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MEDICAL TRAVEL/TOURISM
AND THE CITY

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Introduction

Around the turn of the millennium, a new term captured the popular media’s imagination: ‘medical tourism’. It denoted a novel healthcare-seeking behaviour: patients from high-income countries purposefully travelling to hospitals and clinics in low- and middle-income countries, such as India, Thailand or Costa Rica, for all kinds of medical interventions (e.g., cardiology treatments, standard joint replacements, experimental stem cell therapies, (illicit) organ transplantations, fertility interventions and surrogacy, cancer care and plastic surgery). Medical tourism fascinated and today continues to fascinate, because it challenges conventional notions about how healthcare is delivered and received. First, it seemed to suggest that the pain and suffering leading up to, during and after medical intervention can be compensated for, or at least somewhat lessened, by pleasurable and exotic vistas and atmospheres. Second, the flows and geographical connections the term invokes seemed to reflect an entirely new global order relative to the location and concentration of expertise in medical care. In both mediatic portrayals and destination advertising, the ‘typical medical tourist’, as a result, has been portrayed as a savvy patient-consumer in the Global North, pushed overseas by dysfunctional local healthcare, accessing luxury medical facilities and receiving patient-centric, compassionate care in the Global South (Ormond and Sothern 2012).

However, while many media accounts celebrate medical tourism as a neat confluence of medical care and leisure (see, for example, Appleby and Schmit 2006; Economist 2007; Bernasek 2015), those travelling abroad for treatment generally do not perceive themselves as ‘tourists’ in the conventional sense (Inhorn and Patrizio 2009). The inadequate descriptor underplays the seriousness of their conditions and the ‘medical disenfranchisement’ (Roberts and Scheper-Hughes 2011) and hardships they have frequently encountered in their healthcare-motivated journeys. This has prompted many scholars to instead describe the phenomenon as ‘international medical travel’, ‘cross-border patient mobility’ or ‘transnational healthcare’ practices (Kangas 2002; Ormond 2014; Connell 2015). Indeed, as much recent research has flagged, the origins of people travelling abroad for medical care are much more diverse, and the needs and practices of such travellers are more mundane, frugal and essential than what is commonly depicted in media accounts (Kangas 2002; Bochaton and Lefebvre 2008; Baujard 2012; Ormond 2013, 2015b; Yeoh et al. 2013; Bochaton 2015; Crush and Chikanda 2015; Kaspar and Reddy 2017). However, in spite of its potentially dismissive undertones, the term ‘medical tourism’ has acquired significant currency in destinations’ policies in order to denote, reify and even cultivate a specific type of healthcare- and hospitality-consuming subject, one with few
legal entitlements beyond those of a regular consumer in the countries in which they are pursuing care (Ormond 2014). Thus, in this chapter, we use the term ‘medical travel/tourism’ to capture the social, political and economic tensions both constitutive of and resulting from transnational health-care practices. This enables us to engage in a more nuanced way with some of the intricate, and often ambivalent, ways in which transnational medical travel/tourism practices, policies and materialities interweave with local and global places and circuits.

Two desires interlock to form the medical travel/tourism industry (Müller and Schurr 2016; Kaspar and Reddy 2017): the powerful desire for health, fuelled by unmet needs for diagnostics, therapies and palliative care, on the one hand, and the zealous desire to diagnose, treat and heal (increasingly for profit), on the other. Much of the world’s population continues to have limited nearby access to even primary healthcare, let alone secondary, tertiary and quaternary care facilities, equipment and expertise. Even those fortunate enough to live in proximity to high-quality health-care resources cannot necessarily access them owing to prohibitive costs, long waiting lists and legal restrictions (Connell 2006, p. 1094; Inhorn and Patrizio 2009; Amodeo 2010, p. 66; Bergmann 2011). Thus the (perceived) inadequacy of local healthcare is a key driver for people travelling sometimes very long distances to fulfil their care needs (Cohen, J. 2006). Hence, medical travel/tourism predominantly entails the pursuit of advanced medical care in places outside of travellers’ habitual places of residence. Another key driver is the increasing (re-)articulation of healthcare as a profitable business—the effort put into the promotion of healthcare services is unprecedented in human history (Whittaker 2008). Around the globe, an increasing number of private and corporate

![Medical tourism advertisement with testimonials, Kuala Lumpur International Airport, Malaysia. Source: Meghann Ormond, 2013.](image-url)
healthcare facilities—from diagnostic centres, clinics and multi-speciality hospitals to full-fledged ‘medicities’—are competing locally and often globally for patient-consumers (see Figure 10.1).

The most persistent manifestations of the ways in which these two desires interlock can be witnessed in a growing number of private hospitals and clinics and the urban areas in which they are concentrated around the globe. Owing to their high densities of people, infrastructure and diverse economic functions, cities are widely recognised sites within which tertiary and quaternary medical care concentrate. Thus, given their centrality within regional networks, cities have long served as regional medical hubs for populations in their national hinterlands (Fitch et al. 2003; Hegney et al. 2005; McGrath and Holewa 2012). There is, hence, a historicity to cities as healthcare hubs that currently is being taken to the global level. Metropolitan areas provide effects of centrality on which a growing number of private healthcare entrepreneurs are prepared to capitalise. With infrastructure enabling easy access and a heterogeneous population that hospitals can tap into for anything from world-class medical expertise to (cheap) unskilled labour on which hospitals and clinics rely, cities come to serve as ‘organizational commodities’ (Sassen 2005, p. 39; see also Sassen 2002) facilitating—and constituting ever more relevant nodes in—the globalisation of healthcare. At the same time, however, hospitals and clinics in urban centres are constituted—nourished—by innumerable distant occasions on which the two desires to receive and provide private healthcare intersect, forging and sustaining connections that mobilise people to travel long distances for care. Consider, for instance, a meeting between a caring family member and a healthcare broker in a patient’s source country or a team of medical specialists visiting a city of a target ‘market’ offering free screenings and advice for promotional purposes.

