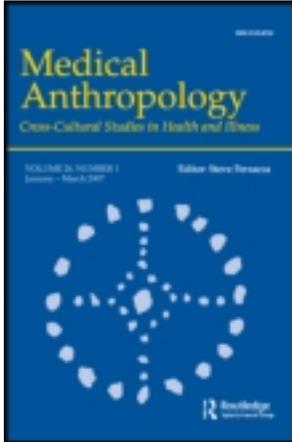


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The Baggage of Health Travelers

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EDITORIAL

The Baggage of Health Travelers

Carolyn Smith-Morris and Lenore Manderson

When seekers of health care cross through a customs gate, they become “health tourists,” contributing to a multi-billion dollar global market driven predominantly by consumers in search of lower-cost medical and health care. This business in health tourism matured on dentistry, optometry, and cosmetic surgery, but it is now booming worldwide for everything from spinal fusion to urology, cardiac surgery to womb rental. One to six million US citizens will travel abroad for health care in 2010, partially in response to rising local health costs, the majority to Asia and Latin America (Pickert 2008; Reed 2010). The United States accounts for just over half the \$3.3 trillion spent *annually* for health care around the world, although the country ranks thirty-seventh in quality-of-care measures (US Senate Special Committee on Aging 2006). Other countries also contribute substantially to health-related travel, with people moving across borders legally and illegally, officially and informally taking advantages of the medical, surgical, and other health care options in different settings. Diverse motives and circumstances influence this extraordinary flow. In consequence, services, public and private administrative structures, and agencies have also flourished, promoting local hospital facilities, medical

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and surgical providers, and tour operators on the one hand, and facilitating travel arrangements and pre- and post-procedure stays on the other. Governments, not-for-profit organizations, and peak bodies—the Australia Health Export Industry Council, for instance, representing the health tourism industry itself—play increasingly active promotional and regulatory roles to ensure quality, safety, and accreditation. For medical travelers, the information available on the Web alone is overwhelming. It is also ironic. Countries where the “best clinicians and facilities, cherry picked for specific procedures” (Australia Health Tourism 2010) are offered to international clients, are also points of departure for people who are unable to afford or gain timely care at home and are attracted by the promise of “high quality, world-standard medical treatment at only 20 percent of the cost of treatment” in their own countries (Health Tourism in Asia 2010). The poorest, of course, have no choice.

The argument about who travels, under what circumstances, and why, adds complexity to the study of health and medical travel, as illustrated by the contributing papers in this issue and as we set out next.

First, not all health tourists are “legal” nor are they recruited through the tourist departments of governments and private industry. Seekers of health care who avoid the customs gate and cross a more remote or unpatrolled portion of an international border reveal the same strategies for better health at lower costs, but they are rarely included in the scholarship about and public discourse on health tourism. Rather, they are likely to be counted and treated simply as “illegal migrants”—their differing motives buried under the more common political and public discourses of nationhood, legality, and cost. Yet, while they may simultaneously desire to work and/or relocate in the new country, their health care patterns are not always predictable.

Second, not all health travelers have quick and successful treatments then return home, as illustrated recently in Texas. Maria Hernandez (pseudonym) migrated legally to the United States on a B-2 tourist visa to receive treatment for her declining liver function. She had had a gall bladder operation in Mexico, during which her bile ducts were severed. Although this was identified and repaired, the repair did not last long. She reached a hospital in the United States with chronically obstructed bile ducts and liver failure. Hernandez left behind her husband and young children in Mexico with every intention to return to them as soon as possible. Months later, her B-2 tourist visa about to expire, her only long-term solution is a liver transplant. Unwilling to cover her surgery and long-term medications, the hospital would not perform the transplant on a patient likely to return to Mexico where she could not afford long-term medications.

Hernandez’ health travel from Mexico to the United States illustrates the need to extend our scholarship on health-related travel. Not always

the glittering makeover vacation advertised online, some health-related travel is emergent, desperate, and unplanned. We most often read of these cases in political and economic contexts, not in relation to tourism but in relation, for example, to Arizona's recent passage of the Support Law Enforcement and Safe Neighborhoods Act as well as in estimates of health care costs incurred by illegal immigrants (McHugh 2009).

