What is health and medical tourism?

by

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Introduction

Sociological studies of tourism have largely categorised tourism as a leisure-related activity separated from the everyday, whereby the tourist gazes upon the ‘other’ in a foreign locale (Urry 2002). Health and medical tourism, however, challenge such understandings on several grounds. Firstly, tourism does not necessarily involve a retreat from everyday experiences. That is, if the tourist has health concerns and issues, these travel with them. As a consequence, tourism may involve an increased rather than decreased engagement with everyday reality. Secondly, this reveals tourism is not necessarily a passive activity, but an embodied experience. For the health and medical tourist, their ‘tourist experience’ is partially or solely motivated by their health or perception of their health. In addition, the intervention upon their body may involve pain and recovery. As a result tourism can be hard work, and is not necessarily restricted by time and place - the intervention remains and travels with the tourist. Indeed, the long term recovery and benefit from health and medical tourism may result at home.

These considerations suggest that a definition of tourism and more specifically, health and medical tourism, might be impossible or undesirable. Before exploring these tensions in detail, it is worth initially exploring the development of health and medical tourism.
Health tourism, with a focus on good health, general wellbeing and its pursuit, is not a new phenomenon. For example, in Italy and throughout the Roman provinces, the Ancient Romans constructed resorts with thermal health spas, and the Ancient Greeks would travel ‘to Epidauria [on the Saronic Gulf] to visit the sanctuary of the healing god, Asklepios, who revealed remedies to them in their dreams’ (Bookman and Bookman 2007: 4-5). From the 15\textsuperscript{th} to 17\textsuperscript{th} centuries, the poor sanitary conditions in Europe prompted an interest by the rich in medicinal spas, mineral springs and the seaside for health purposes. These wealthy individuals would also travel to renowned medical schools for medical assistance (Swarbrooke and Horner 2007: 16, 33). This continued into the 18\textsuperscript{th} and 19\textsuperscript{th} centuries where spa towns, particularly in the south of France, became popular for health cures, the sun, and escaping the cold climatic conditions in the north of Europe (Holden 2006: 21-23). The rapid urbanisation and social change experienced during Industrialisation aggravated the unsanitary and poor living environments in Britain and some sections of Europe, with anti-urban values and a growing concern for health developing as a result (Holden 2006: 30). The formation of the railways allowed increasing and diverse flows of people to more distant seaside and coastal resorts, which provided a distinctive and escapist environment from urbanisation, and the opportunity to practice what was viewed as a healthy pastime of sun-seeking (Holden 2006: 30; Swarbrooke and Horner 2007: 16, 33). At the same time, escaping to spas and seaside resorts for ‘taking the waters’, was not simply about health, as it became a fashionable and sociable activity.
Spa tourism and sun-seeking persisted into the 20th century. Medicinal springs, spas, beaches and resorts, particularly in warm and dry climates, continued to be considered therapeutic through long exposures to the sun, fresh air and water (thermal or sea) (Swarbrooke and Horner 2007: 33). To this day, numerous health and spa resorts exist globally.

In today’s climate, healthcare has become a global market, with emerging, developing and developed nations competing for health tourists. For example, this industry is predicted to be worth US$2.3 billion for the Indian economy by 2012 (Press Trust India (PTI) 2005). Consequently, the political interest in health and medical tourism is based on the financial benefits it can bring. Such economic incentives for the state has also lead to increasing options for medical tourists, who have more disposable incomes and in some cases portable health insurance policies. Therefore, while medical tourists still predominately flow from the developed world, medical tourist sites are found globally, with many medical tourists flowing to world-class facilities in the developing world.

With these considerations in mind, there appear to be some important differences between health tourism of the 21st and late 20th centuries and what has occurred previously. Firstly, we have recently witnessed the emergence of a new term, ‘medical tourism’, which is sometimes differentiated from health tourism and sometimes not. I will return to issues of definition soon. However, it is significant that it appears the types of health and medical interventions on offer have considerably diversified, ranging from superficial treatments (such as facials and massages) to highly invasive and risky surgical procedures (such as open heart surgery) and, in
some cases, a combination of both (for example cosmetic tourism, which encompasses cosmetic and reconstructive surgery and some forms of dentistry).

Another important development in health and medical tourism appears in the emphasis placed on marketing, and the varied priority placed on health. While health concerns may have been a primary motivator for health tourists prior to the 19th century and in particular the 20th century, today the ‘tourist experience’ appears to take precedence over health. Healthcare and beauty treatments may form part of a tourist package in international resorts or on cruises, which often include site-seeing to major destinations. In addition, the focus on the ‘tourist experience’ over the ‘health experience’ means health-related tourism can occur in expensive locations, such as the United States. This is evidenced in the marketing of health and medical tourism overall, which often concentrates on location by emphasising local attractions. Promotions of health and medical tourism from emerging or developing nations, on the other hand, often attempt to alleviate patient fears by highlighting physician training undertaken at Western locations, the high quality of advanced medical facilities, the absence of waiting times, affordability, and both the quality and quantity of care (such as one-on-one nursing).