**Understanding Cities through Their Relations**

In this chapter, we deploy a relational approach to understand the intertwinings of the urban with transnational healthcare. Relational geographies are not a coherent concept (hence the plural), but rather an assembly of different, sometimes contradictory analytical tools (Jacobs 2012). All relational thinking, though, understands places as constituted through dynamic relations with other places across space and time, rather than as isolated, autonomous entities (Massey 2011). Cities thus are built through their relations with other places, past, present and future—through social and cultural heritages, policies and infrastructures, and utopian and dystopian imaginaries—as well as with places physically and virtually near and far (see Collier 2011; Temenos and McCann 2012; Whittaker et al. 2017).

Beyond the basic principle of connectedness, ontologies and foci differ. This can be observed most patently in accounts of cities as assemblages. Beyond thinking about cities as coherent nodes in scalar networks—such as in the global city approach (Sassen 2005)—an actor-network ontology (Mol and Law 1994; Latour 2007) can be used to understand cities as ever shifting assemblages of heterogeneous elements and the relations between them. This conceptualisation shifts attention from focus on connections and flows between places (e.g., cities, hospitals, etc.) to focus on the spatio-temporal processes of assembling and disassembling human and non-human, material and immaterial entities (Andrews et al. 2013; Pordié 2013). Furthermore, it draws our attention to how ‘individual things connect, partially connect or fail to connect to form nets or webs of activity, and . . . how these things change through their connection’ (Fenwick and Edwards 2010, p. 146). Rather than taking cities for granted as cohesive entities altered by flows (e.g., of migrants and financial capital), assemblage thinking shifts the perspective to the dynamics of urban formation and far more radically problematises the human and non-human relations that, through ongoing assembly and disassembly, constitute ‘a city’. Accordingly, ideas, technologies, policies and infrastructures are not instrumental objects but themselves agents (Jacobs 2012). Since the entanglement and disentanglement of agents
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is constantly in flux, urban assemblages are thus ‘never fixed or stable, but always in a process of making or unmaking’ (Jacobs 2012, p. 416).

For this chapter, we draw on assemblage thinking in order to examine how transnationally mobile bodies, ideas and capital simultaneously articulate and get articulated through medical travel/tourism policies and practices and diverse urban assemblages around the world that have (or are pegged to) become destinations for such practices. In the subsequent sections we follow Pordié’s (2013) call to attend to the formation of places through the transnational circulations that accompany medical travel/tourism. We discuss the ways in which three significant types of transnationally mobile agents—patients; information, standards and social norms; and the financial capital undergirding privatised healthcare consumption—assemble in and through medical travel/tourism and articulate themselves in unique forms in and through urban assemblages around the world.

**Mobilities Constituting Medical Travel/Tourism:**
**Bodies, Standards and Capital**

**Patients on the Move**

Medical travel/tourism entails creating new relations. Often, long before a patient reaches a medical travel destination, s/he establishes connections to things and people associated with the destination. Usually, this is an incremental process: connections grow in number, intensity and commitment, constituting increasing entanglement. This usually is accompanied by a change in emotions attached to these connections, with emotions like hope and aspiration constituting bindings in their own right. However, crossing national borders for medical treatment also entails dissociations that might start even before re-associating with distant places. Ormond and Sothern (2012) describe in their analysis of medical travel guide books how readers are invited to come to see their domestic healthcare systems as dysfunctional. Likewise, Inhorn and Patrizio (2009) state that so-called reproductive tourists go abroad because they come to see their domestic healthcare systems as ignoring or neglecting their health needs, turning them into ‘medical refugees’. Repulsion by domestic healthcare results in an emotional and subsequently practical dissociation from it.

The reasons and circumstances that lead to dissociation and re-association vary greatly. Healthcare-based travel is undertaken by people with tremendously heterogeneous medical conditions and concerns with diverse levels of financial, political and social capital, local healthcare conditions and navigational savvy. Accordingly, there is no singular ‘medical tourist’ or ‘transnational medical traveller’. While ‘medical tourists’ travelling from the Global North to destinations in the Global South initially received the bulk of scholarly attention, there is increasing evidence that the majority of people crossing national borders for healthcare do so from within the Global South, and a large part of such travel is actually short-distance cross-border travel (Connell 2016), for example from Laos to Thailand (Bochaton 2015), from Bangladesh to India (Shanmugam 2013), from southern African countries to South Africa (Crush and Chikanda 2015) or from Indonesia to Malaysia (Ormond 2013, 2015b; Whittaker et al. 2017). Additionally, a large proportion of patients originally from the Global North receiving care in Asian destinations are not travellers but, rather, expatriates already living in the region (Cohen, E.C.E. 2008; NaRanong and NaRanong 2011). Because internationally standardised definitions and recording and reporting practices are lacking, existing estimates of medical travel/tourism are partial at best. Estimates of the numbers, origins and economic impacts of medical tourists/travellers often obscure important nuances of the phenomenon, for example by indiscriminately lumping both resident and non-resident foreign patients together as ‘medical tourists’, by selectively including foreign patients at certain hospitals and clinics and excluding those making use of other facilities, or by counting discrete contact moments with patients instead of
individual patients themselves (Ormond 2014). Industry-specific accounting practices thus artificially inflate and homogenise medical travel/tourism figures to such an extent that they reflect national and commercial ambitions more than any sort of on-the-ground reality, thus complicating attempts to assess medical travel/tourism’s impacts on economies, healthcare resources and travel infrastructure (Crooks et al. 2017).

