Reducing the scale? From global images to border crossings in medical tourism

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Abstract *International medical travel has increased in the last 20 years, becoming more diverse and complex, although definitions and data on its growth and structure are inadequate. Many countries, especially in the Global South, have sought to develop medical tourism for both strategic and defensive reasons. Few have been successful. Standard descriptions and images of medical tourism suggest global markets, elite patient travellers and the dominance of cosmetic surgery, alongside the privatization and corporatization of hospital chains. Most international medical travel is, however, short-distance, diasporic, across adjacent and nearby borders, and of relatively poor patients seeking cheaper, more effective or available care in appropriate cultural contexts, for straightforward procedures. Social networks, rather than the internet, shape choices and decisions on destinations. Porous international borders are crucial to medical travel and have resulted in the emergence of formal trans-border health regions in the North and spontaneous informal regions in the South, alongside some regional hubs and hierarchies. Globalization is less significant than the grassroots transnationalism of borderland health care.*

Keywords BORDERS, COMPETITION, DATA, MEDICAL TOURISM, REGIONS, TRAVEL

Introduction: 'a room with a view and a root canal, please'

The introductory sub-title, an Australian national newspaper headline (*Sydney Morning Herald*, 5 April 2013), emphasizes that medical tourism remains unusual: an improbable combination of pleasure and pain, and recourse to distant solutions, despite supposed conservativism and immobility in the face of ill health. This article provides an overview of the growing complexity of transnational mobility for healthcare, and seeks to move from image towards reality, first, by providing an overview of recent trends in medical tourism and travel, despite problems associated with flawed definitions and data. Second, it contextualizes this by examining how medical travel is promoted as a global phenomenon, and a creative means of economic development, but in practice is primarily regional; hence, globalization is something of a misnomer. Third, it examines the extent to which cross-border regions have emerged from

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globalization as borders become more porous for trade, investment, and mobility, and with a mix of formal and informal relationships characterizing informal regions (Chen 2009; Nadalutti 2015). It thus traces the changing relations between healthcare markets and varied forms of entrepreneurialism in diverse regions, and consequently challenges standard, established perceptions of medical tourism, to point to the increased significance of border crossings, local scales and contexts, and new forms of deterritorialization. Rethinking scale emphasizes how the political, social, economic, and legal structures that govern health systems are more evidently tied to culture and territory.

Medical tourism, as widely understood, developed as countries of the 'Global South' became significant destinations – a process of 'reverse globalization'. From the late 1990s, this marked an early phase of privatization and corporatization, with many Asian hospitals seeking profits, new markets, and new clientele in the wake of the Asian financial crisis. That corresponded with the rise of a new middle class with new demands and an ability to pay for healthcare, especially in Asia, the Gulf, Latin America, and, belatedly, Africa and China. People with minimal health insurance, on long waiting lists for non-priority procedures, or unable readily to access domestic healthcare or particular therapies, welcomed medical tourism. The return of expatriates seeking cheaper care in familiar cultural contexts partly stimulated its growth. A globally aging 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. Waiting lists could be bypassed and there was a growing acceptance that most medical practices, technology, and human resources, certainly in the best hospitals in 'less-developed' countries, were the equivalent of those in developed countries – 'First World care at Third World prices'. Various facets of cosmetic surgery became more desirable, from whitening to bodily reconstruction, notably eyelids in Asia, partly stimulated by new workplace preferences, especially in China. Finally, governments, especially in Asia, anxious to see a modern creative biotech and health industry develop with enhanced visitor numbers, adopted medical tourism (Lee and Tee 2009; Ormond 2013). Medical tourism travel companies brokered travel processes. Medical tourism extended beyond established local social relationships between healthcare providers, doctors, and patients, to places that might be culturally, climatically, and linguistically distinct and unfamiliar.

Medical travel represents a dynamic transnationalization and deterritorialization of healthcare, and a challenge to therapeutic citizenship, in an arena and activity once assumed to be quintessentially local and regional, but now radically transformed through new knowledge, communications, aspirations, affluence, transport, and biotechnology (Ormond 2013). It is part of a wider globalization of healthcare and travel, which involves the mobility of skilled health workers, technology, body parts, pharmaceuticals, diseases, lifestyles, hospital chains, public–private partnerships, and global governance. Medical tourism is uneven because of intense competition, political instability and, like the related tourism industry, is subject to shifts in fashion, finance, flight paths and medical technology as it 'becomes infused with the desires of consumer society' (Edmonds 201: 117). Marketing was linked to a widespread perception that medical tourism was steadily becoming a global phenomenon evident in relatively

