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entitlements and attachments

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Transnational medical travel: Patient mobility, shifting health system entitlements and attachments

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Biographical notes

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Abstract

Transnational medical travel -- the temporary movement by patients across national borders in order to address medical concerns abroad that are unable to be sufficiently met within their countries of residence -- is an important therapeutic coping strategy used by growing proportions of peoples with a diverse range of mobility profiles and intensities of global moorings. Studying this phenomenon provides useful insight into the rapidly globalising era of health governance, where an ever-wider array of state and non-state actors are transcending the increasingly restrictive national containerisations of health care and engaging in cross-border action to effectively address contemporary health challenges at both individual and collective levels. In our introduction to this special issue on transnational medical travel, we draw on both 'medical tourism' and migrant health scholarship to acknowledge the diversity of motivations among migrant and non-migrant patients alike and the complex nature of mobile patients' attachments to the multiple places in which they seek care. We then bring attention to how dynamic structural issues in mobile patients' countries of residence and destination shape their attachments to places and health systems over time, examining the linkages between vitality of the political and social systems in these places to which they are differently attached and their dis/satisfaction and dis/enfranchisement with them.

Keywords

Health care, place attachment, transnationalism, migrant health, medical tourism, disenfranchisement

Introduction

Healthcare delivery and receipt have traditionally been seen as bounded by the nation-state, with governments partly deriving their political legitimacy from ensuring the welfare of their national populations. Entitlement to receive health care and responsibility to financially contribute to the health system that provides such care, therefore, are frequently considered part of a broader package of national membership. Not everyone residing within a country's borders, however, is necessarily included in this national social pact, nor are those who are included formally necessarily included informally. How inclusion in and exclusion from national health systems are defined and classified is the focus of heated political and societal debate, especially now when, across the globe, many national health systems are experiencing significant resource strain, leading to the tightening of eligibility criteria and waiting times for treatments as well as the increasing marketisation of health care and self-responsibilisation that have accompanied the gradual dismantling of national welfare states (where these even exist).

JEMS readers will be familiar with how debates around austerity, access to public services, and public health services under strain increasingly coincide with wider debates around migration, where immigrants have been frequently framed as more burdensome on national health systems than contributors to them. Growing anti-immigrant sentiment has led, for instance, to pressure on public-sector healthcare professionals to act increasingly as national resource gate-keepers by checking the passports and migration credentials of anyone seeking care and reporting patients with irregular status to the relevant authorities for fines, detainment and even deportation (Ormond and Nah, this issue). Political and societal debates and actions such as these have, understandably, led scholars working in the field of migrant health to mainly focus on drawing crucial attention to the diverse structural conditions in refugees' and immigrants' countries of residence that shape their access to and use of formal healthcare services and that support or threaten their physical and psychological welfare (Nazroo 2001; Choi 2013; Guinto et al. 2015; Wang and Kwak 2015; European Network to Reduce Vulnerabilities in Health 2017).

Their important work is complemented by another very significant emergent strand of migrant health research that examines refugees' and immigrants' therapeutic coping strategies in the face of the

abovementioned structural challenges (see, e.g., Krause (2008) on ‘therapy networks’ and Phillimore et al. (2018) on ‘healthcare bricolage’). This body of work calls attention to how individuals, families and communities within both resource-rich and -poor environments ‘creatively mobilise, utilise and re-use resources in the face of constraints on access to healthcare services’ (Phillimore et al. 2018, 1) by drawing on diverse knowledges, ideas, materials and networks simultaneously to address health concerns (see also Thomas and Gideon 2013; Villa-Torres et al. 2017). Practices intending to augment or substitute existing resources include not only domestic medical treatment and alternative, traditional and religious approaches to healing but also transnational medical travel, which is the focus of this special issue.

Transnational medical travel is the temporary movement by patients across national borders in order to address medical concerns abroad that are (considered to be) unable to be sufficiently met within their countries of residence. It is an important therapeutic coping strategy in which growing proportions of peoples with a diverse range of mobility profiles and intensities of global moorings – migrants and non-migrants alike, as we shall see -- engage. Studying this phenomenon provides useful insight into the rapidly globalising era of health governance in which we currently find ourselves, an era in which an ever-wider array of state and non-state actors are transcending the increasingly restrictive national containerisations of health care and engaging in cross-border action to effectively address contemporary health challenges at both individual and collective levels (Fidler 2010, 3; Ormond 2013).