While some transnational medical travellers may be wealthy, a large number come from lower- and middle-income backgrounds, perhaps having sold off their possessions, borrowed heavily or relied on the charitable support of a non-profit organisation or national government to cover the costs of their travel and treatment (Kangas 2002; Bochaton 2015; Kaspar and Reddy 2017; Ormond and Sulianti 2017). Medical disenfranchisement in combination with financial and political challenges may lead to the delay of necessary journeys to access healthcare until people’s conditions become advanced and/or acute. Medical travel is not always an isolated event; it often comprises a multi-directional, multi-sited and not necessarily linear series of journeys over time, successively stretching to ever more distant destinations and back. Thus transnational medical travellers sometimes may reach their destinations with complicated, delayed and poorly managed, or un- or ill-diagnosed conditions (Ormond 2013; Kaspar and Reddy 2017). It is not uncommon that repeated trips and/or prolonged stays are required, posing additional organisational and financial challenges as well as difficult-to-predict outcomes.

In contrast with the promotional gloss surrounding medical tourism, everyday transnational medical travel flows are often reluctant in nature. As Exworthy and Peckham (2006, p. 275) have shown, willingness to travel for medical care is conditioned ‘not simply [by] travel distance but [also by] travel time, costs, social dislocation and spatial perceptions’. Travel for medical care is not easily or lightly undertaken within one’s own country. Thus, when international borders are involved, the need to navigate additional legal, regulatory, cultural and linguistic diversity adds to the already existing ‘inconvenience and practical hardship, disruption to everyday family and work routines and demands, isolation and lack of social and practical support . . . waiting, dependency on others and the general strains of travel and unfamiliarity’ (Ormond 2015a, p. 288) that characterise domestic medical travel.

In light of such emotionally charged and organisationally complex situations, patients frequently travel with one or several companions who function as informal caregivers. Companions are usually close family members or sometimes friends, neighbours and more distant relatives. Casey et al. (2013) state that, besides increasing the workload of hospital staff, the presence of companions can have a negative impact on patients. According to our own empirical research, however, companions are instrumental in myriad organisational and emotional tasks before, during and after the journey (e.g., choosing destinations, handling travel arrangements, advocating for patients and making treatment decisions with administrators and doctors, and attending to the nitty-gritty of navigating a foreign city and healthcare system). Additionally, family members and friends who have stayed behind in patients’ places of residence are involved in the endeavour of medical travel. They might offer their emotional and financial support from a distance and demand to be kept in the loop of how things go or to be involved in decision-making. They might also double-check with domestic doctors and continue gathering information from experienced medical travellers on upcoming issues while relatives or friends are abroad. This implies that medical travellers’ and their companions’ disentanglement from domestic healthcare often is not a complete dissociation, but rather a partial, temporary one (Ormond 2015b). Similarly, re-association with domestic healthcare upon return for aftercare can be fraught (Snyder et al. 2012). For example, in the case of complications, doctors in the domestic healthcare system might deny aftercare (Jagyasi 2014). It is, hence, essential to look beyond transnational patients themselves and consider the implications of travel on the broader care assemblages in which they are embedded not only abroad but also at home (Bochaton 2015; Whitmore et al. 2015).
**Circulating Information, Professional Standards and Social Norms**

While patients are the most obvious transnationally mobile agents in medical travel/tourism, numerous intangible entities also circulate, with their own lingerings and detours, such as: information about overseas healthcare facilities; medical, care and hospitality standards; and social norms and trends, generating new desires and needs.

Information on the availability, quality, costs and so on of medical diagnostics and therapies in medical travel/tourism destinations reaches distant places and creates new hopes and opportunities for people looking for medical care through commercial channels, whether in print (Crooks et al. 2011), on the internet (Cormany and Baloglu 2011; Horsfall et al. 2013; Holliday et al. 2015; Moghavvemi et al. 2017) or via personal social networks (Yeoh et al. 2013; Bochaton 2015), on-site brokers, information booths and local offices (Ormond and Sulianti 2017). Medical travellers’ personal accounts of their transformative experiences are especially effective in mobilising others’ travel to specific doctors, clinics, hospitals, cities and even countries considered to be sites of medical repute (Kangas 2002; Kaspar and Reddy 2017). Local communities witness medical travellers’ bodies—ailing upon departure—return healed or healing. A doctor’s business card then switches hands between trusted persons in those communities. Former patients or accompanying caregivers may even return home so enthusiastic that they evangelically spread the word about doctors and medical facilities abroad and may end up professionalising as medical travel/tourism brokers and facilitators. Stories, bodies and business cards circulate through medical travel/tourism destinations and patients’ places of residence in ways that transform listeners’, observers’ and recipients’ understandings of health, diseases and treatments. This generates new desires and new geographies. With respect to new desires, learning about existing treatments elsewhere can transform the mentality of a subject in poor health from one of surrender to one of hope. With respect to new geographies, learning about existing treatments elsewhere can transform people’s images of places. For example, Maggi Grace (2007) describes in her autobiography the journey with her partner from the USA to India for him to undergo life-saving heart surgery. The story tells, among other things, about the transformation of her understanding of India as a site of classical development deficiencies (e.g., lack of hygiene, safety and predictability) to a site of world-class medicine.