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exotic cosmetic surgery (Bookman and Bookman 2007; Reisman 2010). Demands simply for whiteness know few geographical or bodily bounds (Picton 2013; Sumrit 2014) and notions of beauty, nationalism and cosmopolitanism are constantly in flux (Faria 2014). Thus, 'cheap surgical vacations allow quick investments in one's body parts that are then turned into social capital, symbolic capital and even financial gains' (Viladrich and Baron-Faust 2014: 118–19). Medical tourism is a want rather than a need, a rite of passage, an exercise in empowerment and in the discovery of self, and it is distinct from physical notions of 'cure'. It has added one more component to the commodification and globalization of the 'intimate industries', such as beautification, international adoption, retirement, marriage, sex tourism, and sex work. It locates intimate and affective labour in global care chains through multiple, sometimes interlocking, circulating networks (Constable 2009; Deomampo 2013; Dragojlovic 2015; Kim 2015; Sun 2014; Sunanta 2014; Yeates 2009). While reproduction appears a private and intimate affair, it is bound up in national policies (for example towards abortion, adoption, provision of contraception, family sizes and one-child families), in what has been described as a 'global market of commercial fertility' or of 'cross-border reproductive care' (Prasad 2008: 37; see also Inhorn 2011; Payne 2015). Parallel movements, tangential to biomedicine, take 'traditional' healers and their patients across borders, as modern communication technologies increase their global reach (Hampshire and Owusu 2013; Parkin 2014). International mobility becomes more probable and feasible as the privatization of medical care continues, as discontent with public care increases, as cosmetic procedures are marketed, as disposable capital becomes available, as public healthcare in much of the Global South remains inadequate, and as more countries, corporations and hospitals seek to become involved. This broadly conventional perspective of a sophisticated, international industry can now be interrogated.

Holes in the heart: definitions and data

Definitions of medical tourism vary enormously; they may range from wellness to organ transplants, and be linked to duration, volition, who pays, or what is involved. Some procedures, such as stem cell therapies, have sometimes been excluded as having little to do with standard concepts of medical tourism (Bharadwaj 2013). Reproduction is often included, but abortion usually not, while mobility for fertility treatment has been described as 'reproductive exile' (Pennings 2004). Relationships with tourism and leisure, as sources of pleasure and relaxation, may be tenuous or simply absent (Ormond 2015b), yet frequent repetition and industry support, for obvious marketing reasons, ensure that international medical travel remains 'medical tourism'. This article pragmatically includes dental travel. It excludes wellness travel (as without 'medical' significance), transplant surgery, stem cell treatments, maternity, fertility, and surrogacy. In these cases, mobility is at least partly the outcome of individual volition but may result from external constraints and desperation, so becomes 'circumvention tourism' (Cohen 2015), involving reluctant 'accidental tourists' (Sethna and Doull 2012) in 'journeys of hope' (Prasad 2015). This crude but broad definitional boundary

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is problematic, but no workable alternatives have been proposed. What is conventionally regarded as medical tourism is part of a much larger, more complex, and ill-defined whole that is better conceived of as medical travel (Connell 2013a; Ormond 2015a). Nonetheless, since mobile patients (and accompanying friends and family) must travel and stay somewhere, medical travel is intricately linked to the tourism industry (Connell 2011), and widely marketed and advertised as a pleasurable experience (Viladrich and Baron-Faust 2014).

The absence of an accepted definition impedes any assessment of trends in medical travel. Much cross-border travel is unrecorded, and global and national data on medical travel and hospital admissions are usually based on optimistic national and hospital numbers designed to demonstrate success, quality, and rising numbers. Whatever definitions are chosen, numbers are never as great as those offered by the industry, where exaggerated statistics blend into marketing strategies and 'success' stories (Connell 2011, 2013a). Competition discourages accurate data, whether on numbers, market shares, or revenue. For a few countries in the Global South, medical travel ('health service exports') grew substantially from 1997 to 2010, but that growth was otherwise elusive (Lautier 2014; Loh 2014). Moreover, the objectives and outcomes of medical travel, especially in low and middle-income countries, remain 'largely anecdotal rather than statistical' (Chen and Flood 2013: 296). Most studies, especially in the popular media, have centred on dramatic or problematic cosmetic changes (Imison and Schweinsburg 2013), but much medical travel is prosaic and functional, more typically characterized by mundane check-ups, screenings, or simple dental and outpatient procedures. These excite less concern about cultural differences, quality and unusual procedures, and generate less revenue. Similarly, although the broad perception is that medical tourism developed across a range of middle-income developing countries with more developed healthcare systems (notably the Asian 'big four' – India, Thailand, Malaysia and Singapore – and Mexico), multiple forms of medical travel exist.