In our introduction to this special issue on transnational medical travel, we present this phenomenon variably referred to as ‘medical tourism’, ‘medical migration’, ‘medical exile’ or ‘international healthcare consumption’, depending on the political and economic orientations of the patient, scholar, politician, pundit or healthcare industry representative engaging with and describing it (Milstein and Smith 2006; Inhorn and Patrizio 2009; Kangas 2010; Song 2010; Botterill et al. 2013; Ormond 2013b; Ormond and Kaspar 2018) as a transnational living practice that productively, if uncomfortably, unsettles widely-shared, heavily codified notions about place-based attachment and entitlement. We do this by, first, introducing *JEMS* readers to the main bodies of scholarly literature that engage with the phenomenon, identifying their different points of entry and the conceptual foundations that, until recently, have led them to develop largely independently of one another. This provides a foundation for acknowledging the diversity of motivations among patients -- migrants and non-migrants alike -- for engaging in transnational medical travel; of flow frequency, duration and directionality; and of the complex nature of mobile patients’ attachments to the multiple places in which they seek care. We then bring our readers’ attention to how dynamic structural issues in mobile patients’ countries of residence and destination shape their attachments to places and health systems over time, examining the linkages between vitality of the political and social systems in these places to which they are differently attached and their dis/satisfaction and dis/enfranchisement with these.

Who uses transnational medical travel as a therapeutic coping strategy?

People with migration backgrounds have long included transnational medical travel in their therapeutic coping toolboxes. Key drivers for transnational medical travel include dissatisfaction and disenfranchisement with the health systems in their countries of residence, familiarity and identification with the health systems in the countries in which they have lived or visited previously, cultural and linguistic competencies of medical professionals in destination health systems, the presence of extended family support networks abroad, economic differentials between countries of residence and destination, and the ease of cross-border movement (Beijers and de Freitas 2008; Lee et al. 2010; Horton and Cole 2011; Ormond 2013; Ormond 2016; Sime 2014; Şekercan et al. 2015; Şekercan et al. 2018). Migrants, however, are increasingly joined by non-migrants that have likewise experienced some form of dissatisfaction and disenfranchisement with -- or destruction of (Dewachi, Rizk and Singh 2018) -- the health systems in their countries of residence and decided to engage in temporary international travel in order to meet their health needs and wishes.

The bulk of research on medical travel to date has been undertaken by scholars focused predominantly on non-migrants temporarily crossing borders for medical care. This is largely due to concerned

fascination by scholars in the fields of health policy and economics, bioethics, medical anthropology and sociology, health geography and tourism studies with the rapid global emergence and development over the last two decades of so-called ‘medical tourism’ destinations which are concentrated largely in the global South. ‘Medical tourism’ development is underpinned by the increasing commoditisation of health care and -- as evidenced by the number of governments and medical facilities around the globe that have come to see ‘medical tourism’ as an economic growth engine and thus compete with one another for foreign private healthcare custom (Bookman and Bookman 2007; Connell 2010; Reisman 2010; Lunt et al. 2001; Ormond 2013) -- there are significant financial and political stakes involved.

In many ‘medical tourism’ destinations, initial emphasis was placed by government and commercial actors on developing services and infrastructure attractive to specific groups of ‘ideal’ patients from wealthy countries (e.g., Americans and Gulfis) that had little to no prior connection to their ‘medical tourism’ destination countries (Ormond and Sothorn 2012; Ormond 2013a; Whittaker and Chee 2015). This meant that, while touting their local medical personnel’s credentials and competences acquired in internationally-renowned Western medical schools and facilities to prospective ‘ideal’ patients abroad (Connell and Walton-Roberts 2016; Ormond 2016), many ‘medical tourism’ destinations largely took for granted and ignored the emigrant patients and regional patients from neighbouring countries whose stable return custom supported their businesses through volatile global geopolitical and economic times (Ormond 2013; Chee and Whittaker, this issue; Rouland and Jarraya, this issue). Yet, as the dominant global narrative promising an economic boon to destinations courting ‘medical tourists’ with limited prior attachments to these destinations by and large has failed to materialise, these destination governments and care providers have been forced in recent years to increasingly recognise and embrace both emigrants and regional patients from neighbouring countries as fundamental to sustaining their commercial viability.

