TRANSNATIONAL HEALTH CARE AND MEDICAL TOURISM: UNDERSTANDING 21ST-CENTURY PATIENT MOBILITY

TOWARDS A RATIONALE OF TRANSNATIONAL HEALTH REGION DEVELOPMENT

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Dissertation Universiteit Antwerpen

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Some 4 years ago I started to conceptualise an explorative study in a developing research field. Why would citizens travel intentionally for health reasons? It is difficult to understand the logic involved. Why would someone choose to travel to another country when there is enough capacity to treat patients in many health systems?

My first line of interest was in the life-world of an international patient: what does such a patient experience on his health journey? What is involved in travelling with an illness and what are a patient’s experiences in a foreign hospital with a set of medical professionals other than those he is used to. Does the patient use services other than medical ones? Does he suffer from stress during his stay or his travel? Various questions went through my mind when I explored the idea of patient mobility. However, it would be difficult to establish contact with such patients as a source of information in the context of hospitals and organizations who want to protect patient privacy and avoid negative publicity.

Therefore, I chose to focus on factors that play a role for the patient but that are external to his own experiences. At first I conceptualized a framework of patient mobility. Furthermore, I explored the concept of worldmaking as an example of the use of marketing in the context of medical tourism, how this affects the patient, and how it is a tool for professional stakeholders in the field. I investigated how culturalism plays a role in the relationship between provider and patient. The media as a creational player of discourses was observed by analysing local and international newspaper articles on the topic of medical tourism. Quality within the medical sector is another observable factor: how do hospitals and other stakeholders try to guarantee quality for international patients? Finally, there are opportunities for policy recommendations to improve the sector and for governmental stakeholders. There is a potential role for regional governments in steering patient mobility initiatives, and a role for sustainable health destination management (SHDM) within regions for integration of health provision potential in promoting regional assets to prospective users of these health services.

An interesting issue is how these factors can be integrated into one coherent strategy involving many different actors and challenging roles. All the factors are related to each other and represent globalisation of healthcare at its finest, but also with the most imperative consequences.
Some words of gratitude

This manuscript has taken several years of hard work and reflection. It would be impossible to mention every person and occasion that had an influence on this work. However, I would like to highlight those who made a significant contribution to the process of the thesis.

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List of Acronyms

**SHDM** • Sustainable Health Destination Management

**EU** • European Union

**THC** • Transnational Health Care

**TBAS** • Trans-border Access Seekers

**CBAS** • Cross-border Access Searchers

**SCA** • Sending Context Actors

**RCA** • Receiving Context Actors

**MT** • Medical Tourism

**WHO** • World Health Organization

**NGO** • Non-governmental Organization

**THU** • Transnational Health User

**OECD** • Organisation for Co-operation and Development

**UKE** • Universitätsklinikum Hamburg-Eppendorf

**IO** • International Office

**CDA** • Critical Discourse Analysis

**WTO** • World Trade Organization

**TQM** • Total Quality Management

**UZA** • Universitair Ziekenhuis Antwerpen

**JCI** • Joint Commission International

**BRIC** • Brazil, Russia, India and China

**ECJ** • European Court of Justice

**TFEU** • Treaty on the Functioning of the European Union

**OJ** • Official Journal of the European Union

**EEC** • European Economic Community

**CMS** • Centers for Medicare and Medicaid Services

**HSPA** • Health System Performance Assessment

**PID** • Pelvic Inflammatory Disease

**GDP** • Gross Domestic Product

**CBHC** • Cross-border Health Care

**NHS** • National Health Service

**DMO** • Destination Management Organization

**AZM** • Academisch Ziekenhuis Maastricht
CHAPTER 1.

Introducing transnational health care
1. From Medical Tourism towards Transnational Health care: An Introduction

The perspectives of health and tourism studies lead to a position that is sceptical of the term medical tourism, yet at the same time embraces structural bonding between two distinct and unrelated popular social concepts. Medicine and tourism are clearly separate in contemporary popular consciousness: the latter presumes a healthy disposition for participation, whereas the former implies anything but a pleasurable experience. Such popular concepts of tourism and health ignore the historical continuity in their relationship from the 18th century pursuit of a ‘cure’ at resorts and spas, to 20th century notions of holidays as worker welfare through to global patient mobility in the quest for cutting-edge medical interventions in so-called untreatable conditions.

Disciplinary divisions within academia have replicated this popular culture separation, but there is an emerging challenge intrinsic to a number of study domains to rethink the tourism—medicine nexus. To argue in terms of a continuum from wellness to healthcare, with an international patient who chooses to involve mobility in his quest for wellbeing as a central point of reference, we should examine the nature and history of international tourism dynamics. In this dynamic, the tourism market builds on a willingness to provide services to the predominantly Western masses and communicates availability through an increasingly sophisticated array of media opportunities. At the same time, the conscious choice of places to develop as tourism destinations makes this practice a stakeholder-driven activity involving a wide range of private, public and not-for-profit organisations.

The healthcare sector was conceived from an entirely different perspective, to care and cure those who are ill. To do this, high levels of medical expertise and technological development have been developed over centuries (Relman, 1980). Thus, the history and dynamics of tourism and healthcare are predicated on different precepts, in different time frames and under very different circumstances. However, the separation of healthcare and tourism sectors is being challenged by a resurgence of the international patient in search of health solutions regardless of the neatly prescribed boundaries of national healthcare systems. A new industry ethos in healthcare is forcing the health sector, which is dominated by the supply side, to incorporate many of the demand-led industry characteristics associated with tourism. Hence, so-called touristification of healthcare is emerging through the adoption of tourism practices, images and tools, even
though the field still depends on technology-led, medical expert treatment. The linking of tourism to healthcare attributes and characteristics leads to a dynamic world view of globalisation of services and citizenship, affected by new modes of active wellbeing.

To continue with this plea for a combination of tourism and health perspectives and concepts, we need to explain the history of patient mobility in the recent past. As many textbooks and academic papers show, the relationship between travel and healthcare has a long history (Connell, 2011; Reisman, 2010; Smith and Puczko, 2008; Hall, 2012). The wealthy have always travelled for health reasons, be it wellness or healthcare. A common image is Roman baths or, more recently, spas and wellness in the 18th century. The concept of tourism also originated among the higher classes in society. A common feature of tourism and medical travel is that they are both associated with the financial ability to make such a voyage. However, over time tourism has increased from being available to a few rich people to being within the grasp of the masses, mainly in Western countries (Cohen, 1984). Tourism has been socialized as a system much faster then healthcare has developed through the ages. It was only in the 1990s that UK and US hospitals were arguing for attracting foreign patients for profit reasons (Mainil et al., 2011). This differs from the sustainable practice of sending patients with rare and complex diseases to specialized centres, which is based on a humanitarian perspective rather than a product-based conceptualisation of healthcare.