While the global literature has emphasized travel to 'distant', occasionally exotic, locations, there is growing evidence that most destinations are 'backyards', close to source countries, with relatively few distant 'playgrounds' (Ormond 2008). Movement of relatively affluent patients to global centres, such as London and Berlin, has long been significant and contemporary movements between rich world countries, especially across EU borders, is often facilitated and regulated by state medical organizations (Glinos and Wismar 2013). Rather more impoverished patients have moved across nearby borders, in Asia, Africa, and elsewhere. Albeit in the absence of adequate data, it is suggested here, first, that the numbers of people crossing nearby international borders for healthcare are substantially greater than those travelling to more distant destinations. Second, mobility for healthcare usually has little to do with tourism, and is primarily regional, centred on needs rather than wants, sometimes of the desperate and frustrated, where social networks, familial support and loans may be crucial, and far from dominant images of global trajectories in search of expensive and indulgent cosmetic surgery. With rare exceptions, such regional mobility plays a marginal role in national health industries since the ability to pay is limited and it occurs in small towns and regional centres. Policy makers, entrepreneurs and scholars have neglected the

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benefits, challenges and significance of travel flows that do not conform to a North–South binary (Ormond and Sulianti 2014). However, remarkable lacunae in knowledge still exist, stemming from the immediate problem of definitions, the boosting of numbers and the necessary confidentiality and privacy of patient records.

Patients and procedures

In much the same way as medical travellers are diverse, so too are the procedures. Medical travel is invariably undertaken in search of treatments that are unavailable, too expensive, inadequate, or too delayed in the home country – and in areas that cover almost anything. Motivations are likewise multiple and are usually linked to needs. The demand for relatively rare or complex procedures is more likely to involve distant travel than when more straightforward procedures are unavailable or expensive. The ability to pay is critical. Migrant Koreans returned from New Zealand and Canada for anything from routine health examinations, to dentistry and cosmetic procedures (Lee et al. 2010; Wang and Kwak 2015). Patients formally referred to South Africa from elsewhere in sub-Saharan Africa underwent specialist treatments for cancer, reconstructive surgery, cardiovascular disease, and organ transplants, procedures that are unavailable in their home countries (Crush and Chikanda 2015). Complex tertiary procedures (including paediatrics and cardiovascular surgery) brought patients from the Gulf to the UK (Lunt et al. 2015). Cosmetic surgery took a quarter of medical tourists from the UK to Thailand. However, since a third of those who travelled from Britain stayed in hospital for only a day (Noree et al. 2014), surgery was not the main motive for travel. Nevertheless, even cosmetic surgery patients are highly sensitive to price, for many are living on modest incomes in their home countries and so are priced out of the national elective services (Holliday et al. 2015a).

Much intra-south (and intra-EU) mobility, however, is for routine procedures where basic access (including waiting times) and small cost differentials are important. Straightforward procedures, such as much of dentistry, are more likely to involve nearby cross-border treatment. Lao, Rwandan, and Malaysian border crossers sought various procedures, from road accident injuries and back pain to infectious diseases and problems with complications (Anon. 2013d; Bochaton 2015; Ormond and Sulianti 2014). These are frequent, common and not at all exotic or unusual complaints and conditions, with travel consequential on inadequate infrastructure, skilled practitioners and pharmaceuticals, corruption and inadequate diagnoses. Without formal referrals, and often associated insurance or state subsidy, travel is more localized and of lesser gravity. Consequently, relatively little is known about cross-border (and diaspora) travellers, for their experiences rarely 'filter through medical tourism's broader discursive formation' (Solomon 2011: 109).

Likewise, little is known about how potential medical travellers respond to internet advertising. Advertisements and internet sites promoting medical tourism emphasize competence and sincerity (Guiry 2010; Lunt et al. 2010), whiteness (Connell 2013a; Viladrich and Baron-Faust 2014) and the distinctiveness of place (Holliday et al. 2015b). Even the idea of 'medical tourism' creates assumptions about 'race, nation and

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class, with the emblematic medical tourist a wealthy white Western or East Asian tourist who combines cosmetic surgery with a beach holiday' (Whittaker 2009: 323; Wilson 2010), thus privileging the experience of wealthy Westerners (Ackerman 2010; Horton 2013). Argentina thus advertises itself as 'a proto-European country that offers outstanding natural beauty and exceptional sophistication with top-tier cosmetic medicine' (Viladrich and Baron-Faust 2014: 118). Border crossers and diasporic travellers are of little interest in marketing and discourses of success.