This has required more nuanced acknowledgement of a broader range of socio-cultural, political and economic factors that forge and sustain emigrants and regional patients’ attachments to specific medical destinations. Accordingly, ‘medical tourism’ scholarship has begun to pay more attention to a far more diverse range of medical travel drivers, motivations and mobility patterns that previously had been marginalised for failing to match the dominant ‘medical tourism’ narrative (Bochaton 2015; Crush and Chikanda 2015; Hadler 2015; Chee and Whittaker 2016; Ormond and Sulianti 2017). With this expanded scope, more scholars have come to recognise the heavily transnational nature of medical travel flows, given the frequently recurrent basis and the nature of transactions, networks and place attachments between source and receiving countries from which they have resulted and that they contribute to forging (Ormond and Kaspar 2018). Hence, there is growing acknowledgement across a range of fields that patients engaging in transnational medical travel -- migrants and non-migrants alike -- are increasingly embedded in complex, messy transnational ‘fields of contention’ (Ormond 2015) comprising diverse, multiple and overlapping familial, community, private-sector and state resources regimes that together shape these patients’ ties and identities relative to -- and differently privilege or disadvantage them within -- the different countries involved (Ackers and Dwyer 2002; Johnston et al. 2010; Botterill et al. 2013; Choi 2013; Osipovic 2013; Whittaker and Chee 2016).

Transnational medical travel as a transnational living practice

While ‘medical tourism’ literature has recently begun to look to work in migration studies on transnationalism, literature on migrants’ transnational medical travel experiences has still remained largely separate from that on non-migrants. The persistence of this divide, we argue, can be attributed to the narrow conceptual boundaries conventionally drawn between ‘migration’ and ‘tourism’ that scholars themselves also, though perhaps unwittingly, frequently reproduce.

Migration and tourism are routinely understood to comprise two ends of a mobility spectrum (Williams and Hall 2000). Migration, on the one end, conventionally presumes permanence in one’s country of residence that involves, for instance, taking up paid employment and residence for an amount of time that the country’s governing body deems sufficiently substantial in order to be conferred legal rights and responsibilities (e.g., permanent residence permits, residence-based

taxation, legal employability, public schooling, state-subsidised health care and welfare benefits, etc.). Tourism, on the other end, conventionally presumes temporariness that involves one staying only temporarily in a given country primarily for pleasure. A tourist, having the intention to leave the country, does not take up paid employment or long-term residence and is not (desirous to be) conferred the above-mentioned range of political rights and responsibilities by the governing body of the country which she/he is visiting.

The migration/tourism duality can be seen clearly in scholarly debates around the problematic term ‘medical tourism’. While the term continues to be widely used in popular media coverage and within policy and industry circles, it has been widely condemned by scholars for its inability, at best, to capture the desperation felt by patients crossing borders for medical care and for its ability, at worst, to undermine the formal and informal recognition by others of that desperation. If several scholars have advocated for the use of more neutral alternatives like ‘international medical travel’, ‘transnational patient mobility’ or ‘transnational therapeutic travels’ (Kangas 2010; Botterill et al. 2013; Ormond 2013b) in its stead, many others have argued for the explicit use of more politically-charged terms like ‘medical migration’, ‘medical exile’ and ‘biomedical pilgrimage’ to underscore the disenfranchisement that patients have experienced and drives them abroad to rectify (Milstein and Smith 2006; Inhorn and Patrizio 2009; Song 2010; Ormond and Kaspar 2018).