We should also include the notion of health systems in the discussion. The mode in which a health system moves and acts plays a significant role in the development of contemporary patient mobility. This leads to a difference in the concept of medical travel in the EU versus US and Asian contexts. Equity has always been the basis used in the EU to provide patients with healthcare in a controlled manner based on social rights. This explains the different historical development of patient mobility, which began as individuals contesting their right to receive healthcare in an EU state other than their own (Mainil et al., forthcoming) and resulted in an EU directive on patient rights (Council of the European Union, 2011) after wide debate among member states. This historic evolution, carefully monitored by institutions such as the European Observatory on Health Systems and Policies, led to a discourse on cross-border healthcare, first evident in activities between bordering regions (Brand et al., 2008) and then in a shift towards EU citizens choosing healthcare abroad without coverage (Glinos, 2010). The focus of our study is on patients whose primary purpose is to travel for planned treatment for health reasons, but this is not the
most significant type of patient mobility in the EU. Tourists with emergency
cases, senior pensioners in southern destinations using foreign health systems,
professional workers abroad using foreign health systems, and migrants us-
ing foreign or home-based health systems are seen as very significant fields of
interest and policy. These are international patient types that are increasingly
common in Europe and around the world.

Why is there a focus on patients (public) or even medical tourists (private)?
Medical experts have always been mobile as a professional community. This can
be attributed to humanitarian reasons or on the desire for individual economic
prosperity. However, it is interesting that it is also possible to move patients
around the globe, in the same way as travellers go to Spain for holiday purposes. It
would be wrong to project such travel as if it were related to tourism for leisure
reasons, but it is still a travel process combined with medical treatment.

As we observed a movement from tourism for the few towards mass tourism in
an era of globalisation and commodification, health-related travel seems to be
following the same trend, from a few to larger numbers of patients in search of
a solution to their health problems. This is possible because healthcare as an
industry is now seen as commodified and transnational in many regions around
the world, as opposed to ideals of continental Europe. Therefore, the aim of this
thesis is to observe the evolving transnational movement of patients and the
factors that play a role in this movement and to suggest policy routes to guaran-
tee a humanistic approach towards transnational healthcare, as I am convinced
that a pure market-driven transnational health industry would do more damage
than good for current and future generations.

Several scholars have investigated cross-border healthcare and medical tour-
ism (Bridges and Carrera, 2006; Smith et al., 2009; Legido-Quigley et al., 2007;
Glinos, 2010; Carrera and Lunt, 2010). Such research provided theoretical
frameworks based on patient motivation, concepts of citizenship and consumer-
ism, and the first conceptual exercises in the field. Turner (2010) and Crooks et
al. (2011) addressed more specific areas such as quality and different stakehold-
ers in the professional arena and their ethical implications. Geographers (Or-
mond, 2012; Connel, 2011), anthropologists (Kangas, 2010; Inhorn, 2011), and
bioethicists (Pennings, 2005) have reported several groundbreaking case stud-
ies. The study area is now an established academic field of knowledge develop-
ment. Against this background, I introduce the following research problem:
Analysis of factors in the construction of transnational healthcare settings for the development of relevant policies
As decisive factors we observe terminology issues; marketing and world-making issues; cultural issues; media discourse issues; quality management issues; and public health issues.

The following research questions serve as the basis of this dissertation.

a. How can transnational healthcare and patients be translated into a valid model?
Cross-border healthcare and medical tourism as concepts have been analysed in the past (Glinos, 2010; Snyder, 2011). However, in view of future developments and professionalisation of mobile healthcare settings, it is necessary to argue in terms of transnational healthcare (THC) as a transnational network of organisations and stakeholders that provide transparency for patients in making proper choices regarding their health situation.


b. Which methodologies are appropriate for researching THC-related services?
In the academic fields of tourism, health and sociology, it is now accepted that qualitative research, possibly in a mixed-method approach, is a valid counterpart to more quantitative-oriented approaches. Patient mobility is a multifaceted and complex field that requires such mixed-method approaches, with qualitative research as an important ingredient.


c. What effect has the concept of worldmaking on international patients?
A large number of websites are advertising healthcare for patients who would like to travel for health reasons. Worldmaking (Hollinshead, 2007; Mainil, 2011) implies the use of false images to attract consumers to places abroad. In a tourism context this seems to be acceptable within limits, as no effects on health conditions are involved, but in the case of medical travel it is an issue.

d. What role does culturalism play in the relation between THC and international patients?

Jurgen Habermas described the difference between communicative action and strategic action (Habermas, 1982). This difference plays a role in the professional processes inherent to transnational healthcare. Cross-cultural professionalism can function as a mediator between these two lines of action in the continuation and construction of the life-world.


e. What is the discourse on THC portrayed in the classical media in the last decade?

The media have changed their discourse on medical tourism over the last decade. An ethical perspective was much more evident in the past (awareness of medical tourism), but it is now normal to debate in terms of a market discourse: THC could have economic benefits for both industry and a country, as well as patients.


f. What is the effect of quality on THC contexts?

If healthcare becomes mobile, quality measures should be in place. Hospitals sometimes choose to formalize their international patient management through the creation of an international office. These offices deal with issues other than medical services, such as financial, facilitation, cultural and language services. Quality management in such settings could be seen as relevant for professionalisation of the THC sector.


g. What is the relationship between public health and THC?

In the EU the patient has always been seen as a citizen with rights, as well as a consumer of health services. It would be worth combining several patient mobility frameworks to construct several patient types linked to considerations and scenarios for future European public healthcare and cross-border healthcare.

h. Can SHDM play a role in the future of THC and its stakeholders?
By giving steering power over which THC initiatives to select and promote in their region, regional governments could position themselves transnational health regions. By controlling the right stakeholders, taking into account the local population and trying to position themselves in an integrated framework of regions, regional governments could deliver sustainable health destination management (SHDM) for cross-border healthcare and medical tourism practices.


2. Study limitations
This study is largely influenced by great thinkers in several fields of academic expertise. The study focus is at the most theoretical and conceptual level to facilitate reflection on policy- and decision-making on transnational patient mobility. Therefore, at some points the study lacks empirical quantitative data on international patients. However, this lack of empirical data for transnational patient mobility is known in the academic community. Several research groups are currently starting to collect the first streams of empirical data. This should open avenues for greater professionalisation and analysis of the strengths and weaknesses of globalised healthcare.

This study was complex because it combines concepts from several disciplines, including tourism, (medical) sociology and health management. It was not easy to start with such a multi-disciplinary approach. Tapping in on a plurality of disciplines also makes this dissertation less straightforward to read and to understand, but this reflects that fact that the research involved a postmodern exploration of a complex phenomenon. I hope that readers will approach the manuscript with the understanding it deserves.
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CHAPTER 2

Methodology

Narrative analysis as a tool for contextual tourism research: an exploration

Abstract

Narrative analysis within the social sciences has evolved throughout this decennium as a mature qualitative methodology. An extensive body of academic publications has already been portrayed. The urgency of a narrative analysis becomes even more obvious in light of the emerging network-society and the tacit knowledge, hidden in its interacting networks. Narratives are vehicles par excellence to uncover this hidden information. The growing attention within the academic and professional community for the attribution of implicit, contextual information that should make social reality more visible in everyday life, is related to the growing significance of narrative analysis for research into tourism. How can stories of silent voices in the tourism field be related to the main developments in tourism theory and practice? In this article a conceptual frame will be developed as an answer to this question and a methodological design will be suggested for further use.

Key words


In order for something of quality to take place, an empty space has to be created

(Peter Brook, director of the Royal Shakespeare Company)
Introduction

A new type of society is emergent (Castells, 2000; Appadurai 2001 inter alia) in which historically new social structures stem from a segmentation of the global economy, an international division of labor, informational based production and consumption and an increasing diversification worldwide but also within each region. There are several centres, several peripheries and some regions according to some analysts even seem to have become structurally irrelevant. And tourism is no exception.