Although 'without the internet medical tourism would probably not exist in its present form' (Holliday et al. 2015a: 301), at every scale, especially around borders and in the diaspora, word of mouth over the quality of care is of crucial importance (Bochaton 2015; Kangas 2007; Ormond 2015a; Stan 2015). Personal experiences and recommendations are more important than formal accreditation, a keystone for the industry but without meaning to most potential patients (Wilson 2010). The main influence on the majority of medical travellers at Bumrungrad International Hospital (Thailand) and in Kuala Lumpur (Malaysia) hospitals was advice and referrals from friends and family (Musa et al. 2012; Veerasoontorn et al. 2011; Yeoh et al. 2013). Word of mouth was the primary means of attracting dental travellers to Phuket, Thailand (Knox 2014). In Oman, more than 70 per cent of medical travellers got their information from friends and a further 19 per cent from family (Al-Hinai et al. 2011). East Asians (Chinese, Japanese and Koreans) preferred recommendations from friends rather than the internet (Yu and Ko 2012), and in a large sample of medical travellers in four different destinations, almost half (45 per cent) learned of opportunities through friends, relatives and colleagues (Alsharif et al. 2010). Patients may travel in small groups for friendship and reassurance (Connell 2011) and social networks facilitate choice of procedure and destination (Bochaton 2015; Hanefeld et al. 2015). Informal studies corroborate such conclusions, emphasizing that, where family ties and trust are important, healthcare is small-scale and a highly personal experience.

Medical travellers: regional and diasporic mobility

Medical tourism is generally associated with about thirty key destinations mostly in Europe, America, and Asia, with rich countries, including the Gulf states, supplying most of the patients. However, considerable health mobility occurs within Europe and, while sometimes formally organized across EU borders, it is rarely actively promoted because of the implications of policy failure. Much mobility is over short distances; Greeks travel to Bulgaria; Finns travel to Estonia. Lithuania's main markets are Belarus and Russia (Muth 2015). Almost all dental travellers in Hungary are from Austria (Österle et al. 2009); dental travellers in Mexico are from the United States. In many countries, people in remote areas are poorly served by medical care and it may be closer, more convenient, and less costly across a nearby border. In Europe, this has resulted in the emergence of 'health regions' spanning international borders, with routine patient mobility across borders, alongside the mobility of health workers and cooperation between hospitals and bureaucracies (Brand et al. 2008; Glinos and Baeten 2014; Glinos and Wismar 2013; Mainil et al. 2012; Volgger et al. 2015). Such regions

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have emerged to take advantage of complementary skills, facilities and needs on different sides of borders, and a general equivalence in standards.

More informal medical travel is often relatively short distance, regional, cross-border and diasporic, so less likely to cross cultural boundaries. Medical travellers cross from Laos to Thailand (Bochaton 2013, 2015), from southern African countries to South Africa (Crush and Chikanda 2015), from Indonesia to Malaysia (Ormond 2015a, 2015b) and, in multiple poorly documented contexts, within asymmetrical border regions. While some of that movement is 'high-end' medical travel from the North to the South to access high quality private care, the majority of medical travel into and between countries of the 'South' is by the 'poor and medically disenfranchised' (Roberts and Scheper-Hughes 2011) seeking basic therapies and drugs unavailable in their home countries. Agreements exist between South Africa and 18 countries in sub-Saharan Africa to formalize cross-border movements (Crush and Chikanda 2015), but most of this mobility is informal.

Regional health mobility is widespread. Although many formal, documented medical travellers in the major Thailand metropolitan hospitals are from the United Arab Emirates and other Gulf states, substantial numbers also come from neighbouring Asian states (Noree et al. 2014). In provincial hospitals, the converse is true. Thus, a 'quarter' of the Lao people living in Thai border towns and villages, from across the socio-economic spectrum, have received treatment in Thai hospitals for a range of procedures, usually after exhausting local options. Affluent Lao people may pay for private care in large metropolitan hospitals, but considerably more of the less affluent ones go to the nearest facility. In some Thai border hospitals the majority of patients actually come from Laos (Bochaton 2013, 2015). Some 19 per cent of medical travellers in India came from neighbouring countries with similar cultures – Bangladesh, Nepal, and Sri Lanka – and 43 per cent were from Afghanistan and the Middle East (IWHTA 2010). Papua New Guineans used cross-border kinship ties to travel (illegally) to Australia across the Torres Strait (Doudy 2013). Libyan and Afghan medical travellers go mainly to Tunisia and Iran respectively. Azerbaijanis, Omanis, and Iraqis, especially from Kurdish areas, travelled to Iran (Jabbari et al. 2014; Noubar et al. 2014). Comorians travel to either Mayotte or Tanzania (Sakoyan 2012). Diverse flows of medical travellers cross from Myanmar into adjoining Mae Sot in Thailand. Singaporeans travel to nearby Johor Bahru in Malaysia (Ormond 2013). Medical travellers from Chile, Bolivia, and Paraguay access nearby regional hospitals in Argentina (Vindrola-Padros 2015). Mongolians travel to China (Snyder et al. 2015), and Maldivians to India and Sri Lanka (Suzana et al. 2015). Many Rwandans travel to Burundi, where the costs are lower (aided by an exchange rate that favours them), and the service is faster and more efficient. Cultural and linguistic differences are trivial and several Burundi hospitals are near the border and thus closer to many Rwandans than the national hospitals. The poorest people from the most densely populated areas have been the main border crossers, mainly for minor ailments (Anon. 2013d). Some 89 per cent of medical travellers in South Africa are from elsewhere in southern Africa. This has nothing to do with any 'surgeon and safari' image, for they take no part in conventional tourist activities other than shopping. In fact, the majority are 'medically disenfranchised' and