On top of new desires and geographies, medical travel/tourism also creates new affiliations and networks that form communities consolidating around a certain biological or health condition, a formation Paul Rabinow (2005) terms ‘biosocialities’. In Uzbekistan, for example, biosocial communities have emerged around veteran and prospective medical travellers to India. Through their use of social media, they organisationally, emotionally and financially support members’ pursuits of medical care abroad. Hospitals and medical travel agents try to capitalise on the relating work of medical travellers’ word-of-mouth ‘advertising’ by multiplying positive accounts. Some medical tourism companies even go as far as inventing patient testimonials (Patra and Sleebom-Faulkner 2011). This variety of actors and activities reflects the range of stakes—blurring altruism with profit—that drive the circulation of information on medical travel/tourism.

Formal ‘international’ standards in medical care—such as Joint Commission International (JCI) accreditation (Bagadia 2010) or trends in hospital architecture (Bochaton and Lefebvre 2008; Cohen, L. 2011)—are adopted by hospitals promoting medical tourism around the globe ‘to confirm membership of international knowledge communities’ (Larner and Le Heron 2004, p. 216; Ormond 2013, pp. 53–57). Founded in 1994 by the Joint Commission, an independent, not-for-profit organisation widely recognised for accrediting ‘nearly 21,000 healthcare organizations and programs in the United States’ (Joint Commission n.d., emphasis added), JCI frames itself as ‘the gold standard in global health care’ (Joint Commission International n.d.). Its 20% annual growth in accredited organisations (Joint Commission International n.d.) speaks to the transcendence to which many hospitals aspire by being able to demonstrate their compliance with ‘Western’ medical safety and quality standards.
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This can further be seen in how some hospitals establish joint initiatives with prestigious North American medical institutions (e.g., the Johns Hopkins Singapore International Medical Center), while others contract advisory services from their international subsidiaries in areas like strategic planning, infrastructure, facilities and systems planning, quality management and professional development (e.g., Partners Harvard Medical International’s involvement in Dubai Healthcare City and India’s Wockhardt Hospitals) in order to meet JCI accreditation requirements. Such partnerships foster medical research and consultation practices that facilitate knowledge transfer between transnationally networked hospitals in ways that spatially and socially re-order healthcare provision (Cartwright 2000).

A certain design vocabulary or set of medical facility standards like those of JCI can be understood as ‘global forms’ (Ong and Collier 2005). Global forms are elements with the ability to dissociate from a context (de-territorialise) and travel to another context, where they re-associate (re-territorialise) (Ong and Collier 2005). This does necessarily mean, however, that global forms unidirectionally ‘happen to’ places. Massey (2011, p. 8) warned about the risk of over-emphasising the formation of places through global forms, of viewing places as ‘victims of globalisation’ (original emphasis), deprived of agency. Rather, she argues that relations with the wider world are two-way. Globalisation is not always an external force, arriving from somewhere else. Logically, anyway, this is impossible. For globalisation is made in places. As there is the global production of the local, there is also the local production of the global.

Global forms such as medical standards have to dissociate from their local site of production (i.e., de-territorialise) and then re-associate with another site of production (i.e., re-territorialise) in order to travel (Ong and Collier 2005). Therefore, internationally standardised medical care in Cleveland will differ from that in Delhi.

Health and beauty standards and norms also circulate, driving a growing number of medical travellers abroad for plastic surgery. Subjecting our bodies to greater scrutiny and seeing them as malleable sites of medical intervention more than ever before (Connell 2011; Mazzaschi 2011), ‘aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems’ (Clarke et al. 2003, p. 161). Physical beauty constitutes a key site of medicalisation, with growing numbers of people around the world opting for ever more invasive procedures like face-lifts, nose jobs, gastric banding, breast augmentation, liposuction and so on in order to correct and improve on their bodies. And, while beauty norms differ across time and space, trends have increasingly circulated globally as a result of media and travel—hence Holliday et al.’s (2015) notion of ‘beautyscapes’. As a result, a number of countries—like Brazil, South Africa, South Korea and the USA—have gained renown for their plastic surgery expertise, attracting medical travellers from both near and far.

Take, for instance, South Korea. With an estimated 20% of its population having undergone some form of plastic surgery, South Korea is home to the world’s highest proportion of such procedures per capita (Marx 2015). Given the great socio-economic relevance of beauty for both women and men in contemporary South Korean society, the national beauty industry is thriving. With ‘K Wave’ pop culture, Korean aesthetics have travelled globally, significantly impacting South Korea’s destination image no longer only as a site of ‘technical advancement and modern style’ but also as home to the beautiful people and places depicted in its widely exported television dramas and music (Holliday and Elfving-Hwang 2012). Korean ‘big business’ and governmental bodies’ efforts to ‘transform Korean wave fans into consumers of Korean products and services’ (Kim 2007, pp. 52–53) have boosted leisure tourism to the country in recent years. They are also using the ‘K Wave’ to promote South Korea as a medical tourism destination specialising in plastic surgery. This is especially
visible in Seoul’s upmarket Gangnam district, home to just over one-half (792) of all of the hospitals and clinics in the capital city officially involved in medical tourism, where some 400–500 cosmetic surgery clinics are now thought to be concentrated within a single square mile inside the district (Marx 2015; Seoul Metropolitan Government 2016) (see Figure 10.2). The significance of this is not lost on the municipal government, which has begun to collaborate with the Korea Health Industry Development Institute (KHIDI) and the Ministry of Health and Welfare to manage the ways and spaces in which medical tourism manifests itself within Seoul by establishing and monitoring standards and reviewing and selecting medical facilities (e.g., hospitals and clinics) and tourism service providers (e.g., accommodation, shopping, leisure, and medical travel brokers) deemed capable of attracting and accommodating foreign patients.