Global movements in financial, technological and informational networks constitute a level of power that remains decisive in its influence on the world economy and power-structure. Huge groups of people are economically incorporated in the structures of these emergent and powerful, capitalist networks. Whole industries in Western society have been transferred to the Southern part of the globe where labour is cheap. And more non-Western expatriates than ever are moving over the world but also more highly qualified specialists from India and other developing countries than ever are involved in the most recent developments of information technology or other areas of applied sciences. Groups of people from various parts try to connect with these powerful networks. At this level changes seem to have far-reaching consequences.

At a next level of such a network-analysis these most powerful, global networks interfere with the networks of regions, states and with the international networks already in existence. These interfering processes have a lot of social and cultural consequences for various groups of people. Therefore, what happens in the interrelations between these networks? What happens with migration-patterns all over the world, what happens with the positions of men and women?

An interesting global phenomenon is the deterritorialised ethnosapes of Appadurai (2001) which starts with the migration-patterns. Varying groups of ethnic, religious or other composition are scattered around the globe with less and less a concrete basic land as their point of reference. This historical phenomenon takes place on a larger scale than ever and makes the relation between the global and the local even more troubled. In huge parts of the non-Western post-colonial world this deterritorialisation even is much more striking as Achille Mbembe demonstrates (Appadurai, ed., 2001). Boundaries in Africa are produced by moving already existing ones or by doing away with them, fragmenting them, decentring or differentiating them. There are different boundaries
caused by different mechanisms of which colonialism is just one. Oil-networks on the West-African coast with its hinterland, urbanisation by regional migrations to Johannesburg, Casablanca, Cairo, Kinshasa, Lagos, Douala, Dakar and Abidjan. Islamification, Christianisation, tribal controversies with a long history are symptomatic for the multiple geneeses of the current African boundaries. And this remodelling is still going on following a variety of unstable patterns. Boundaries of territories have been shifting all the time.

This is not only true for spatial boundaries, but for symbolic ones as well. In the same book there is an article by Zhang Zhen (Appadurai, ed. 2001) on the changing images of young Chinese women in urban China. Presentations on TV series such as Public Relation Misses attract a huge audience and correspond to ongoing changes in social space and encourage identification and mimetic desire. The magazine Chinese Woman published a long-running debate forum in 1994 entitled “The Value of Women – The Issue of the ‘Rice Bowl of Youth’”. The Rice Bowl of Youth represented the new symbol of a mainly female and young public that took its opportunities to participate in a new ‘global’ hedonistic culture in China’s metropolis. Editors of the magazine asked readers: what is the appeal and value of feminine youth in a society dominated by the drastically expanding market economy? Hundreds of replies to this question resulted in a hodgepodge of (Appadurai, ed., 2001, 139):

“... perspectives often confounding preconceived discursive boundaries between socialist and capitalist values, modern and traditional worldviews, official and non-official attitudes, and collective and private concerns.”

And a little bit further the author concludes (Appadurai, ed. 2001, 153):

“With the steady enlargement of the rice bowl of youth into a media event, the kind of debate carried out in ‘Chinese Woman’ has allowed a vast array of voices to enter the public space”

Therefore, at a micro-level of this multi-layered model to understand the nuanced tension of the global versus the local, an attempt must be made to understand how people from various interfering networks translate all these influences in their everyday lives. The analysis also entails activities at the level of the household, the kin groups and the community as they are influenced by these networks. In order to understand the game of cultural globalisation on a micro scale even better it seems relevant to construct ‘true’ pictures of selves in vary-
ing networks. Within these networks actors with ‘selves’ play the roles that to an important degree are determined by these networks in their everyday life-world. During the process of modernisation in the nineteenth century the social sciences had their Western origins, discarded by their universal orientation. Within a network-society this universal orientation, that originated in the West, needs to be relocated from within the diversity of the interacting networks from all over the world. Many (Nisbet 1966; Corijn 1998; Hall, 1996) have referred to the biases, presented as universally valid, that survived this Western origin. Especially the exclusion of ‘local perspectives’ has been considered as a major threat to a culturally diverse human existence to be explored. For example, a post-colonial perspective claims to stimulate (counter)discourses in which diversity and ‘genuine’ localness might be related to a more subtle discussion of the global versus the local. According to Stuart Hall, this perspective takes place even in a new epistemological space as introduced by Foucault. In such a space, (Foucault, 1966) taught us, within a short period of time the whole grill through which scientists and other people understand reality shifts into a relatively stable and completely new one, a new episteme. Hall, much inspired by Said (1974, 2003), speaks about such a post-colonial episteme and eminent writers in literary criticism like Spivak (1987, 1999) and (Bhabha, 1994) pretend to work in the same emergent ‘discourse’.

A discourse seems to be a too essentialist concept in our contemporary network-society and pluralism seems to be a necessary element in these network-discourses. In this sense Foucault’s ‘discourse’ still seems to have a Western flavour that needs to be removed from it. And what is more, in a network society Foucault’s relativism is not an answer to the differences in perspectives that need a confrontation from the more universal orientation in social sciences. So, diverging perspectives will never be understood as isolated wholes that are not in need of critique from the outside.

However, this post-colonial episteme indicates the necessity to consider the often hidden colonial influences in various forms of sociological, anthropological and philosophical thinking. As (Bhabha, 1994) states, the culture of Western modernity must be relocated from a post-colonial perspective. The question, therefore, of how to organise this type of relocation or reorientation in the social sciences of our network-society, becomes a crucial one. By trying to relocate this modernist perspective (Hollinshead, 1998) accentuated the relevance of Bhabha’s treatment of the concept of hybridity in this network-society, especially in the tourism field.
“Bhabha’s research agenda – or rather, his critical program – on the sense of disorientation and the disturbed discriminations of post-colonial life is a huge contribution to the emergent trans-cultural inquiry within postmodern scholarship: tourism studies theorists of culture production simply cannot overlook Bhabha’s fresh insights into hybridity – for, to repeat, tourism is very much the, or a, imaginary business of ‘difference’-making!” (Hollinshead, 1998, p. 135)

According to (Bhabha, 1994) – and Hollinshead, already in 1998, introduced this need in the field of tourism studies – there is a need for a theory of hybridity, in which room will be made for new, emergent voices, and the ‘translation’ of social differences that goes beyond the polarities of Self and Other, East and West. Too often these differences are not heard in the official discourses, in tourism as elsewhere.

1. Silent voices in the tourism field

Too often actors in networks remain silent and there are different reasons for this silence. In many cases power is the name of the game and voices became silent because they were silenced down. But, in cultural respect as a rule, background assumptions may remain silent because they belong to a self-evident ‘mental program’ that has been learnt by all members of a particular culture. They are not questioned when everybody thinks in the same self-evident manner and the question is how to generate these silent voices into the public domain of the tourism field. Self-evident, silent voices from different cultural backgrounds originating from within our network-society emerge in contemporary, global discussions. More contextual analysis is needed in this respect in order to generate these voices to the academic and professional debates, also in the tourism field. The problem often is that there seems to be a strong Western bias in these global discussions, that abstracts too much from these voices. There is a long tradition of Western predominance in tourism studies as a whole (Hollinshead, 1998) and the reason is obvious. Tourism as a mass-phenomenon generated in the West and has been studied as such since that moment. A growing middle class from North-Western Europe and Northern America became rich enough to travel in their leisure time. Leisure time itself was defined right from the start as ‘non-labor time’. Through that definition the ‘rest of the world’ already became excluded because they lived in a different, survival economy, did not have any ‘non-labor time’ and had no opportunity to travel at all. In
tourism studies this introduced a strong focus on these Western tourists as representatives of a touristic, but essentially Western culture. Their search for authenticity or for pleasure, the commodifying influence of tourism on everything that it is confronted with, the dominance of Western organizations in the academic and professional field, this all became symptomatic for the main interests of tourism studies as an academic discipline.