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covering their own costs, though a minority are referred and funded by their home governments (Crush and Chikanda 2015). Those who fund themselves stay for an average of only two days, which is indicative of their undertaking basic procedures.

Numbers may be substantial. Reports suggest that 'at least one million Indonesians', including the growing middle class, travel to neighbouring Singapore and Malaysia for medical care (Ormond 2015a, 2015b; Ormond and Sulianti 2014). Distances are minimized. In Borneo, few Indonesians travel beyond the nearby Malaysian provincial capital of Kuching. Taxi drivers play key roles in patient advocacy, triage, translation and general advice on facilities, inside both the Malay and Thai borders (Bochaton 2015; Ormond 2015a), which is very different from the formal procedures that both countries use to attract business. So substantial and frequent is medical travel across the Indonesia–Malaysian border that it 'becomes a feasible way to manage chronic health needs with people commuting on *a routine basis* for treatments, check-ups and refills' (Ormond and Sulianti 2014: 15; italics added). Many such patient-travellers are relatively poor farmers and street hawkers, medically, bureaucratically or financially disenfranchised in their home countries, supported by family, and engaged in a 'political economy of hope' (Petersen and Seear 2011). Other than in South Africa almost all such mobility is undocumented, with the travellers clandestine and invisible.

Informal border health regions have appeared in Asia, Latin America, and Africa as places of dynamic social and spatial practices. Lao border crossers engaged in shopping and timed hospital visits to coincide with market days, while people crossing the border for other reasons, such as small-scale traders, used such mobility to access healthcare facilities (Bochaton 2015; Phadungkiati and Connell 2014). Thai doctors regularly crossed into Laos to cement ties with frequent 'customers' and check up on patients (Bochaton 2013). Without exception, Indonesian patient-travellers across the border in Malaysia 'had been there previously on business, to visit friends and relatives or to shop or engage in other leisure pursuits' (Ormond and Sulianti 2014: 11). Across the Myanmar–Thai border, refugees and labour migrants merge with medical travellers. Through such multiple processes of mobility, within familiar cultural and linguistic settings, distinctive, asymmetrical border regions have emerged, characterized by complex bidirectional flows, cheap accommodation and food outlets, and a flourishing informal economy of care (informal agents, pharmaceutical purchases, accommodation, taxis, and associated trade), with national boundaries increasingly blurred and erased, where states are permissive and regulation weak.

A further significant component of medical travel is of diaspora patients returning to familiar, usually cheaper circumstances. Such travellers have also been poorly documented, being of limited economic significance to the industry and difficult to distinguish from local patients. Relatively wealthy migrants return from New Zealand and Canada to Korea, from other parts of Europe to Romania, and from Spain to Britain. They do so for a number of reasons, including language issues, inadequate or non-existent insurance, a preference for particular cultures of care, affordability, perceived quality, distrust and unfamiliarity with healthcare systems (Horton 2013; La Parra and Mateo 2008; Lee et al. 2010; Migge and Gilmartin 2011; Nielsen et al. 2012; Stan 2015; Thomas 2010; Wang and Kwak 2015). Mexican migrants in the United States,

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especially when close to the border and uninsured, often return to Mexico for medical care, where the key destinations are also close to the border (Brown 2008; Horton and Cole 2011; Martínez 2014). The return migration of Indians effectively instigated medical tourism in India; at least 22 per cent of medical travellers in India are non-resident Indians (NRIs), from many countries, plus second-generation overseas Indians who are not classified as NRIs. Only 10 per cent were of American and European ancestry (IWHTA 2010). The Philippines is said to have 'been dulled by the captive market of overseas Filipino workers … resulting in less attention to other untapped markets' (Anon. 2013h). Cultural and linguistic familiarity, proximity, speed, effectiveness, and cost are all advantages (Collins et al. 2008; Horton and Cole 2011; Martínez-Donate et al. 2014). In India, Mexico, Turkey, and the Philippines, overseas nationals are a significant proportion, perhaps a majority, of medical travellers and that may be true elsewhere (Connell 2011; Glinos et al. 2010).