Clearly, distinctions are far from robust and their socially constructed boundaries are constantly exceeded. Various forms of ‘migration’ and ‘tourism’ confound conventional articulations of permanence and of temporariness (e.g., seasonal labour, nomadic living, irregular lifestyle migrants making routine ‘visa runs’ to renew their tourism visas, backpackers taking up short-term paid employment to finance their journeys, etc.) (Williams and Hall 2000). The growing significance of transnational living practices like these -- transnational medical travel included -- are challenging long politically-enshrined distinctions between permanence and temporariness in profound ways. Indeed, there has been increasing scholarly and political attention over the last two decades focused on people who have residence, entitlement to social security and benefits, and citizenship in different countries simultaneously and to how these people spread both their physical presence and feelings of identification among the multiple countries in which they are living or have lived – i.e., what constitutes ‘where is home’ (Williams and Hall 2000, 21; see also O’Reilly 1995; Ackers and Dwyer 2002). Within the scope of the recent Transnational Lives in the Welfare State (TRANSWELL) project, for example, Talleraas (2019) notes how Norwegian welfare authorities are grappling with how to accommodate an ever-wider array of people leading transnational lives who form attachments to two or more countries for longer or shorter durations without necessarily officially changing their residency and who are attached to Norway through their entitlement to Norwegian social security. Transnational attachments, she reminds us, encompass migrants and non-migrants, nationals and non-nationals, and residents and non-residents alike.

While national governments with fairly robust welfare states like that in Norway are grappling with how best to respect the multiple and overlapping attachments of people who lead transnational lives, governments with waning welfare states, by contrast, are trying to figure out how best to benefit from the cleaving, reformulation and reassembly of these attachments. Examining the ways in which people leading transnational lives are signified as being ‘deserving’ of health care in the places with which they have permanent, temporary, frequent and/or intermittent attachments, therefore, offers powerful insight into their diverse incorporations in these countries’ politics and economies (Ormond and Nah, this issue).

Grounding transnational medical travel in broader global processes

This special issue uses health care to shed light on contemporary political quandaries around the world regarding how to manage an ever-growing volume of people engaging in transnational living practices that fundamentally challenge conventional conceptualisations and spatialisations of attachment and, hence, entitlement and responsibility. The articles in the collection -- first presented at the 2016 Academic Conference on International Medical Travel and Cross-Border Healthcare in Madrid, Spain -- examine transnational patients’ complex relationships with the diverse health

systems to which they have formed attachments in specific contexts in Western and Central Europe, North America, Southeast Asia, and North and East Africa. Each article contributes to the urgent task of reflecting on the social, economic, political and biological consequences of diverse societal actors' (re-)interpretations and (re-)negotiations of conventional forms of attachment and recognition in an ever-more mobile world, while at the same time fundamentally rooting them to the broader structural dynamics out of which transnational exchanges, linkages, identities and practices emerge. They do this by demonstrating how geopolitical and global economic processes intertwine over time and lay the dynamic foundations for differently-mobile patients' dis/satisfaction, dis/enfranchisement and attachment/detachment/re-attachment with diverse health systems around the globe, shaping the ways in which connections are forged, maintained and dissolved; institutions are built and collapse; transactions are constructed; and local and national events are influenced (Portes et al. 1999).

Early scholarship on the emergence of 'medical tourism' focused on the potential of (bio)technological developments, low-cost travel, cultural commodification and healthcare commercialisation to together forge a flattened globalised healthcare marketplace. As noted earlier, the grand 'medical tourism' narrative it followed -- inhabited by rational high-end healthcare consumers in pursuit of 'First-World health care at Third-World prices' (Turner 2007; Keckley and Underwood 2008) -- was limited and naive. However, an enduring strength of 'medical tourism' literature has been its ability to draw attention to the ways in which the broader dynamics of national and international politics, health system volatility and economic restructuring shape cross-border healthcare seeking and provision practices (Reisman 2010; Lunt et al. 2011). Hence, transnational medical travel flows -- such as those from the United States to Mexico (Vargas Bustamante, this issue), from the UK to Poland (Horsfall, this issue), from Libya to Tunisia (Rouland and Jarraya, this issue), and from Indonesia to Malaysia (Chee and Whittaker, this issue) -- function as useful bellwethers for grasping the economic climate, domestic policy changes, political instability, travel restrictions, advertising practices and geopolitical shifts in patterns of consumption and production of domestic and overseas health services of the countries to which transnational patients have developed attachments.

