical care. An ebullient expression of late capitalism, in the heady days before the Global Financial Crisis it also seemed remarkably glamorous. Most accounts of medical tourism, certainly in the popular media, centre on cosmetic changes, often dramatic, sometimes problematic, but capable of transforming lives (Jones, 2008). Yet, as this special issue has well demonstrated, much of medical tourism is quite prosaic and functional, and transnational health care is very much more than simply medical tourism. These papers have combined to add significantly to collective knowledge of international medical travel, reveal its diversity, and develop an agenda for the future.

Whatever definitions of medical tourism are chosen, numbers are never as great as those offered by the industry, where optimistic national and hospital numbers are designed to demonstrate success (Connell, 2013a). Tourism, as a source of pleasure and relaxation, is also an inadequate noun for medical travel across international borders. Unsurprisingly the medical tourism industry markets itself as offering a vital but pleasant experience, yet many mobile patients cross borders for medical care unwillingly, out of necessity, desperation and frustration, with no thought of tourism in mind. Growing discontent with the broad concept of medical tourism suggests that international medical travel offers a more inclusive and more appropriate generic term (Ormond, 2015), with medical tourism a small component of that.

Multiple factors came together, both supply and demand, to create the steady growth of medical tourism from the late 1990s. The rise of a new middle class with an ability to pay, especially in Asia and the Gulf but also in Latin America and belatedly Africa, increased the demand for health care (Connell, 2011; Ormond, 2013a). Many patients lacked health insurance, faced long waiting lists for non-priority procedures, or had no national access to certain procedures. The return of expatriates seeking cheaper care in a familiar cultural context, and a globally ageing population – especially baby boomers – created new demands. Air travel became cheaper, exchange rates were favourable, tourism (assisted by television and the internet) increased familiarity with distant places, and there was a growing recognition that most medical practices, technology and human resources, certainly in the best hospitals, were the equivalent of those in developed countries: ‘first world care at third world prices’. An early phase of corporatization resulted in many Asian hospitals seeking profits and new clientele in the wake of the Asian financial crisis (Whittaker and Chee, 2015). Finally medical tourism was eagerly adopted by governments anxious to see a new ‘creative industry’ develop.

That has stimulated the much discussed context of contemporary medical tourism, but there has always been significant movement of the affluent to global centres, such as London and Berlin, and more desperate ‘refugee’ movements of the poor across nearby borders (Crush and Chikanda, 2015). As this collection also shows, there have been substantial contemporary movements across EU borders, facilitated by medical establishments (Glinos and Baeten, 2014; Volgger et al., 2015) that owe nothing to tourism, but that simply represent a cross-border expansion of more or less standard tasks of internal referral and servicing in a new political and economic climate. Multiple manifestations of international medical travel have hitherto been marginalised in favour of discussion of the tourist exotic.

2. Who, what, where?

Defining medical tourism involves a complex combination of procedures, duration, intent and, presumably, some hint of the pleasure that is supposedly associated with standard tourism. Broader readings of medical travel emphasise that much cross-border movement has no resonance in tourism; journeys are brief and actual tourism in any hedonistic form is largely absent (Kangas, 2002; Crush and Chikanda, 2015). Health care, at various scales, is embedded in a broader array of international flows, where distinctions between trade, tourism and travel are neither easy nor helpful. Yet without data and definitions it is simply impossible to establish whether medical travel is growing, how it might be changing and what particular impacts have been. For medical tourism at least, exaggerated statistics blend into marketing strategies and ‘success’ stories. Competition and branding discourage accurate data.

Further complicating conceptualization, this special issue demonstrates that international medical travel is diverse, has a legacy in internal mobility (with more complex procedures sought in and referred to metropolitan centres) and is quite unlike popular notions of medical tourism. Travel may be for specialized treatments for cancer, reconstructive surgery, cardiovascular disease and organ transplants, or for procedures unavailable in home countries (Crush and Chikanda, 2015), as well as for basic needs – check-ups and dental procedures – that are much more mundane (and also excite less concern about quality, cultural differences and strange or uncertain procedures). Dentistry however is often disregarded as a medical procedure. Wellness is usually ignored, too. No single or

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simple definition of either international medical travel or medical tourism exists.

Rather than being grand airline travel from the countries of the north to those of the south, much medical travel is now seen as relatively short distance, regional (rather than truly global), cross border and diasporic (and so less likely to cross cultural boundaries), and of limited gravity, despite cosmetic surgery (and to a lesser extent fertility) dominating media discourses. This collection has put to rest the perception that medical travel is centred on some twenty or so key destinations, mostly in Europe or North America, alongside the 'Big Four' in Asia: Thailand, Singapore, Malaysia and India. It is much more geographically diverse.