How far people are willing to travel internationally for medical care is poorly understood, but is a function of location, the gravity of the procedure, cost, income, culture, language, expectations, and experience. Short distances reduce costs and increase familiarity. Preferred destination hierarchies exist, but relatively poor rural patients travel shorter distances across adjacent borders (Bochaton 2015; Kangas 2002). Russians who live in the east go to Asia; those in the west prefer Germany. The elite private Bumrungrad International Hospital (Bangkok) argues that patients are willing to travel for up to seven hours, effectively the flying time from the Gulf, but that is too far and too costly for many, especially when patients go with carers, friends and family (Casey et al. 2012). From the limited available data on international medical travel it is clear that, while hospitals proclaim the market reach of globalization, most travel is across the nearest, sometimes familiar, borders, amid people with broadly similar cultures.

Medical travel under neo-liberalism: the rise of regions

Medical travel provides foreign exchange and employment; earnings from incoming patients are potentially greater than from domestic patients, especially where the public sector dominates healthcare. In addition, partly because of the duration of stay, medical travellers usually spend more than standard tourists. The national and institutional interest that various countries have shown in economic development and diversification has instigated both 'strategic' investment to encourage inward flows of medical travellers and 'defensive' investment to discourage outbound travel and capital flight. Medical travel provision is consumer-oriented and competitive because some procedures do not need to be undertaken, and most are possible in many countries, usually including home ones.

Many countries and hospitals have sought to develop medical tourism, despite the challenges of breaking into a crowded market, where experience is invaluable, and word of mouth vital. Several Asian states, such as Malaysia and Korea, have been vigorous national proponents of the industry, as a modern, strategic growth strategy, with hospitals subsidized through advertising, tax reduction, or infrastructure support

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(Connell 2011). Following apparent Asian successes, innumerable potential global players and improbable claimants have emerged. When Rwanda proposed becoming a 'medical tourism hub' in 2013, it was noted (Anon. 2013a) that the country first

> needs better hospitals, better-trained medical personnel and specialist skills … foreign investors prepared to build and run these new hospitals [but] there is a shortage of doctors, while waiting time for non-urgent treatment is often long. A substantial number of women leave the country just to give birth. The country has little medical training and no pharmaceutical industry. State of the art medical equipment is expensive and requires trained staff to operate it, and there are few of these in the country.

Rwanda acknowledged these problems, indicating that it was initially concerned with defensive investment to stem the outward flow of 'politicians, local officials, army officers and business people' (Anon. 2014f). Cyprus took an early interest, but despite it being a tourist destination with a diasporic population and adjacent to potential European and Middle Eastern markets, that faded. This was because the 'level of investment required in equipment, resources and human resources to turn Cyprus into a regional medical centre' was too high (*Cyprus Mail*, quoted in Anon. 2013e). As in parts of the Caribbean, some countries have geographical and cultural advantages, are adjacent to a large market, have reasonable tourist reputations, political stability, and a significant diaspora population, but lack surplus skilled human resources because out-migration has created shortages (Connell 2010, 2013b). Small states with limited human resources are particularly disadvantaged.

Moreover, some existing players have struggled. India, initially successful because of its diaspora, developed slowly because of problems of language and translation, visas, bureaucracy and negative perceptions of standards. Mexico has sought to overcome perceptions of poor quality care, violence and drug wars (hence the clustering of facilities close to the US border). Like tourism, medical travel is sensitive to political unrest. In Thailand, political turmoil from late 2013 saw a drop in foreign patients in the first quarter of 2014 (Anon. 2014a). Ukraine's aspirations recently dissolved. Indian hospitals lost patients from Iraq and Syria in mid-2014 when increased insurgency resulted in medical travellers being unable to buy plane tickets, the Iraqi government being unable to fund them, and visa restrictions and security concerns preventing Indian doctors from travelling to the region to engage in preliminary consultations (Anon. 2014b). South Korea was badly affected by its MERS outbreak (Youngman 2015).