The articles in this collection reflect a continuum of *dissatisfaction* with access to health services, a deeper process of medical *disenfranchisement*, moving towards mobility as a result of health system *destruction* in the various countries to which transnational patients are attached. This continuum, encompassing drivers that encourage patients to look overseas or across borders, does not equate demand with volition, consumerism and choice. Rather, it is mediated by degrees of familiarity and identification with health systems, degrees of cultural and linguistic competence on the part of patients and medical professionals, and the presence of extended family support networks. It is shaped by wider structural dynamics: socio-economic processes, legal status and the ease of cross-border movement (Lee et al. 2010; Horton and Cole 2011; Sime 2014; Şekercan et al. 2015; Şekercan et al. 2018), and, notably, regional politics and domestic instability.

Dissatisfaction

Horsfall (this issue) and Lunt (this issue) note that formal entitlement to the UK's National Health Service (NHS) may be a necessary but insufficient condition for Polish and Somali nationals residing in the UK to make use of NHS care. The groups they studied have been found to encounter important informal limits to access, like linguistic barriers and lack of awareness of entitlement to the use of the NHS, that lead them to opt for treatment abroad. When they do access the NHS, however, they may also be dissatisfied with service delivery (e.g., waiting lists, gate-keeping by general practitioners that hinders access to specialists, perceptions of under-medicalisation, etc.) and desire services abroad with which they may feel more familiar and that they believe may be better suited to their health needs. Dissatisfaction may lead migrants to return to their source countries or established diasporic hubs in third countries for medical care; it might also mean that non-migrant family members and friends travel to migrants' countries of residence and other established diasporic hubs to address their medical needs.

Whether such dissatisfaction declines over time is a moot point. Horsfall (this issue) found that, for Polish nationals residing in the UK, travel back to Poland for treatment is largely undertaken by first-generation migrants and, as successive generations become more familiar and confident with accessing healthcare services in the UK, their will to engage in transnational medical travel may wane. However, Vargas-Bustamante (this issue), like Şekercan et al. (2015) and Beijers and de Freitas (2008), suggests that, while transnational medical travel is much more common among first-generation migrants, the practice – though less frequent – is not necessarily uncommon among the second and third generations. Dissatisfaction is itself a multidimensional concept, and whilst there may be increased linguistic ability and familiarity with treatment processes and practices over time, more fundamental differences may still remain about treatment, including access to specialists or what are perceived as appropriate interventions.

Disenfranchisement

Dissatisfaction with treatment options and health systems goes hand-in-hand with formal access to such services and the availability of safe and high-quality interventions. Moving further along the continuum, we find examples where, despite formal eligibility, patients are unable to acquire the necessary appropriate quality and safety of medical care at home, experiencing a form of disenfranchisement whereby formal rights to health care cannot be fully exercised. Chee and Whittaker's (this issue) contribution speaks to the emerging disenfranchisement among Indonesians with domestic treatment, Indonesian patients' travel to Malaysia, and these patients' justifications for doing so being rooted to perceptions and experience with Indonesian doctors' incompetence, negligence, or unethical practices (see also Ormond 2015b; Ormond and Sulianti 2017; Chee, Whittaker and Por 2018). Patients report misdiagnosed or incorrect treatments, and see Malaysian equipment, facilities, drugs, and doctors as better quality. The logic of need, fuelled by the risks and fears of seeking care in Indonesia, that Chee and Whittaker (this issue) outline, justifies the common-sense necessity of travelling abroad to obtain medical care. In capturing views of patients, hospital staff and agents, a picture emerges of Indonesian patients who are not simply dissatisfied but more broadly 'disenfranchised'.

A second type of healthcare disenfranchisement, on formal grounds of citizenship or residency, is examined in Vargas Bustamante's (this issue) study: three-fourths of US residents seeking treatment in the Mexican state of Baja California were born in Latin American countries or were US-born people of Latin American background. He observes how legislative changes made in recent years in the United States (US) to facilitate citizens' and authorised residents' access to affordable health care simultaneously served to foreclose care options for people with irregular status in the US who have limited recourse to transnational medical travel due to the risks associated with border-crossing. He notes that, for those who can more easily cross borders, transnational medical travel ends up supplementing rather than fully substituting healthcare provision in patients' countries of habitual residence. For example, while more people have been able to access affordable medical care in the US under the American Care Act (ACA), dental care coverage has remained inadequate. This significant gap in US insurance coverage has led to the proliferation of dental clinics along the US-Mexico border. ACA's potential repeal, meanwhile, promises to generate more transnational medical travel to Mexico for diverse medical needs of those disenfranchised.