At the same time it became clear that this Western dominated attention is not adequate enough to understand the new situation in tourism as situated in our network-society. Professionals in the field witness emergent markets from Japan, China, India and Russia. Their motives and lifestyles are not understood well enough by standard social scientist explanations (Platenkamp, p. 33-37). Extrapolating the wishes of mass-tourists in the Western past to the Chinese tourists of today seems to be more problematic than scientists and marketers realize. Chinese tourists for example abhor ‘la dolce faniente’ of the Western tourists on the beaches of Ko Samui in Thailand. Pleasure trips, touristic roles and motivations, sustainability, modernization, authenticity, just to mention some of them: they all need other voices that should explicitly resonate in this so-called but still too Western tourism discourse. What does leisure mean according to the Indian Hindu background? What does sustainability imply on Bali? What types of modernization through tourism can be distinguished in Cameroon or in Mexico? What does authenticity mean for a Buddhist?

The answer to this type of question implies a thorough reflection on how to include contextual information into academic and professional discourses in tourism. First one needs to understand modernisation in Cameroon or the meaning of authenticity in a Buddhist environment, before one might translate these insights into academic and professional activities. This first phase of contextualisation needs much more attention than is often available in the tourism field. Therefore the ‘international classroom of tourism studies’ (Lengkeek and Platenkamp, 2004) offers a unique opportunity to bring this phase of contextualisation into practice. In this practice students from all over the world experience culture-shocks in their ‘stock of life world knowledge’ (Schutz and Luhmann, 1974) that make them sensitive to the type of problems we are referring to. In organising this life world knowledge a contextualised perspective in this international classroom proves its contribution to understanding the new type of question from above in the tourism ‘field’ (Bourdieu, 1980) of the contemporary network-society.
This emergence of sensitised points of reflection can be understood as the effects of allodoxas’, in Bourdieu’s sense of the word. A doxa is implicit and self-evident. It is what people in a particular life world or culture share and which goes without saying, it is a ‘adhésion aux présupposées du jeu’ (Bourdieu, 1980, p.111). Allodoxas are doxas that come from ‘different and independent historical sequences’ (ibid, 89). During a culture shock doxas and allodoxas from different backgrounds clash and become visible because of this clash. Then, it appears, what North Africans think about the way Western Europeans treat elder people or how to evaluate gender-relations in Western Europe.

There is a crucial relation between these (allo)doxas and the concept of a ‘habitus’ in the work of Bourdieu, that’s relevant for our purposes. For Bourdieu doxas emerge from within the dialectic relation between a field and a habitus. A field, according to Bourdieu, points to the external, objective power structure of relations between positions that emerge from the historical state of affairs of historical struggle. A habitus, in relation to this field, stands for the inner ‘dispositions’ that enter the individuals as sustainable schemes of perception and evaluation and that push them to practical actions. The habitus is the incorporation of the immanent structure and necessity of the field, whereas it contributes at the same time to the survival of the field by being the origin of practical schemes of representation, of meaning and of action-strategies. In this sense our social actions are guided by a ‘practical feeling’ or a ‘feeling for the game’ in the field. In the context of this study the awareness of interacting networks refers to the interaction of ‘fields’ as well. Fields from various parts are in a closer contact than ever before and when one speaks e.g. about ‘creolisation’ (Condé, 1995; Bhabha, 1994) this implies the interference of various fields with their habitus that clash, conflict, lead to misunderstandings or interact in diverse other ways. Therefore, clashes of allodoxas imply the enunciation of parts of the underlying habitus and fields that constitute the basis of these allodoxas.

Doxas and allodoxas in this perspective are established forms of thought that serve as common sense at a particular moment in a particular field. When Western tourism professionals are confronted with the lack of interest in beach-tourism among the Chinese, the underlying habitus in the field of leisure-time of Chinese tourists is involved as well. What allodoxa makes the Chinese tourist not sensitive to any beach-tourism at all? This question still can only be asked by a Westerner in this way. Therefore, if this professional also tries to be self-reflexive, he or she becomes aware of his own habitus as a Western professional that assumed wrongly that Western tourism behavior would be universal. This
professional starts to be interested in this difference from the moment on that Chinese tourists get to the positions in the tourism field that were occupied by Westerners only before. The power-constellation in the field changes, so will the concomitant habitus and the knowledge that goes with it. More fields and habitus, more doxas and allodoxas enter the tourism and leisure discourses in international tourism destinations.

This goes for international destinations but for local cultures in a globalizing environment as well. During rituals, parades, festivals but also in education and the transmission of cultural competences, organized religion, capital-C ‘Culture’ and popular culture these relations between positions in different fields and their changing habitus become manifest and open to deciphering. When a barber becomes a hair-stylist, many things in the habitus have changed before this could take place. In a habitus one sees institutions in a ‘field’ tied together in their production of particular perspectives, like the ones that produce a ‘hair-stylist’. Habitus amongst others become ‘lenses of mankind’ and therefore the relevant question, here, refers to the relation between a doxa (that we wish to make explicit) and a habitus, related to a sub cultural field, gender relations or the educational field.

When these ‘lenses’ of communication have been internalised by the individual members of a culture, they may constitute doxas as well. Becoming aware of such a doxa, in a reverse movement, implies therefore a first step to understand part of the habitus that relates to this doxa. ‘Vedantic Writings’ belong to one of the cornerstones of the habitus of many Indians in their interpretation of leisure as ‘an internal journey’. It has been internalised by many Indians who see this inner journey as a self-evident mentality that goes without saying, as a doxa.

This makes a doxa relevant for the purpose of getting at information from silent voices. A doxa can be made explicit and because of that lies at the edge of implicit and explicit life world-knowledge. As explicative life world-knowledge it becomes a point of departure for the translation into the habitus. Understanding the perspectives and the knowledge that stem from this habitus implies a more intense study than is possible here, but forms the necessary next step in order to get to more insight into silent voices and their tacit influence on leisure and tourism. This translation constitutes the last part of this movement of contextualisation in the tension between the global and the local. It creates the opportunity to get at the richness of contexts as systematically as possible. A narrative approach in these contexts leads to the awareness of some relevant and sensitised points of common sense (doxas) in the widely occurring cross-cultural encounters of our global village. Taking these sensitised points of reflection as a starting point to get
at a deeper understanding of the habitus (and fields) that are lit up within these rich contexts that go with them, implies the last step in order to get at a more substantial understanding of these contexts. In the ‘international classroom of tourism studies’ this can be elaborated in an exemplary practice that might resonate in other tourism practices as well. Here, in a more refined manner, new voices from the various contexts in our network-society are to be included in order to understand the shortcomings of the academia and of professional life in the tourism field in-between the global and the local.