At the same time, health may remain the primary - or only - motivator for travel. This can be influenced by delays in or the unavailability of medical treatment/s at home. Transplant tourism, for example, occurs because of (i) the long waiting lists for kidney transplants in the developed world that may lead to death before the individual can receive a transplant, and (ii) an apparent willingness of people in the developing world to sell their kidneys. Significantly, people waiting for a renal transplant are
unlikely to be well enough to engage in traditional tourist activities such as site-seeing (though this might be partly circumvented if transplant tourism can be combined with dialysis tourism). Similarly xenotourism, which links tourism with receiving an animal-to-human transplant (xenotransplantation), exploits the unavailability of this treatment in other parts of the world. Xenotourism additionally shows how medical tourism can allow patients to bypass local restrictions and laws that may ban particular treatments (see Cook et al. 2005). As a result, health and medical tourism can involve transgressing and breaking of the rules, by both the tourist (demand) and provider (supply).

These considerations reveal that health and medical treatments can be considered an addition to the traditional tourist site-seeing experience (Goodrich and Goodrich 1991), and a significant or sole motivator for travel. These two categorisations could possibly be linked to subjective motivations for tourism - namely, is the tourist influenced by a specific and serious medical condition, or by a more general interest in health and wellbeing?

**Health and medical tourism: A definition?**

Clearly, transplant tourism and xenotourism involve different considerations and risks to spa and wellness tourism for patients, physicians, providers, insurers and policy makers. Furthermore, despite the obvious social, economic and political interests in health and medical tourism, they have received scant attention in academia and in the tourism literature generally.
It is therefore perhaps unsurprising that there are many differing definitions of health and medical tourism. Some of these appear to be influenced by the previously explored history of health tourism, which is largely based on resorts, spas and general wellness. For example, Bennett et al. (2004: 123) acknowledge a liberal definition of health tourism would be ‘any pleasure-orientated tourism which involves an element of stress relief’, meaning it is an enjoyable and relaxing activity. Pollock and Williams (2000: 165), Laws (1996 in Henderson 2004: 112) and Schofield (2004: 137) expand this definition to encompass a separation between the ordinary and the extraordinary; the everyday world of work and home versus the combination of health and tourism in ‘leisure, recreational and educational activities’ (Pollock and Williams 2000: 165), which focus on the improvement of ‘physical, mental and social well-being’ (Schofield 2004: 137). These understandings largely replicate the traditional understandings of mass tourism in sociology, where tourism is understood as binary structure that operates as escapism from the everyday and routine, and with work and leisure distinguished.

Others acknowledge health tourism is a very broad category that encompasses a wide variety of treatments and services. In such understandings, medical tourism becomes a subset of health tourism. For example, Henderson (2004: 113) views health tourism as ‘travel where the primary purpose is treatment in pursuit of better health’ that may involve ‘hedonistic indulgences of spas and alternative therapies’, while medical tourism ‘incorporates health screening, hospitalization, and surgical operations’. Similarly, Carrera and Bridges (2006) and Connell (2006) identify health tourism with general health and wellbeing, while medical tourism combines tourism with medical,
surgical or dental intervention to improve or restore health in the long term. Therefore, health and medical tourism are differentiated by the level of surgical and physical intervention on the tourist’s body. However, many tensions arise in these definitions when considering the practices and reality of health and medical tourism.

**Health and medical tourism: Is a definition possible?**

Many understandings of tourism rely on dualisms to establish what tourism is and is not. Health and medical tourism are no different. While health and medical tourism could be separated on the seriousness of illness and disease and the consequent level of physical and surgical intervention required, this ignores how an individual constructs their own embodiment, condition and treatment, as well as how some treatments may traverse simple categorisation. This is demonstrated by human embryonic stem cell tourism (hESCtourism). In India, hESCtourism targets tourists with a range of human heart, nerve and immune disorders (Davies 2007; Padma 2006). Russia, on the other hand, offers hESCtourism (and porcine ESC tourism and human adult stem cell tourism) in beauty salons and private clinics for cosmetic purposes, including wrinkles, skin problems (such as dry skin and cellulite), and hair loss (Titova and Brown 2004). Clearly, these two forms of hESCtourism attract tourists with contrasting motivations who, in turn, expect differing outcomes. At the same time, they all desire a certain health-related experience and reward that will eventuate from treatment with and their consequent embodiment of stem cells. Additionally, both forms of treatment involve the same level of physical invention (injections of stem cells into embodied sites identified as problematic), while also
transgressing and challenging Western scientific concerns on the risks of using embryonic and adult stem cells to treat humans (*Nature* 2008: 969). Consequently, while it might be possible to differentiate health and medical tourism on the audience targeted (supply) and tourist motivations/desires (demand), it is more difficult to separate them in practice and risk (both on a personal and professional level).