Developed countries such as the UK, Germany and the USA remain prominent destinations for the relatively well off. A very considerable movement occurs within Europe, partly formally organized across EU borders – though surprisingly little is known about this cross-border mobility, despite it being substantial and often regulated (Volgger et al., 2015) – and partly less formal mobility, often for dentistry (Glinos and Baeten, 2014). So substantial are these collaborative cross-border linkages that some European border regions have been conceptualised as 'health regions', indicative of the extent of medical mobility across European borders (including that of technology and health workers), the increasing insignificance and permeability of some borders and substantial complementarity across these borders (van Hoof et al., 2015). A borderless Europe may have precedents for ASEAN and elsewhere. Though there remains a large 'national' component in health care, one that such regions have struggled to formally transcend, the wide-ranging mobility of patients across European borders is substantial enough for there to have been widespread popular concern about 'welfare tourism' – unconstrained mobility to access generous benefits systems and health care in western Europe without contributing anything in return. While access to health care benefits is complex, it is evident, at least in Britain and Ireland (Lunt et al., 2015; Stan, 2015) and almost certainly elsewhere, that this is largely mythical and that migrants contribute much more that they take from welfare systems which they poorly understand or are unqualified to access.

Trans-border movements are in fact widespread. Little was hitherto known about cross-border and diaspora tourists, much beyond a handful of studies of Mexicans (e.g., Horton, 2013), and despite countries often targeting diaspora populations (Ormond, 2013b), but this collection has provided a more appropriate global dimension. Libya and Afghanistan have been sources of medical travellers over the past five years, and similar inadequately described 'tourists' will cross amenable borders – for example between Papua New Guinea and Australia, the Comoros and Mayotte, or Rwanda and Burundi. In many contexts some people are marginalised by economics, distance and culture in their home country (Bochaton, 2015; Kangas, 2002). Many medical travellers cross sub-Saharan Africa borders into South Africa (Crush and Chikanda, 2015), Laotians – and Burmese – routinely cross into Thailand (Bochaton, 2015) and Indonesians cross into Singapore and Malaysia (Ormond, 2015). These and many similar movements are local and regional, centred on needs rather than wants, of the relatively poor, desperate and frustrated, with family support and loans, and through word of mouth rather than internet connections. These movements have nothing to do with tourism, and are far from the images of global trajectories in search of expensive and indulgent cosmetic surgery. Taxi drivers play key roles in patient advocacy, triage, translation and general advice on facilities – a far cry from the formal procedures that countries have sought to convey and attract business (Ormond, 2013a). Other than in South Africa, almost all such mobility is undocumented, and the travellers are clandestine and statistically invisible. But, above all, they are numerous. Critically, in this way, the bulk of 'medical tourism' is south–south rather than north-south.

A substantial part of medical travel is of diaspora patients returning 'home' to familiar (and usually cheaper) circumstances. Like border crossers, little has been written on such travellers, because they are of limited significance to the industry, not easy to distinguish and even harder to document. Yet the return migration of Indians effectively instigated medical tourism in India. Many patients travel home to familiar cultural and linguistic circumstances, partly because they cannot understand or afford local health care (Lee et al., 2010; Stan, 2015).

Some medical travellers are moving from countries where certain procedures are impossible, even illegal, and so seek to evade laws and regulations, especially related to abortion, infertility and surrogacy, and to avoid absent legal recognition for minority groups such as lesbians (Lozanski, 2015; van Hoof et al., 2015). Such movements constitute 'circumvention tourism,' as patients travel abroad for services that are legal in the destination country but illegal in the patient's home country (Cohen, 2011). Once again such often desperate, last chance, movements to escape moral pressures and 'illegality' are very far from jolly images of tourism.

While more prominent destinations, such as Bumrungrad International Hospital in Thailand, proclaim global sourcing (Connell, 2011), truly global markets are quite uncommon. Many medical travellers are the relatively poor – street hawkers and small farmers – crossing local borders, having been medically, bureaucratically or financially disenfranchised in their home countries, again so different from the formal promotional literature (Ormond and Sulianti, 2014). Even cosmetic surgery travellers may not be wealthy but have modest incomes and are price sensitive (Holliday et al., 2015). Culture, cost and quality are important for every medical traveller.

While 'without the internet medical tourism would probably not exist in its present form' (Holliday et al., 2015), at every scale – but especially around borders and in the diaspora – word of mouth is of crucial importance (Bochaton, 2015; Hanefeld et al., 2015; van Hoof et al., 2015). Personal experiences and recommendations are vastly more important than either formal accreditation, which has no meaning to most potential patients, or the most elegant and costly internet advertising. The main influence on the majority of medical tourists at Bumrungrad International Hospital (Thailand), in hospitals in Kuala Lumpur (Malaysia) and in dental surgeries in Phuket (Thailand) is advice and referrals from friends and family (Connell, 2011; Ormond, 2013a; Knox, 2014). That also suggests that international medical travel is small-scale enough to be a highly personal experience, where family ties and social networks are important. Likewise most medical tourism companies – essentially specialized travel agents – are small (focussing on a few procedures and a few destinations, even a single hospital in one country) and they too rely on word of mouth – often by organizing group get-togethers where potential tourists meet past tourists (Connell, 2011).

3. Capitalism and complexity

The growth in transnational health care exemplifies an industry that is increasingly privatized, competitive and consumer-oriented. The basic economic rationale for entry into the industry is evident: earnings from incoming patients are greater than from domestic patients, especially in countries with strong national health systems, such the UK, Costa Rica and Israel, hence the drive for new markets, and the challenges this presents to sometimes staid public sectors unfamiliar with competition and entrepreneurship (Lunt et al., 2015). Nonetheless, national and institutional interest in economic development and diversification has instigated both 'strategic'

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