Earlier (Platenkamp, 2007) a general approach has been designed in order to include contextual information into the official academic and professional discourses of tourism. In this article a methodology has been reflected on that might enable us to generate this contextual information to tourism discourses.

a. Cross-cultural shocks as a source of information

The boundaries set by culture often become apparent in cases of ‘anomalies’, ‘problems’ or disjunctures identified by social actors. This type of clash can become a window through which otherwise latent cultural elements and their mutual connections can be identified. Cultural shocks can offer us this type of opportunity.

In the studies on culture shock the focus mostly is on the individual and his or her reactions to an unfamiliar environment. The individual handling of this type of situations is the main concern of these psychological studies (Ward, Bochner and Furnham, 2001, Hofstede 1980). In the context of the creation of knowledge the value of a culture shock lies more in the liberation and understanding these clashes generate: the full realisation that other customs are not quaint or meaningless to those who practise them. In cross-cultural encounters people seem to depart from the superiority of their own customs, their own doxas. The everyday life-world is organized in terms of their own culture with a specific meaning structure which seems to be self-evident and relevant in all everyday life cases. Therefore, according to (Schutz, 1974), the transition from one ‘province of meaning’ (meaning structure) to another can only be accomplished by a leap (following Kierkegaard), which is accompanied by a shock experience. The feeling of this self-evident superiority is under pressure, even being threatened. And this is exactly what happens in a cultural shock as we perceive it. It offers the opportunity to practice cultural perspectivism more in depth by focussing on cross-cultural misunderstandings through culture shocks.
b. A lifeworld shock at the start

But a cross-cultural shock involves more life-worlds at the same time in a context of different ‘provinces of meaning’, which have become part of a new everyday life in this globalized world. These ‘provinces of meaning’ coexist juxtaposed to one another, but they can clash as well. People experiencing such a clash, a culture shock, are thrown out of their closed everyday life-world. This event cannot be underestimated in its far-reaching consequences. A person’s life-world is a person’s guarantee of survival in a particularly structured environment. When this guarantee is taken away, the world may become a chaotic and threatening jungle. People with a long experience in another culture recognize this shock without exception.

In a local, regional, national, transnational, deterritorialised and global world where networks are more complicated than ever before this type of transitions seems to be highly current. Self-evident background assumptions – the doxas of Bourdieu – which attribute a lot to the self-evident positions of many people in traditional and modern everyday life are questioned in this context. The enormous amount of art-production within this globalized context is an obvious symptom of this questioning. That’s what makes a cross-cultural shock so important in this discourse.

In this world cross-cultural shocks are an important source of information. Writers such as Rushdie or Kureishi in Great Britain – but in each European country there is a huge production of literature by writers in-between cultures – have testified this convincingly. Looking for a sense of ‘belongingness’, they traverse these frontiers in different forms of cultural life.

Cross-cultural shocks may also be related to the awareness of the almost impossibility of coping with ‘cultural differences’. A main reason for this is, that it is not just a question of different cultures. It is a clash of life-worlds in the first place, that include cultural elements amongst others as attempts to structure the chaos. The outcomes of these attempts to survive are uncertain and the awareness of this uncertainty makes these clashes so intense and important to understand. That’s why the concept of ‘life world-shock’ will be welcomed as better than a (cross-)cultural shock. There is more to cope with in these situations than culture alone.
c. Sensitising perspectives during lifeworld-shocks

During a life world-shock one enters an ‘open situation’ in which varied forms of differentiated, habitual knowledge become thematic in a new reality and the question comes up how deep to the bottom one must go to master the situation.

New problems are created by gaps in the interpretations of the new provinces of meaning that get reality for them because of the eruptions in their stock of knowledge. And the relevance of all this is that ‘familiarity is usually grasping only in the negative, through “effects of alienation” which occur when something hitherto stable suddenly explodes’ (Schütz, p. 159).

A Cameroonian male student who enters a mixed student house for the first time, is shocked by the gender-relations in The Netherlands and starts to reflect on the same type of relations in his home country. He becomes sensitised to this topic and from there on he will focus on this difference in background assumptions. Therefore, he might start to develop a new (sensitized) perspective to gender-relations in cross-cultural contexts at the end of the day.

What happens here is comparable to the sensitising concepts of symbolic interactionism where the possibility has been introduced ‘of finding a processual, interpretive social science that would utilize sensitising concepts grounded in subjective human experience’ (Denzin, 1992, p.56). Concepts, in this tradition, are not operationalised and tested thereafter, but at a start they are loosely defined and are supposed to get their fuller signification during the process of interpretation of these human experiences. If concepts are replaced by (sensitising) perspectives, the outcome suits the purpose of the international classroom to generate perspectives that may evoke tourism discussions.

The purpose, here, is to stimulate these sensitising perspectives in narrations from students abroad after their confrontation with their new Dutch environment. At the end of the day, these perspectives might lead to the uncovering of some ‘common sense biases’, some doxas, from previously silent voices in theories that are also related to tourism and leisure.

During a life world-shock elements of tacit background assumptions, so-called doxas – ‘adhésions aux présupposées du jeu (Bourdieu, 1980, p.111) – are ‘shaken loose’ in confrontation with the (Dutch) host culture. By referring
to these unique experiences students develop their sensitising perspectives by telling their stories and clarifying them in a dialogue with Dutch students.

A basic question, here, is how to develop strategies to involve these insights, hidden in important elements (doxas) of this background knowledge, in the common sense biases that lurk at the background of academic tourism discourses.

2. Narrative methodology in the social sciences: a powerful relationship

The social sciences want to research society in all its aspects. In this simple statement lies the link with the narrative world and its methodology. According to Barthes, who sees a central role for the narrative in social life:

“Caring nothing for the division between good and bad literature, narrative is international, trans-historical, trans-cultural: it is simply there, like life itself” (Barthes, 1977, p.79)

The social sciences are interested in the social life of every actor. The relation with the field theory of Bourdieu is a nice example of this way of thinking. Or as Macintyre would put it: social life is a narrative. In sociology this basic idea has been elaborated within the paradigms of phenomenology and ethnomethodology. Both emphasize the interactions of social actors. Within this interaction lies the force of the narrative. Through interaction the narrative is the outgoing dynamic into social life. (Czarniawska, 2004, p. 6) points out this important role of the narrative for social sciences:

“Social sciences can therefore focus on how these narratives of theory and practice are constructed, used and misused.”

In fact the social sciences have also a quest, a search for meaning in the lives of social actors and the social world. Narrative methodology could make this quest more fruitful and easier to explain. The way individuals deal with their lives, the interaction that they share with each-other, all this can pointed out in a narrative tale. In our terms: a narrative can set the agenda of social scientific issues in interaction as in social life in general. Of course in the social sciences there are limitations to the narrative methodology. (Czarniawska, 2004, p.132) puts this in the right words:
“But worries about the status of the narrative material are relatively small compared to the worries about ‘narrativized’ social science. Does anything go in social science writing?”

Therefore if we want to move from general social science towards the relation between narratives and research into tourism, we also will have to deal with the typical post-modernist way of thinking ‘Anything goes’ (Feyerabend, 1975). This crosses also the meaning of a methodology, which indicates and supposes structure and methodical reasoning.