**Liberalised Flows of Capital**

The World Trade Organization’s 1995 General Agreement on Trade in Services (GATS) opened the floodgates to neoliberal policies that, according to Hopkins et al. (2010, p. 193), ‘expanded space for privatised healthcare market growth in much of the world’ by enabling foreign direct investment (FDI) in signatories’ health systems and by fostering the economic and political conditions for medical tourism to grow. In light of this, and buoyed by a raft of supranational and national neoliberal reforms already (re-)articulating healthcare as a profitable business in the 1980s and 1990s (Chee 2007; Whittaker 2008; Ormond 2013), numerous hospitals and clinics in the Global South have

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**Figure 10.2** Cosmetic surgery advertisement and clinics in the Gangnam district of Seoul, South Korea.

expanded their reach beyond national borders, both by spurring competition between countries, regions, cities and hospitals for ‘medical tourists’ and by forging major multinational medical conglomerates (e.g., IHH Healthcare Bhd’s Parkway Pantai, Acibadem and Apollo holdings) from the late 1990s onwards (Ormond et al. 2014).

Many national governments—officially recognising medical tourism as a driver for economic growth in the health and tourism sectors, capable of reviving and diversifying national economies, but also as having the potential to sustain and boost their populations’ access to advanced medical care, subsidising hospital infrastructure and medical expertise (Chee 2007; Whittaker 2008, p. 275; Ormond 2013; Supakankunti 2014; Ormond and Mainil 2015)—have assumed a pro-active role in the development of medical tourism (e.g., Singapore, the emirate of Dubai, Malaysia, India and South Korea). They attempt to harness and anchor flows of global capital via, among other measures: relaxing regulations regarding immigration entry requirements and medical advertising; enabling hospitals to be owned by foreigners, to make profits and to benefit from tax exemptions throughout a country or in designated special economic zones (SEZs); adapting accreditation standards; and allocating greater resources for medical training and attracting and retaining nurses and medical specialists (Ormond and Mainil 2015).

**Urban Manifestations**

Common facilitators of globalisation such as the increased affordability and ease of engaging in international travel and the increased availability of information via the internet have greatly increased healthcare providers’ potential to attract distant patients. Since the liberalisation of international trade has not spared health services, medical travel/tourism patterns have significantly diversified and—while exact figures are contested—the volume of foreign patients has undeniably grown in many places (Connell 2011). While scholars have attended to national-level impacts of medical travel/tourism practices and policies (Pocock and Phua 2011; Johnston et al. 2015), however, and despite the relevance of cities as medical travel/tourism destinations, little consideration has been given to how such practices manifest themselves at the urban level. In the following sub-sections, we examine some of the key ways in which medical travel/tourism practices manifest themselves within cities. The described manifestations reveal that, while medical travel/tourism ‘plugs into the city’ and uses its amenities, infrastructures and resources, it also adds new elements to the urban fabric that reverberate beyond the realm of healthcare. In sum, medical travel/tourism to the city prompts the urban to re-assemble in multifarious ways.

**The Hospital in and beyond the City**

Hospitals and clinics that serve as medical travel/tourism destinations entertain an ambivalent relation to the cities in which they are physically located through a set of entangling and disentangling strategies. Many are fostered within the scope of urban and/or national development projects, and thus benefit from a range of financial, infrastructural and regulatory conveniences (Smerdon 2008, p. 23; Reddy and Qadeer 2010, p. 70)—several of which were enumerated at the end of the previous section. Furthermore, in making use of nearby hospitality and transport infrastructure and a pool of available skilled and unskilled labour, they directly depend on and benefit from the broader urban assemblage in which they are embedded. At the same time, however, these facilities deliberately disentangle and differentiate themselves from their immediate surroundings. Their architecture may evoke a consumerist, cosmopolitan atmosphere through a generic—if luxurious—design vocabulary borrowed from the hotel industry (Whittaker and Chee 2015) (Figure 10.3). Similarly to the ‘non-places’ evoked by Augé (2008), these hospitals may attempt to evoke an atmosphere of being ‘anywhere but here’ (Cohen, L. 2011; Solomon 2011) in an effort to keep specific less desirable elements of their local contexts at bay. L. Cohen (2011, p. 32), for example, describes how ‘five-star’ hospitals located...
in Indian cities attempt to hermetically seal themselves off from the surrounding poverty and ‘racialised, postcolonial Indian landscape’ that are assumed to trouble foreign patient-consumers.