Success requires an industry, investment, image, identity, and political stability. These are difficult to create in a volatile, competitive context in which some countries are barely known, even in what they perceive as future markets. Some regional hubs have succeeded; Iran has drawn medical travellers from the nearby troubled Islamic world (after initially entering the industry for 'defensive' reasons), as has Tunisia for the Maghreb, while Jordan has targeted the Arab diaspora. Korea, promoting medical travel within a broader tourism policy, has focused on linking cosmetic surgery to wellness tourism and targeting Russia, Mongolia, Kazakhstan and China. Costa Rica

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has sought to be a regional alternative to Mexico. Dubai aspires to turn the tide and be a hub for the Gulf, but high costs have limited success. Saudi Arabia seeks to gain entrance through high quality facilities and staff, and links to religious tourism (Khan and Alam 2014). Sri Lanka, with only a limited modern healthcare system, has successfully targeted patients from the Maldives (Anon. 2014d; Suzana et al. 2015). Thailand has increasingly oriented itself to neighbouring Cambodia, Laos, Myanmar, Vietnam, and Bhutan, where Buddhism is dominant. Bumrungrad Hospital has established a network of 16 referral offices, mainly in Southeast Asia, as part of a 'hub and spoke model' (Pornwasin 2014). Vietnam has begun to draw patients from Cambodia, after Singapore became too expensive (Anon. 2015). Malaysia has focused on its status as an Islamic state to seek Indonesian, Brunei, Bangladesh and Gulf travellers and, as a state with a third of its population Chinese speakers, on a growing Chinese market – a policy of 'strategic cosmopolitanism' (Ormond 2013). One Thai hospital has a floor dedicated exclusively to Burmese patients, a further indication that medical travel is regional, while several Thai hospitals provide halal food. Familiar language and culture underpin and support medical procedures, and emphasize regional relationships, border crossings, and diasporic travel. Potential and existing destinations have thus increasingly targeted nearby regions.

Other countries have sought to develop better national facilities to reduce the numbers leaving for medical care. Even medical travellers have expressed remorse, regret, and resentment that they and their money leave the national system (Ormond 2015b). In Laos, a costly flow to Thailand is officially regarded as fashionable but unpatriotic: citizens should boost the national economy by using local services (Bochaton 2013). Nigeria has long been concerned over such outward migration. 'The Nigeria Tourism Development Corporation claims that about 60,000 Nigerians each year go to Europe, Asia, America and other parts of the world, and that in 2012 Nigeria spent $260 million in India for medical care … [although] neither of these figures can be traced to a reliable source' (Anon. 2013f). Nigeria has considered restrictions on government referrals and sponsorships of public servants, privatization of local hospitals to improve the quality of care, and sharing scarce specialist expertise and facilities with other West African countries. However, two-thirds of Nigerian doctors work overseas (Anon. 2013b, 2014e). Limited human resources are again a constraint. Similar problems pervade Kenya, Zambia, Indonesia, and Mongolia (*Medical Tourism Magazine* 2014; Ormond 2015b; Snyder et al. 2015). In every case, the rationale for improved local care systems has focused on lost revenue rather than concern over health status.

Recognition of significant numbers of medical travellers leaving Kenya and Nigeria for foreign destinations opened up investment opportunities, and increased competition with domestic health services. Turkey is 'the latest country looking to gain entry into the Kenyan outbound medical tourism market' with the Medical Park Hospital Group, a consortium of 19 hospitals in Turkey, orienting to Kenya (quoted in *Medical Tourism Magazine* 2014: 22). By contrast, in Nigeria, an Indian consortium, Manipal Health Enterprise, as its director noted, sought to take 'an international standard of medical service to Nigeria which has been suffering from serious disease outbreaks' (quoted in Anon. 2013g). Other international corporations have similar plans. It has been said that

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'when [the large global chain] IHH considers entering a market, it notes a country's Gini coefficient, a measure of inequality: higher inequality implies wealthier patients willing to pay for treatment' (Anon. 2014c: 56). One of the largest hospital chains, Apollo of India, has sought to move offshore (to build or invest in hospitals in Indonesia, Cambodia and Tanzania) since 'the numbers and profit from inbound medical tourists are offering lower returns than overseas investment' (Anon. 2013c). Two quite different national strategies, alongside those of hospital chains, are indicative of the increasingly complex globalization of healthcare, bidirectional flows of patients and investment, the extent of corporatization, centralization of profits, and orientation towards those who can pay (rather than those in need). Border crossers and basic needs are absent from all such strategies.