In the sense of a narrative methodology, this means that certain concepts occur and have to prove their intellectual usefulness. Following the theoretical body of (Bal, 2004) we can speak of narrative texts (a text in which an agent relates a story in a particular medium) of a story (a fibula presented in a certain manner) of a fibula (a series of logically and chronologically related events that are caused or experienced by actors) of an event (transition from one state to the other). We choose to adapt this simple methodology, in fact it can easily be translated towards its use for social sciences.

Events, Acts and Actors: these are the elements of every day life, once beautifully described by (Goffman, 1974), who developed a still challenging dramaturgy to be applied to the untheatrical.

The narrative way of structuring reality is being adapted by certain authors within the field of the social sciences: In this way, the construction of someone’s own identity through narrative methodology, is beautifully portrayed by (Haynes, 2006), in which she is interested in the social world of accountants. The author uses a narrative methodology, based on biographies, to get closer to the identity of the social actors. This is a very clear example and proves that a plot of the social sciences and narratives could enhance a better understanding and recognition into the field and habitus of Bourdieu. A target in this paper is to see if such possibilities are also open towards tourism research.

3. Narrative methodology and tourism (industry)

Taking the basic concepts related to narratives and the specific context of tourism into consideration, it seems that within the field of Bourdieu, tourism could be seen as a social reality, a social framework. Also stories, narratives, events and actors play a role within this framework. If you consider research
into tourism as a part of the social sciences, the possibility should exist to use also the narrative methodology in this field of expertise. To state it very simple: also tourists and tourist professionals have stories to tell, experience events and practice acts. Therefore the body of knowledge that could be explored within this field are numerous.

Some authors have taken this path. It is possible, following (Obenour, Pat-
terson, Pedersen and Pearson, 2006), to adapt tourism services on the basis of narrative interviews with tourists. However they also report the danger of incompleteness, ambiguity and contextuality (Riessman, 1993). Also the experiences of families with young children could be explained, using narratives from these families. It gives an insight in the social lifeworld this people, and enhances the relation with the specific touristic contexts. (Gram, 2005) performs this narrative exercise; which states also the very specific relationship between narrative methodology and qualitative research. But also in the framing of tourism destinations, such as Portugal and Spain, relating to the image that tourists have of this destination, the usage of narratives could be seen as a possibility. (Santos, 2004) describes the different frames of Portugal (Contemporary and Traditional) which are determined by narratives such as ‘Romanti-
cized perceptions and implications of the past’ or ‘Urban Portugal’.

Narrative methodology is used in research into tourism, as a very broad research field. New, exciting publications suggest that also the narrative is finding the turn to be functional in an academic mode of knowledge. How-
ever, tourism being also a very practical and professional work field, narratives should also have the capacity to deliver and suggest real-time solutions for the tourism professionals and tourists. In this article this narrative methodology has been used to see how tourism students and their different cultural back-
grounds are translated in very specific doxas and presuppositions. With Bar-
bara Czarniawska the authors are convinced, that narrative methodology is a powerful tool to detect what is hidden or latent in the tourism field and context.

4. Narrative methodology and silent voices

One needs an academic attention for the attribution of implicit contextual information (tacit knowledge) of insiders, these are the ‘silent voices’ which make the true social reality visible in everyday life. Contexts that are hidden, stories which only occur when you see or hear them in stories, tales... in other
words: narratives. Starting from the basic concepts in narrative methodology: Acts, Events, Actors and Stories: ‘How can this methodology contribute to the detection of silent voices?’ First of all people and tourists do find it comfortable to tell narratives if you create the right atmosphere as a researcher. If you want to embark to the discovery of the self-identity of backpackers, and how they change throughout their experiences with narratives, you need as a researcher a certain anthropological quality. (Noy, 2004) states in his article that:

“The narratives exhibit a clear connection between the touristic experiences their narrators underwent while traveling and the unique experience of self-change of which they tell: the former is narratively presented as the basis for the latter”

The internalised world of the backpackers can be seen as a hidden world, which one could facilitate through narratives. These silent voices could also help professionals to adapt their touristic products along several touristic categories. ‘Silent voices’ could emerge from events that are seen as unusual, unexpected or unique (Labov & Waletzky, 1967), but maybe also from classes of stories out of the mundane and commonplace (Lerner, 1992 and Gabriel, 2000 in McCabe and Foster, 2006). Silent voices might be conceived of as an outskirt of the Narrative Unconscious in relation to culturally unconscious memories. (Freeman, 2004) states:

“What the idea of the narrative unconscious suggests, to me at any rate, is that there is a deep ‘otherness or alterity within the fabric of identity, that alongside the manifest narratives we might tell about ourselves there are indeed latent counter-narratives, narratives that are different, that have little to do with events or scenes or (my) experiences but instead with supra-personal structures of meaning and significance (i.e. culturally-rooted aspects of one’s history that have not yet become of one’s story)”

In this quotation the common root of silent voices methodology and narrative methodology is set forward. As a narrative researcher, interested in silent voices, you want to discover the Narrative Unconscious. This narrative unconscious could be related to the Doxa principle of Bourdieu. Hidden doxas in the life-world of the tourist are showing the researcher what the historical supra-personal structures of meaning are. Examination of narratives, counter narratives, resulting in the narrative unconscious, proves its success by the cross-cultural global reality. By listening to African tales also European
counter-narratives can be explained and pointed out. This is only a first and incomplete elaboration on the narrative methodology of silent voices, but it could have its use and meaningfulness for future research into tourism and beyond. A final and tentative methodological frame will support this elaboration.

In this article an attempt has been organized to develop a search for hidden information starting with clashes of interpretations that emerge during life world-shocks. This hidden information is to be organized in doxas that constitute the main elements of the sensitizing perspectives of the interpretations at stake.

Once these perspectives have been activated, a polyphonic dialogue (Clifford, J. 1988) can be created that involve the testimonios of the perspectives involved. This dialogue presupposes egalitarian relations between the participants as this forms also a main element of the concept of a testimonio (Denzin & Lincoln, 2005). In a silent voices methodology a first focus is on testimonio approach of egalitarianism between narrator and researcher, but a second focus is also on the researcher who tries to evoke silent voices into his dialogue with the participants. This implies that silent voices methodology maintains the primacy of the narrator, but adds the professional skill of the researcher to detect what is formerly hidden.

First of all a training needs to be provided to the interviewers into the theory of silent voices. Also the idea of the polyphonic dialogue as practice and concept plays a role here. But in addition a more active empathic role from the interviewer must be added. Secondly, in order to discover silent voices within a tourism context into a possible research project the use of stakeholders is recommendable. Tourists, professionals and local residents could tell their stories to a trained interviewer. Next to this effort, the method that could be used is this of storytelling in conjunction with the practice of testimonios. An interviewer sensitive to the discourses within the interviewee(s) could not only receive information but also steer the dialogue in search of the silence voices. By means of storytelling the narrative concepts could then elicit the narrative unconscious. Stories will include the contexts that are hidden in the normal pragmatic discourse within the tourism sector. A fifth step in this process is a validation or triangulation of another source of information. Secondary data in the form of brochures, images, videos, focussed on the same topic or context will be confronted with the stories so that these stories and discourses can be tested on their true value as information. A final important issue are the results which only possess real value if the detected silent voices offer also explanations and tools for multiple stakeholders, such as the tourism industry and professionals.
Table 1: Silent Voices Methodology for tourism studies research
A 6-step model to detect silent voices in doing qualitative research with an active role as a social researcher

5. Discussion

Cultural encounters play a significant role on different levels in the interacting networks of our network-society. Many words have been spoken (Hollinshead 1993, 1998, 1999 and 2007) already about the complexity of these encounters in international tourism destinations. An important part of this complexity is being played by the hidden information that lurks at the background of variegated and interacting, cultural contexts. The assumption, here, is that there are not many hard bedrocks of cultures in isolation to be found, but there are many possible mutual reactions between cultural elements in the encounters of this network-society. Hybridity (Hollinshead, 1998) seems to be an important concept in this complex cultural game. In order to reach to the hidden information that goes with this concept of hybridity, a discussion has been organised in this
article about a theoretical and methodical approach towards this hidden information that lurks at cultural backgrounds and influences much of our behaviour in this network-society.