Moreover, defining health tourism as pleasurable subsumes certain activities experienced by the tourist that may not be enjoyable or relaxing. For example, medical checkups might deliver unpleasant or disturbing news, or a beauty treatment could illicit an allergic reaction or, more simply, the individual may not be able to unwind or derive pleasure from the treatment. Accordingly, the aim and expectation - either from the perspective of the provider or client - may not match the outcome and reality. Furthermore serious medical conditions, such as renal failure, involve highly invasive surgical procedures and painful physical recovery and recuperation; hardly a pleasurable experience. At the same time, Bennett et al.’s (2004) previously cited definition of health tourism could still apply to more serious forms of medical tourism. That is, if we understand tourism as an embodied experience that continues when one arrives home (for example, through activities such as reminiscing), then pleasure from the tourist experience can extend beyond or occur after travel. In addition, despite discomfort and pain, medical tourists may gain pleasure through their recuperation and recovery by witnessing, experiencing, feeling and communicating improvements in their health status. The tourist expectation is that these improvements will continue and increase, meaning the ultimate benefit from and the further development of the tourist experience occurs at home. For example, the transplant tourist might be able to resume ‘normal’ everyday activities, such as
preparing dinner or returning to the paid workforce. Consequently, the tourist experience is not isolated to travel; rather it travels with the tourist regardless of their location and can continue for years to come.

The possibility of becoming or returning to ‘normal’ through health and medical tourism also challenges traditional sociological conceptions of tourism, namely that it is an escapist leisure activity from everyday reality (for example, Boorstin 1963; MacCannell 1976). In the case of some health and medical tourists, seeking the ‘normal’ through tourism renders their everyday experiences as ‘abnormal’. In other words, an aspect of their embodiment is rendered deficient and in need of correction or repairs. The tourist experience is consequently a continuation of and influenced by this embodied state; with the supplier targeting and marketing to this embodiment. Consequently, the everyday cannot be ‘escaped’ and separated from tourism, as the tourist’s embodiment as it exists is the reason - in part or in full - for the tourist experience. The aim is to transform their abnormality into the extraordinary which, in this case, is normalcy.

These understandings bring us to another important point - the connection between health and medical tourism and embodiment. Traditional sociological understandings of tourism ignore the active tourist body by considering it passive; involving the tourist gazing at the ‘other’ (for example, Urry 2002). However, health and medical tourism are driven by, and the marketing is targeted towards, the tourists’ experience of embodiment, time, and their perceived state of health and wellness. This could be influenced by a perceived desire for relaxation, rejuvenation, revitalisation, maintenance, improvement, reversal and change. Furthermore, the body techniques
engaged in by health and medical tourists are also about slowing down or challenging
time, such as delaying the ageing process (for example, cosmetic tourism), or
attempting to negate the degradation of health or to avoid death itself (for example,
transplant tourism). This again reinforces that health and medical tourism are not
simply pleasurable. Body projects involve body maintenance or improvements that
are hard work and persistent, and which may begin before and continue after tourist-
related travel. Once again therefore, tourism is not temporally restricted to being
‘there’ over ‘here’, but timeless and homeless.

Conclusion

Clearly, as health and medical tourism expose, tourism is not necessarily a passive
and escapist leisurely activity that is restricted to places that are ‘other’. Significantly,
tourism can involve an increased engagement with, and be motivated by, current
everyday experiences of embodiment. Furthermore, as health and medical tourism
involve direct intervention with and on the body, it can be hard work that involves
pain, recovery and recuperation. This means that the ultimate benefit might be gained
after the tourist arrives home. As a result, health and medical tourism are timeless and
spatially dislocated, as the tourist experience is not restricted by time and place.

Perhaps these considerations reveal that health and medical tourism are not tourism at
all. However, this would ignore that tourism can take many forms, and each of these
are at the intersection of various competing interests and forces. Furthermore, due to
developments such as hESCTourism, it appears that answering what tourism and more
specifically, what health and medical tourism are, seems to be irrelevant. This is not
to subsume the importance of tourism and the growing political, economic and social
interest in health and medical tourism. Rather, it appears more relevant and important
to examine and understand these phenomena subjectively and socioculturally,
including the political tensions arising between competing interests.

References


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