The language of contemporary international, corporate healthcare involves public relations prose, aggressive marketing, profitability, business models, and trade fairs. In Asia especially, regional and global networks of hotel chains have grown, with packages linking tourism, airlines, healthcare (Toyota et al. 2013), and 'hospitels'. These hospitals resemble hotels and are designed to represent the global in the local – a 'transnational assemblage' (Whittaker and Chee 2015; Wilson 2010). Healthcare is labour intensive, yet many countries where medical travel has emerged, or is proposed, have existing skilled labour shortages, uneven access to healthcare, and an internal brain drain of skilled health workers. The emergence of two-tier systems raises concerns in several destinations. The increased marketization of healthcare, and the mobility of patients and health workers, have not resolved problems of inadequate and inequitable access to care, but have tended to exacerbate them (Connell 2011, 2013a; Jarman 2014; Vindrola-Padros 2015), further contributing to localized international medical travel in the Global South. The rise of regional strategies, as in Sri Lanka, Thailand, and Malaysia, demonstrates that although medical tourism providers would prefer global sourcing, and a share of the income of the relatively rich, and thus market accordingly, a pragmatic reduction in scale has occurred.

Conclusion: patients without borders?

Inadequate data necessitate somewhat speculative conclusions about medical travel. The entry of new players, and strategic investments, suggest growth, but as is evident in Laos, Indonesia, Rwanda and elsewhere, informal medical travel across immediate borders may be growing faster than long-distance, formal global mobility. While imagery and early literature have emphasized travel to 'distant' locations, exemplified by intercontinental travel for cosmetic surgery, global flows and a North–South trajectory, most destinations are neighbours of source countries. Emerging border health regions are indicative of the extent of medical mobility in Europe (including that of technology and health workers) and of the increasing insignificance, permeability and irrelevance of EU borders. Less well documented border health regions have emerged in Asia, Africa, and Latin America through parallel cross-border medical mobility – a steady transition towards 'patients without borders' (Whittaker et al. 2010), characterizing often remote areas beyond the purview and regulation of states. Thailand,

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Malaysia, Mexico, and India are important destinations, but for localized medical travel as much as the more vaunted, valuable and promoted medical tourism. Most medical travel is banal and functional – routine check-ups and non-critical conditions. For most diaspora travellers and border-crossers travel is too brief and focused for engagement in anything other than routine healthcare, and small-scale commercial transactions, shaped by trust, in what are often culturally familiar places.

The incursions of capitalism and commodification into hitherto personal and intimate experiences, from birth to death, partly suggestive of a materialist, narcissistic entitlement society, appear symptomatic of much of medical tourism, which has both stimulated and responded to such trends, but this is far from the entirety of cross-border travel. Cosmetic surgery of the affluent is only the tip of the iceberg of medical travel. Patient-travellers have moved away from difficult local circumstances (as in Iraq and Syria), absent or inadequate care (Cambodia, Laos and Indonesia), long waiting lists and spiralling costs. Frustrations with local healthcare have created new, increasingly distinctive, border regions. Medical travel has reinforced privatization, inequality and the ability to pay, alongside technological and political perspectives on the health system where medical services can be bought from the lowest cost provider, rather than wellbeing created by remedying the social, political and economic determinants of health. Medical travel is unlikely to be a panacea for any state, for either health or economic development, and may distort national healthcare systems and provoke dissent, but there has been inadequate empirical analysis of this. It is one more marker of the demise of locality and the 'family doctor'.

Political instability and fragile failed states unable to deliver services adequately, ensure there will always be sources, but impecunious travellers attract little interest in the industry where ability to pay and stay is welcomed. With fewer countries able to meet the basic health needs of their people, South–South 'intra-regional medical travel is ever-more banal' (Ormond and Sulianti 2014: 15), and it is becoming increasingly more visible. Multiple local border crossings rather than globalization characterize medical travel, in asymmetrical and unregulated African and Asian border regions, unlike their more regulated, symmetrical European counterparts.

Medical travel generally, and border crossings in particular, emphasize how the political economy of healthcare is no longer tied to territory, especially in the Global South, but takes advantage of porous, fluid borders. Patients of even minimal means are not necessarily limited by place or policy; the contemporary promotion and analysis of medical tourism privileges elite mobility, while more prosaic medical travel is ignored because of the industry's preference for high-spending and high prestige customers whom marketing can target. Countries, regions, hospital chains, and insurance companies have been drawn into medical tourism, seeing it as part of a modern, creative city strategy and a means of developing an unusual economic niche. While such global themes remain fashionable, localized regional cross-border movements demonstrate a more expansive bottom-up transnationalism, the unheralded, ignored but widespread core of a still poorly documented international medical travel that has emerged without state promotion, and where fillings are more important than root canals or views. It does not concern tourism and is not global; it relies on social

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networks and word of mouth rather than on the internet or advertising; it focuses on needs not wants, and has created new socio-economic border landscapes, shaped and reshaped by diverse transnational flows.

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