Crucial in this approach is a first step of contextualisation. During life world-shocks information is generated around some theoretical concepts that Bourdieu has introduced. With (allo)doxas, habitus and field as main anchor points sensitised perspectives have been developed that organise this hidden information in a perspectivist and narrative approach. It can be seen as knowledge that is of a latent structure, which has to be uncovered. Silent voices refer to that latent structure of knowledge which could be uncovered by narrative qualitative analysis. In this sense, (Freeman, 2004) refers to the ‘narrative unconscious’ and of counter narratives. A last question in this article has been how to develop a methodological strategy in order to systematise the presented approach of this article in a more concrete manner. The chosen model offers a possibility to use the narrative methodology to uncover silent voices, using a blend of neighbouring qualitative paradigms ethnomethodology and hermeneutics. Of course, it can be subject to argumentative limitations such as the communicative skills of participants or availability of secondary data used for validation and cross-checking sources. However, silent voices can only be uncovered in a research methodology which is flexible and sensitive to unexplored contexts from which they originate.

6. Prospect

Silent voices are a substantial element in the main debates on tourism in this complex world in-between the global and the local. They cause a lot of confusion in academic and professional discourses where they are often admitted as important but not taken seriously into account because they are not heard enough. Therefore, it remains crucial to break the silence and to involve the silent voices in these discourses in many contexts all over our contemporary network society. The methodology, proposed in this article, serves as an attempt to introduce the sound of these new voices into the concerto of a polyphonic dialogue. This dialogue is impregnated in the communicative environment of an interaction between various cultures that should be treated in an egalitarian manner.
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CHAPTER 3

Theoretical framework

Transnational health care:
From a global terminology towards
transnational health region development

Abstract

Within European cross-border patient mobility, recent studies have identified several types of international patients. In the Anglo-Saxon setting another terminology is used (medical tourism). The analytic purpose of the paper is reflected by this semantic difference which can be overcome by suggesting an alternative terminology which proposes ‘transnational health care’ (THC) as a context-controlled coordinated network of health services.

For demand-driven trans-border access seekers (TBASs) and cross-border access searchers (CBASs), there is a need to opt for regional health policy strategies. For supply-driven sending context actors (SCAs) and receiving context actors (RCAs) there would be organizational benefits by means of these strategies. Finally the paper - as a normative purpose - wants to use this terminology to introduce a policy route for transnational health regions. It is suggested that the development of transnational health regions, each with their own medical and supportive service characteristics, could enhance governmental context-controlled decision power in applying sustainable health destination management (SHDM).
1. Introduction

The purpose of this paper is two-fold. First, it wants to develop a global terminology for transnational health care (analytical purpose). Second, it wants to use this terminology to introduce a policy route for transnational health regions (normative purpose).

The analytical purpose is designed to indicate the differences and similarities in terminology between cross-border health care and medical tourism. The former is built on a demand-side logic (the patient and the patient's needs), with the latter built on a supply-side perspective (the sector and the wants of the sector). Furthermore, an alternative transnational health care terminology is suggested, leaving the division between previous concepts behind. The new concepts are compared with the existing typology of (Glinos et al., 2010), based on which an argumentative process yields 12 types of transnational health care.

The normative purpose of this paper invites the reader to think more in terms of regional development for transnational health care. Regional development is seen from the following two sides: first, a larger role of the regional government to contextually control transnational health care initiatives, excluding large competition between national health systems; and second, the possibility to manage these regional initiatives by means of sustainable health destination management (SHDM), including stakeholder theory and practice (i.e. the application of clustering of significant multi-disciplinary stakeholders). This being stated, the policy concern of this paper is to enable national health systems and their populations develop further towards transnationalism, combining public health benefits with governmentally controlled market development.

Embarking further on why regions should invest in supply shortages in other regions/countries, (Mainil et al., 2013) suggest a scenario in which, ‘based on the assumption that the implementation of current regulations (i.e. EU patient rights directive, which is the regulatory EU legal framework for patient mobility in providing and instigating instruments to the member states) will create a dynamic with impacts on citizens, patients, health care service providers and third party payers, the material dimensions of citizenship and health systems (patients, third party payers, health services) become “transnational”. They will not be primarily organized within the boundaries of Member States any more. Social rights are fully linked with EU citizenship, and third party payers as well as health service providers operate and develop structures across borders.’

A limited literature review was performed on the different existing concepts around patient mobility. On another scale this is a conceptual and theoretical
paper, employing different influences from health policy, health, and tourism management. The primary focus of this paper is on developing a typology for patient mobility, rather than on the full scope of cross-border health care (movement or collaboration of providers); however, the regional development perspective opens the path for more stakeholder (for which read collaboration and movement) involvement.

2. Cross-border patient mobility and medical tourism

Europe has always had a particular perspective with respect to social security systems and health policies. It refers to the existence of several different health systems, but with a common focus on the citizen and his rights. This also incorporates a difficulty to organize an EU supra-national health policy framework. It is therefore reasonable that a different perspective - different from other parts of the globe - occurs in the case of patient mobility. Even if small in number and volume (De Neve, 2010), cross-border health services and patient mobility are high on the agenda of EU policy-making (Council of the European Union, 2011). Although still in its infancy, this trend has had a significant impact in some regions (e.g., Euregios/Euroregions (Brand et al., 2008)). Also, there is a fair amount of willingness among European populations to travel to another member state to receive treatment (average in the EU= 54% - overall N=27228; (Flash Barometer, 2007)). Because these patients cross national borders, the phenomenon is often referred to as cross-border patient mobility (Glinos et al., 2010), described by Glinos et al as: ‘at a minimum involves a patient who travels to another country for the purpose of receiving planned health care.’ A clear focus on the demand side of health care occurs here, as Glinos et al. state ‘rather than focusing on the suppliers of health care and their interests in patient mobility ... the industry-driven term “medical tourism” insinuates leisurely travelling and does not capture the seriousness of most patient mobility’, which brings us to other parts of the world, such as the Asian and US context, where medical tourism (Crooks et al., 2011) is the term which is mostly used, defined by Snyder et al. (2011) as: ‘it is a growing industry that involves patients intentionally travelling abroad for non-emergency medical services. Here a supply side logic and the focus on the role of the medical tourism industry seem to be the semantic focus. The proximity of the EU nation states could be partly held responsible for the semantic difference between cross-border health care and medical tourism. In the past, EU cross-border research projects were often centered around neighbouring countries. Medical tourism is often brought in
relation with larger distances between sending and receiving contexts. Medical tourism professionals are also using much more financial means and personnel to market their services. Health care is observed here as being dominated more by private investors, an aspect much less present in the context of cross-border health care, with its larger governmental rationale.