Disentangling from the local context may also involve entangling with what are perceived to be ‘global forms’ (Ong and Collier 2005) of expertise and world-class technology, articulating topological proximity with ‘the West’. Health professionals’ cosmopolitan attributes, such as doctors’ and nurses’ English language proficiency and cultural competence as well as ‘Western’ education and training (Bochaton and Lefebvre 2008; Ormond 2013, 2016), function as valuable currency frequently highlighted in destinations’ official promotional materials and circulated through informal word-of-mouth advertising. Likewise, the presence of brand-name cutting-edge medical technology (e.g., Siemens, General Electric, Phillips, Samsung, etc.) serves as an important marker in the promotion and recognition of hospitals and clinics as worthy destinations (Wilson 2010; Toyota et al. 2013, p. 37; Ormond 2014, p. 428). In James’s (2012, p. 130) study of Bangkok hospitals engaged in medical tourism, one hospital manager interviewed, for instance, suggested that ‘with the new technology it [the hospital] was no longer seen as a Thai hospital but an international hospital in a Thai setting’. Disentangling from the local context is continued in hospitals’ interior spaces, where foreign patient-consumers are invited to dwell in spaces that separate them from domestic patients (e.g., international patient centres, lounges and wards), are cashed out differently, follow expedited procedures to meet doctors and receive test results, and can access an extra service package including language translation, airport pick-up and drop-off, ‘international’ cuisine and so forth (Ormond 2013; Toyota et al. 2013; Whittaker and Chee 2015; Kaspar and Reddy 2017).
**Intersecting and Overlapping Urban Resource Use**

Medical travellers entangle with the urban infrastructure of their destination by using its amenities and resources. This use overlaps with that of conventional short-stay tourists and, significantly, with that of local residents and domestic medical travellers in ways that conventional tourism does not. Since medical tourism destinations are multiplying principally in lower- and middle-income countries, numerous scholars have raised concern about the health equity consequences of efforts to support the development of the private health sector, possibly in lieu of investing in public facilities and services (Sengupta and Nundy 2005; Reddy and Qadeer 2010; Connell 2011). With the proportion of non-resident foreign patients in private hospitals in renowned destinations capable of reaching 40% or more (Ormond 2013; Kaspar and Reddy 2017), it is feared that transnational medical travellers may directly compete for finite hospital and specialist medical resources, drawing skilled health workers from rural to urban areas and from the public sector to undertake possibly better-remunerated private-sector work. Yet, deploying an economy of scale argument, destination governments frequently justify medical tourism on the basis that foreign demand for specific types of medical specialties, facilities and technology may in fact enable and subsidise the existence and use of the same expertise and equipment by local residents (Yap 2007). In addition to competition for unevenly distributed health resources, however, transnational medical travel/tourism also has the potential to generate novel relations, spaces and services specific to the unique needs and demands of travelling patients who are neither ‘tourists’ in the conventional sense nor local residents, leading—as we will see below—to the emergence of care practices and accommodation options that can directly and indirectly draw on, challenge and enrich existing urban resources.

A growing number of cities attracting, or seeking to attract, domestic and transnational medical travellers have been actively re-envisioned and adapted as medical tourism destinations. Take, for instance, the world-renowned Mayo Clinic, which brings some 400,000 patients to the US city of Rochester, Minnesota each year—roughly double the number of residents in Rochester’s metropolitan area (Forbes 2016). Approximately 40% of its patients hail from more than 500 miles away, and some 8.5% travel from more than 140 countries to receive medical care there (Weisman 2015). In light of this constant inflow of short- and long-stay visitors and the Mayo Clinic’s uncharacteristic unwillingness to establish branches in other parts of the world (as, for example, Johns Hopkins did in Singapore or Narayana Health did in the Cayman Islands), Rochester’s municipal government launched a dedicated economic development agency to adapt the city’s hospitality infrastructure to the needs and expectations of patients and their companions visiting the Mayo Clinic. The agency’s existence attests to the significant role of domestic and transnational medical travel/tourism to the city’s economy, given the significant amount of time spent by patients and their companions year round in the Mayo Clinic—one of Rochester’s largest employers—and in the city itself, making use of transport and urban infrastructure, lodging, restaurants, shopping, entertainment and cultural amenities and interacting with local residents (Weisman 2015). Illustrative of how global capital uses cities as ‘organizational commodities’ (Sassen 2005, p. 39), this example highlights how cities—especially small and medium-sized cities—can become highly dependent on a single high-end service industry. Rochester’s future depends on its ability to improve its image and reorganise its offerings in order to satisfactorily reflect (and retain) the ‘world-class’ hospital located within it and meet the needs of what Weisman (2015) has dubbed its ‘reluctant tourists’.

Whereas conventional tourists are unlikely to return to a city after having visited it (Ashworth and Page 2011), transnational medical travellers are more likely to repeatedly visit a destination—especially those satisfying routine care needs and from nearby countries, but not limited to them. This creates a rhythm of repeated association and dissociation of patients and accompanying informal carers with the city. Additionally, a considerable portion of medical travellers stay longer than a couple of days, and some even remain over months. Only a fraction of medical travellers travel
by themselves and stay as inpatients in hospitals; a large part undergo short diagnostic procedures and minimally invasive treatments that do not require hospitalisation. Also, some treatments (e.g., cancer care) require hospitalisation, but are followed by a series of outpatient visits for follow-up care and testing that might stretch over weeks. Diagnosis alone can take several weeks. Therefore, foreign patients and their companions require accommodation close to hospitals and clinics, allowing smooth transfers between where they stay and where they receive treatment. This has led to the growth of lodging alternatives, with the emergence of ‘meditels’ or ‘hospitels’ (Han and Hyun 2014) that combine hotel accommodation with on-site medical and wellness treatments, and hospitals making arrangements with nearby guest houses, hotels and resorts for patients and their companions throughout patients’ treatment and for patients’ post-operative convalescence, as well as short- and long-term rental of private-sector housing used by patients and their companions throughout the period of treatment (Ormond and Sulianti 2017).