Third, as noted for the United States, travelers may combine illegal migration with long-term health needs. From fiscal and resource distribution perspectives, these cases are enormously informative of the market conditions that have inspired and filled the Joint Commission accredited hospitals in Thailand and India. Ana Puente was a health tourist to California, although she had longer-term intentions about her stay in the United States. Her story begins with illegal immigration to the United States, then three state-funded liver transplants. Then, at age 21, because of her medical condition, she qualified for the state's Medi-Cal coverage of a fourth transplant and continued medication and follow-up.

The *Los Angeles Times* staff writer Anna Gorman (2008) framed the debate in the following inflammatory manner: "Should illegal immigrants receive liver transplants in the U.S. and should taxpayers pick up the cost?" Within this country, more than 90 percent of transplants from the United Network for Organ Sharing (UNOS) go to US citizens. Although UNOS regulations do not distinguish between resident and illegal aliens (they do address non-resident aliens), undocumented immigrants have limited access to UNOS organs because they are ineligible for state or federal health care cover. Hospitals often deny transplants to anyone lacking the financial resources (or insurance) to cover hospitalization and surgery, anti-rejection medication, and follow-up care for one year. The cost of a liver transplant, for example, equates to about US \$390,000 and around \$30,000 annually for medications. In Ana Puente's case, State funds were available to pay for the cost of her care, regardless of her immigration status.

The fourth point relates to emergent health tourism and medical travel and the ways in which medical services are extended across borders. Antonio Torres migrated legally to the United States for work, but after a car accident that left him comatose and connected to a ventilator, he was repatriated to Mexico by his Phoenix, AZ hospital. He went directly to an emergency department in Mexico until, days later, his parents found a hospital in California to treat him, and he was driven back into the United States. The Emergency Medical Treatment and Active Labor Agreement guarantees patients dialysis in the emergency department of any hospital until their blood levels have stabilized, stipulating more generally that emergency medical care must be provided to anyone who makes it within

250 yards of the facility—inspiring some “drop and run” patient arrivals. Sontag (2008) was to draw on Torres’ experience subsequently as an example of “the haphazard way” in which the American health care system handles cases involving uncompensated care.

People, for reasons of cost, familiarity, or confidence in communication, travel *from* the United States *to* Mexico. The United States is only one example of the geography of medical travel. People move to and fro across the Canadian/US border for health care, treatment advice, and medication. Lao and Cambodian villagers who row across the Mekong to seek treatment in a Thai hospital, for instance, are also medical travelers, subject to local policies that balance cost, citizenship, and humanitarian responsibilities. Thais and Indonesians travel to Peninsular Malaysia for surgery in private hospitals. Malaysians and Singaporeans move both directions over the causeway that connects the two nations, motivated by affordability, promptness of treatment, presence of family, and assumed technological skills. The porosity of land borders and local seaways, the relative ease or difficulty of cross-border travel, the legality of movement, and length of care all illustrate the need to extend our enquiry beyond “medical tourism.”

As the authors of this issue of *Medical Anthropology* illustrate, the ability of people to find and exploit new health care markets outside national borders highlights the infrastructural, technical, and educational inequalities between nations. Ironically, doctors and nurses leave poorer countries to work in superior clinical and research settings in highly industrialized settings, even more sharply delineating global inequalities mapped onto local geographies. In addition, as illustrated briefly before, while traveling for care is not confined to certain countries and populations, still the primary flows are *from* developed *to* less developed nations. The combination of low-cost and world-class facilities is seductive, and for those unable to afford timely care at home, an obvious choice. The contrast of these facilities with their surrounds—the urban slums and squatter settlements—is a visual reminder of the distributive inequity that private sector health care offers at the expense of the public sector (Ramirez de Arellano 2007), and of its global reach. Here anthropology has both empirical and ethical tasks.

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