Similar processes of disenfranchisement are also outlined in the article by Ormond and Nah (this issue), which describes how the Malaysian government has declared immigrants residing in the country no longer deserving of publicly-subsidised medical care. In progressively stripping them of their previous legal entitlements and forcing them to become privately-insured healthcare consumers, the Malaysian government has effectively created a multi-tiered hierarchy of public healthcare 'deservingness' with enfranchised Malaysian citizens at the top and disenfranchised non-citizens below. Ormond and Nah (this issue) highlight how the curtailing of political entitlement to publicly-subsidised health care has played out differently among a range of documented immigrant categories. They describe, for instance, how economically-privileged immigrants (e.g., temporary highly-skilled economic migrants, retirement migrants and international students) -- highly desired by the government for their economic contribution to the country primarily as consumers and investors --

pursuing treatment in the Malaysian private medical sector are officially recorded as ‘medical tourists’ despite receiving health care in their main country of residence.

Invoking transnational insights, we may also see healthcare disenfranchisement experienced by local people living in medical travel destinations as a consequence of the transnational medical travel of incoming patients and visitors. Transnational medical travel has the potential to exacerbate existing healthcare inequities among local residents by diverting destinations’ limited medical care resources – including skilled health workers (e.g., medical specialists, nurses, clinical diagnosticians and technologists) and medical facilities and equipment (e.g., hospital beds, operating theatres and imaging equipment) – from being used to care for locally-resident public-sector patients to those non-residents willing and able to pay a premium in the private sector for medical conditions more associated with transnational medical travellers than with local populations (e.g., high-technology orthopaedic, dental and reproductive procedures and treatments) (Ormond, Wong and Chan 2014; Snyder et al. 2015).

Vargas Bustamante (2018, this issue), Chee and Whittaker (this issue) and Rouland and Jarraya (this issue) contribute to this ongoing debate. Vargas Bustamante (2018, this issue) argues that the extent to which local residents in medical travel hubs see themselves as competing for limited health resources depends largely on their own healthcare entitlements and degree of access to care where they live. He also points out that not all destinations are affected in similar ways by transnational medical travel. The Mexican towns and cities in his study with heavy concentrations of dental clinics and pharmacies clearly will attract different types of transnational healthcare consumers from those in Mexico more renowned for invasive treatments like surgeries and experimental stem-cell therapies. Indeed, while some patients may travel abroad only for major medical concerns (e.g., surgeries and advanced or hard-to-access therapies), others may more frequently cross borders to not only meet their major but also their routine medical needs (e.g., purchasing pharmaceuticals, getting routine medical check-ups and dental work, specialist consultations, etc.) (Chee and Whittaker 2018, this issue; Rouland and Jarraya 2018, this issue; Vargas Bustamante 2018, this issue).

Yet both Chee and Whittaker (this issue) and Rouland and Jarraya (this issue) argue that the constant flows of transnational patients and the frequent nature of their visits have undeniable impacts on their destinations’ local economies and the viability of these places’ private health services. Rouland and Jarraya (this issue) observe that local medical care providers are highly conscious of this. The financial director of a Sfax private clinic they interviewed, for instance, notes that, ‘Without Libyans, there would be no private clinics anymore’ (Rouland and Jarraya, this issue, page number to be assigned). Chee and Whittaker (this issue) point out that transnational patients themselves are likewise alert to their influence on – indeed, their legacy in -- the places in which they received treatment. This is evidenced in their interview with a transnational patient residing in the large Indonesian city of Medan that travels to the Malaysian ‘medical tourism’ hub of Penang for treatment: ‘It’s not an exaggeration to say that Penang hospitals [in Malaysia] are built by the Medanese’ (Chee and Whittaker, this issue, page number to be assigned).