A significant, largely informal economy has developed around transnational medical travel/tourism, engaging many small-scale lower- and middle-class entrepreneurs specialising in lodging, transport, linguistic interpretation, brokering and catering (Ormond and Sulianti 2017). In Penang, Malaysia’s most popular medical travel/tourism destination, for example, small, low-key informal guest houses accommodating both short and long stays have existed for several years for patients and their companions travelling from afar. The emergence and expansion of ‘sharing economy’ networks (Netter 2016) such as Airbnb overlap with some medical travellers’ needs that conventional hotels are unprepared to meet, such as cooking facilities.

However, sharing economy, medical travel/tourism and conventional tourism networks not only overlap and mutually benefit from synergies, but they also collide. For example, local Penang residents in one apartment building concerned with the health and security risks posed by a constant flow of ‘sick’ strangers lodged legal complaints in 2016 to stop fellow apartment owners from making commercial use of their properties (Star 2016). Such tensions attest both to the precariousness of transnational medical travel/tourism’s direct economic impacts and to its contentious social impacts at the micro-level. In the context of the ‘sharing economy’, an increasingly diverse range of everyday people—entangled in medical travel/tourism as lodging owners, cleaners, neighbours, local transport operators and so on—are now confronted with how to appropriately manage and accommodate patient-consumers with compromised health. Such alternative lodging may be medical travellers’ only affordable option, however, especially since—for many from lower- and middle-income countries—hotel prices may simply be out of reach and hotel rooms, with limited opportunity for self-catering, are often unfit for longer periods of stay (Ormond and Sulianti 2017).

Conflicts over the presence of ‘sick’ people can also occur in conventional hotels. In Gurgaon, India, for example, a hospital receiving a regular influx of patients sent by the Iraqi government holds an agreement with a nearby hotel. However, whereas the hotel management are happy to receive patients during the low season in order to fill vacant rooms, they suspend the agreement in the high season. The hotel management suggest that foreign patients are not the most desirable guests because they have special demands (e.g., halal food) and some encounter difficulties in using the facilities (e.g., toilets), as they have never been in a building like it before. The hotel’s non-medical traveller guests from India and other parts of the world also complain about illness and suffering in the hotel, a presence made especially visible when guests with bandages and walking aids join conventional guests in the hotel’s dining spaces.

These tensions and conflicts in guest houses and hotels arise because two networks overlap, creating physical proximity between elements usually separated. As Foucault (1994) reveals in his history of the clinic as a medico-social institution, hospitals were set up to separate ‘sick’ bodies from ‘healthy’ bodies. In the hallways, lobbies and dining rooms of hotels and guest houses, this separation collapses. The undesired proximity of bodies supposed to be kept apart is even more striking since conventional hotel guests usually are on holiday or a business trip. Such journeys both conceptually
and emotionally are associated with cheerfulness and joy, fitness and performance, hence starkly clashing with the associations of suffering, decline and death a ‘sick’ body evokes. Hotels and guest houses therefore can be seen as exemplary sites in the city in which different networks not only overlap and co-exist, but actually intersect and collide. Since the networks involved are of conventionally mutually exclusive symbolic and emotional natures, intersections create tensions and conflicts over the ‘proper’ use of such urban infrastructures.

Another still largely invisible challenge posed by transnational medical travel/tourism to urban development is increased consumption of resources and the need to dispose of waste. Noting that hospitals are major consumers of energy and water, Johnston and Crooks (2013) have called attention to the expensive, limited supply of fresh drinking water and electricity in medical travel/tourism destinations as well as the limited local capacity to treat and manage the large amount of medical and non-medical waste transnational hospitals generate. Mumbai hospitals, for example, have been found to be especially wasteful with regard to water consumption (Masandi 2011). When it comes to waste, Vijay (2007) estimates that a large urban corporate hospital in India generates 2 million tonnes of medical waste per year and that, in the absence of proper medical waste management systems in low-income countries, unsorted medical waste—of which an estimated 10–15% is infectious and 5% is hazardous—simply gets (insufficiently) incinerated or dumped. Hence, increasing numbers of medical travellers could further exacerbate already existing urban waste management problems. Dubai authorities, for instance, are prepared for medical infectious and hazardous waste to increase from 20 to 35 tonnes per day by 2022 as a direct result of transnational medical travel/tourism (Middle East Waste and Recycling 2017). Yet some waste management companies see medical travel/tourism—as along with population ageing, the growth of lifestyle diseases and infectious disease outbreaks—as a boon for industry growth and innovation (Fatiha n.d.).

Finally, re-zoning and state seizure of land for the development of private for-profit facilities engaging in medical tourism are not uncommon in the context of proliferating government and private-sector plans linking medical tourism with urban development (Smerdon 2008, p. 23; Reddy and Qadeer 2010, p. 70). Special economic zones (SEZ), in particular, have been designed to incorporate FDI-friendly medical tourism facilities (e.g., Malaysia’s Iskandar Region, a strategic overflow space for the nearby city-state of Singapore (Ormond 2013); Dubai’s Healthcare City; and Healthcare Town in South Korea’s Jeju SEZ) in a bid to generate new markets and job opportunities through the development of related industries and sectors such as: biomedical research and development; medical education; tourism, retail and hospitality; long-term care, wellness and ageing; and construction and real estate (Murray et al. 2016).

Such urban development initiatives do not go uncontested, however. In 2014, for example, Taiwanese unions, professional associations and political youth groups supporting healthcare reform gathered in Taipei to protest about the government’s medical tourism plan’s disregard for ongoing labour and national healthcare system concerns, decrying it as ‘a ploy for favouring big corporations by allowing them to set up profit-making medical centres’ (Hsu 2014) in SEZs like the Taoyuan International Medical Zone proposed to be established in Taipei’s greater metropolitan area. In other words, people criticised a lack of entanglement of this new element with the existing urban assemblage; they wanted the respective networks to intersect and not just overlap. On the contrary, officials proclaimed intersections that yielded trickle-down effects. By enabling medical institutions to operate as corporations in order to be able to charge foreigners full fees and by attracting foreign biotechnology and medical supply services investment with special fiscal incentives, officials argued, the SEZ would not only contribute to the local economy, but also make the most cutting-edge technology available to local residents. Ironically, while the SEZ’s implementation has been held up, this has not been due to popular concern about how medical tourism could ‘siphon off
resources, time, and talent for the benefit of tourists’ (Silver, in Barker 2015) but rather to conflict at the municipal level over how to transplant communities that would be displaced by its construction (Barker 2015).

**Conclusion**

Transnational medical travel/tourism, by and large, involves travel to cities and metropolitan areas. Only urban areas possess the sufficient volume and variety of world-class medical expertise, cutting-edge technology, transportation infrastructure, communication and mediation facilities and hospitality services and infrastructure to be able to emerge as transnational medical travel destinations. Yet how cities and transnational flows of patients, standards and capital interact to generate new urban assemblages and new assemblages of healthcare is a story that has yet really to be told. While research on transnational medical travel/tourism is becoming more nuanced, involving a broader variety of perspectives, actors and medical mobilities, any attention given thus far to urban areas has been largely implicit and, thus, conceptually under-explored and -utilised.

In this chapter, we have argued for the value of a relational approach in thinking about both cities and transnational healthcare. The number of cities or regions announcing their aspirations to become medical tourism destinations continues to grow, and they include such starkly different places as Rochester in the USA (Weisman 2015); Sfax, Tunisia’s second largest port city (Boechat 2014); and Chandigarh, a city at the foot of the Himalayas in North India (Bagga 2016). We might understand these declarations as ambitions to get a foothold in the global economy or to secure their position within it. We have shown in this chapter that medical travel/tourism multiplies and intensifies connections between places through the mobility of such heterogeneous elements as patients, medical standards and capital. Accordingly, medical travel/tourism serves as a vehicle to increase a place’s connectivity (Kaspar and Reddy 2017). With news outlets reporting medical travel/tourism success stories that capture imaginations, medical travel/tourism becomes a mobile policy moving around the globe, not just among major cities, but also between central and hitherto peripheral places.

Following a relational approach inspired by assemblage theory, we have further highlighted that not only do the assembling and disassembling processes prompted through medical travel/tourism create new healthcare networks, but the elements themselves change, too. As myriad elements become mobile, circulate and assemble to form medical travel/tourism, this assembling work gets entangled with the elements and relations that constitute the urban. The presented cases show that networks are fluid and constantly being made, as elements entangle and disentangle and, through relational processes of dissociation and re-association, themselves transform. Through the assembling of medical travel/tourism, hospitals’ incomes can rise and their interiors can be ‘internationalised’; neighbours and hotels can learn to accommodate or resist the presence of ‘sick’ bodies; patients can become health consumers and, perhaps, evangelise about the benefits of travelling abroad for medical purposes; penniless patients and wealthy doctors alike can become care brokers; and, last but not least, hopeless and ignored ‘medical cases’ at home can become hopeful, desired customers abroad.

However, this chapter is far from comprehensive. Despite their relevance, owing to size constraints some issues were not addressed. These include, for example, and perhaps most importantly: how major cities relate to peripheral cities and how both relate to their respective hinterlands through the commodification of bodies (Waldby and Mitchell 2006; Parry 2008, 2015) through care labour (Sassen 2002; Yeates 2009); transnational reproductive medicine, particularly surrogacy (Gunnarsson Payne 2015; Schurr 2016); and organ trafficking/donation (Schepers-Hughes 2001, 2011; Cohen, L. 2011). Empirical work in these fields most plainly reveals the unequal power relations at work, asymmetries characteristic of all kinds of transnational care practices.
We suggest that our approach be seen as a first step—and hence an invitation for further research—towards conceptualising cities through medical tourism/travel. Paralleling McFarlane’s (2011, p. 360) work on the city as a *learning* machine, we suggest conceptualising the city as a *healing* machine. Medical travel/tourism can be seen as ‘a political and practical domain through which the city is assembled, lived and contested’ (McFarlane 2011). Since health and healthcare increasingly are being (re-)articulated as highly profitable commodities and services, respectively, the (trans)formative ways in which health and healthcare are imagined, invoked and deployed at not only the national but also the urban level merit more scholarly attention. The relationship between cities and transnational healthcare—a potent manifestation of the economic globalisation of healthcare with significant implications for health governance—has given us the opportunity to begin to build on growing critical scholarship on the relationship between cities, health and healthcare. This includes work, for example, addressing city-level policies and practices to make urban environments healthier and to even out health outcomes and access to healthcare (see, for example, Harpham 2009; Temenos and McCann 2012). However, we have only just begun to scratch the surface.

Notes
1 Because the European Union (EU) has enshrined freedom of mobility within EU borders as a key element of supranational EU citizenship, transnational patient mobility within the EU constitutes an exception (see Glinos et al. 2010).
2 For this reason, we do not engage with the wide-ranging scholarly, governmental and industry-derived estimates of the number of people travelling outside of their countries of residence for medical care in this chapter.
3 To date, it has mainly focused on the processes and practices within medical tourism destinations, and focused less on medical travellers’ habitual places of residence and the spaces and places in between (but see, for example, Ormond 2014, 2015).

References
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