Destruction

Transnational health-seeking behaviour -- for migrants and non-migrants alike -- depends on the stability of the political systems in patients’ countries of residence and treatment destination. Hence, shifting political circumstances (e.g., uprisings, armed conflict and health system destruction) in them both enable and hinder patients’ border-crossings in profound manners. Lunt (this issue) and Rouland and Jarraya (this issue), like Dewachi, Rizk and Singh (2018), address what happens when national governments are no longer able to sufficiently treat people within their borders or to honour bilateral agreements with other countries’ governments and private hospitals for outsourcing the care of their citizens.

Lunt (this issue), in his exploration of nomadic health-seeking behaviour, notes that Somali nationals residing in the UK understand Somalia as a fragile state that has been under siege for a very long time. As a result, their medical travel appears to be almost exclusively into third countries, given constraints on accessing good quality care in Somalia. Rouland and Jarraya (this issue), meanwhile, bring a rare longitudinal geopolitical perspective to the topic of transnational medical travel with their study of Libyans receiving care in Tunisia. Libyans living along the Tunisian border have routinely

turned to the Tunisian city of Sfax for private medical care since the 1960s, yet the porosity of the border has changed over time with bilateral trade agreements between Tunisia and Libya. In the relatively good times, transnational medical travel was facilitated by citizens' visa-free movement between the countries and the Libyan government's outsourcing of select Libyan patients' health needs abroad to Tunisian medical providers that, in turn, over time came to heavily depend on Libyans for their livelihoods. In the bad times, however, transnational medical travel took on fundamentally different characteristics. The 2011 Libyan civil war not only made it dangerous for Libyans to reach and cross reinstated border checkpoints but also destroyed the Libyan health system's ability both to treat Libyan citizens in Libya and to reimburse Tunisian clinics and hospitals for treating its citizens. While transnational medical travel continued from Libya to Tunisia, it did so under considerable strain for both patients and providers.

Conclusion

The focus on transnationalism in more recent migrant health research regarding how people express agency through networked relations could benefit, we argue, from more thoroughly taking into account structural constraints and how these impinge on volition. Likewise, we can draw on particular insights of the 'medical tourism' literature to ground transnational living practices within broader global processes, whilst eschewing any broader narrative of consumer choice within a flattened global marketplace. Acknowledging the contributions of both the 'medical tourism' and migrant health literatures enables us to better articulate how transnational living practices go beyond such either/or distinctions, enlarging the empirical and conceptual purchase of transnational medical travel.

By framing transnational medical travel as a transnational living practice, we have endeavoured in this special issue introduction article to broaden understandings of patient mobility by acknowledging the diversity of mobile peoples' statuses, motivations and attachments to the multiplicity of places in which they seek health care. Our reading complicates conventional national framings of healthcare responsibility and entitlement with its attention to the structural forces shaping, and shaped by, transnational living practices in and across the countries to which mobile people have formed attachments. In attending to them, we aim to call attention to the dynamic and 'unique local moral and ethical assemblages' (Zigon, in Chee and Whittaker, this issue, page number to be assigned) that emerge with transnational medical travel, enfolding seemingly disparate spaces and subjects. This has allowed us to highlight the unstable conditions upon which formal and informal attachments are forged, extended, withdrawn and negotiated not only in mobile patients' countries of residence but also in their treatment destinations, leading variably to their dis/satisfaction and dis/enfranchisement.

With people more mobile than ever before and major transformations underway in countries around the world regarding how health care gets organised, delivered and accessed, transnational medical travel will continue to develop. Yet, as this transnational living practices become more visible, we must be alert to how taking transnational health-seeking for granted can serve to further dilute and erode domestic healthcare citizenship, both with regard to formal access and to (perceptions of) service appropriateness, effectively cementing further forms of medical disenfranchisement. New mobile flows and patterns will generate fresh empirical studies both in localities where political and civil unrest put health systems under increased pressure and in contexts of economic integration and flourishing regional development. Alongside these spatial considerations is an enduring temporal question of whether mobile patients' descendants embrace the health-seeking practices of their parents and grandparents. Newer variants of transnational connections may emerge, including investment in health systems with which diasporic groups have attachments and return travel and settlement by clinicians to regions or countries that have grown more safe and stable. Given that mobile patients' therapeutic health-seeking practices may not conform to predetermined understandings and processes, our research agendas must embrace unpredictability and novelty. Such likelihoods lend support for continued investigation of transnational living practices like transnational medical travel and their imbrication with broader global processes.

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