This generates a shift between EU perceptions of patient mobility and Asian/US perceptions of the medical tourist. Therefore, this paper suggests a terminology which fits both types of discourse and practice. One can state that if coordinated actions and enhanced structure and formality take place in cross-border and medical tourism services, we refer to them as transnational health care (THC). Transnational health care is recognized by the existence of extended global and local communicating professional networks within the provision of health care services. Patients would have to possess the possibility to make an appropriate and knowledgeable choice on the basis of these networks to go abroad and to receive health care. This could be seen as opposed to existing services, certainly in medical tourism contexts, where there is still a gap between what the patient needs and what the sector offers, arguing in terms of quality of care and supporting services (Turner, 2011; Lunt and Carrera, 2010). Also, in cross-border health care these globalized professional networks need to be engineered, as it concerns mostly small-scale local initiatives (Brand et al., 2008).

As a central point of reference in this paper we acknowledge an ethical stance which builds on the premises that hospitals and primary health care services need to be available to the patient in the most accessible way (access as a primer for universal health care); however, the reality is different to the extent that distance plays a role in the provision of health care. If patients or globalized citizens do not have access, in the form of waiting lists or the non-existence of a health service in the parent country, or simply cannot afford it, they should have the right to seek it elsewhere, in the most beneficial situation, with support coverage by the parent health system as described in the EU Patient Rights Directive or through the patient’s own financial capacity in the case of no coverage. In both cases the patient should have the right to search for the optimal solution for his or her own health and well-being. Therefore, this paper connects an alternative global transnational terminology to the central theme of access to health care.

Several types of international patients were identified in recent studies (Legido-Quigley et al., 2007; Glinos, 2010). Glinos (2010) provides a typology vis-à-vis the introduction of types of patient motivations (availability, familiarity, afford-
ability, and perceived quality) and schemes of funding (cover and no cover). This results in eight types of patient mobility. Although these patient motivations are observed as being useful for categorizing patient mobility, another set of categories could be used to segment patient mobility in view of transnational health regions. These categories are as follow. 1. Proximity/distance: what is the travel distance to the foreign health provider (the provider being part of a transnational health system: access to health care for transnational populations)? 2. Cultural proximity/distance (Bell et al., 2011): to what extent is the (medical) culture different in the foreign country to be visited? 3. Deployed searching or seeking effort: what is the difficulty or ease with which international patients are able to find access or need to seek for a health solution in another country? On this basis, one could depict cross-border access searchers (CBASs) as very common in Europe (patients crossing borders between proximal and/or related countries - EU countries could be defined as proximal to each other). This type includes ‘access searchers’ as an important aspect because it could be linked to European citizens who search actively for an access point in another national health system. Alternatively, it concerns US citizens crossing the border to Mexico to receive health care (Laugesen and Vargas-Bustamente, 2010). Trans-border access seekers (TBASs) are a better fit in terms of classical medical tourism, involving a larger geographical and cultural distance. The aspect of ‘access seekers’ refers to the risk patients from other cultures and distant nations take to go abroad, referring to an example of Arabian patients choosing to seek health care in Asia or Europe, hence the difference between ‘seeking and searching.’ This type of patients is taking the risk of longer and more exhausting travel efforts. In our view, ‘trans-border’ refers to these extensive travel efforts in combination with the health status of the patient, as opposed to ‘cross-border’: crossing a border is going outside your own country’s borders to a proximal and/or related country’s health system. This is a more conservative view of the term of ‘cross-border’ than that Glinos (2010) depicts as cross-border patient mobility.

The category of proximity/distance is related to the patient motivation of availability (Glinos, 2010): the geographical distance that needs to be overcome will have an effect on how available a medical service or provider is. The category of cultural proximity/distance could be related to the patient motivation of familiarity: if another health system is more familiar, it would also be culturally close. Finally, the searching/seeking effort can be linked to both familiarity and availability: the more available and familiar another health system is, the less searching/seeking is involved. By establishing the connection with patient motivation, the target is to refine the complexity that currently typifies international patients.
Table 2: Clarifying the terminology present in transnational health care

**TRANS-BORDER ACCESS SEEKERS (TBAS)**
Y is a cancer patient from Oman who needs a stem cell treatment not available in her own country. With help from her uncle, a search through the internet puts her in contact with a reputable hospital in Germany, which has a history of treating foreign patients. She will travel with two close family members. The hospital takes care of the lodging and paperwork for the family and the patient. The medical procedure is carefully planned and the patient travels to Germany for treatment. Travelling is not the best option, but is the only one which has some chance for survival. The international department of the hospital guides the service process and takes care of translation and social guidance. After a longer stay at the hospital the patient returns to Oman. The payment for the care was supported by a local insurance scheme. In the case of no coverage support the patient would have had to pay out-of-pocket.

**CROSS-BORDER ACCESS SEARCHERS (CBASs)**
X is a Dutch patient who has to cope with a long waiting list regarding his condition. His knee needs to be replaced. He can only have the surgery performed in the Netherlands in 6 months. He suffers from severe pain. Therefore, he chose to make an appointment with a Belgian border hospital. After the appointment it is clear that he would have the possibility of being hospitalized in 2 months. After a short stay in the hospital he could return to the Netherlands. He needs to check with if his private health insurance to cover this procedure under the new EU directive on cross-border health care. There is not a large cultural shift between the Belgian and Dutch medical settings.

**RECEIVING CONTEXT ACTORS (RCAs)**
Y is a local health care provider in Turkey. It is trying to attract foreign patients to heighten its productivity of health services. In order to do this the provider is contacting several medical tourism facilitators to make its services visible to other markets. The main strategy is to establish the idea that the medical procedure is cheaper and thus more affordable to the international patient. Several marketing efforts are being made. In this way the health provider is able to attract several cases of patients with a diverse array of therapeutic and medical outcomes. Follow-up procedures are not high-lighted in the marketing communication.

**SENDING CONTEXT ACTORS (SCAs)**
X is a health insurance scheme which is observing that it would be more cost efficient to send national patients for some specific health procedures to another country, with a different health system and procedures. It would mean for the patient a longer but controlled travel scheme. The quality of the foreign health system has been checked for and is similar to the home-based one. This concept is copied by other health insurance networks, some in combination with employers, who also see this as an efficiency exercise. The insurance sector is being observed as one of the advocates of controlled patient mobility.
Furthermore, the patient motivation of ‘affordability’ (Glinos, 2010) could be translated as a supply-driven tendency: how affordable is transnational health care for sending context actors (SCAs), such as health insurance schemes and sending context governments? The patient motivation of perceived quality is linked to the terminology of receiving context actors (RCAs): the providers and receiving context governments that are attracting international patients and so are interested in raising the perceived quality of their services. Finally, it is worthwhile to indicate that TBASs and CBASs are two types of transnational patient mobility which are at either end of a continuum, based on Distance/Proximity, Cultural distance/Proximity and High level searching/Low level searching, which means that richness of such a continuum foresees the existence of other combinations, such as for example Austrians going to Hungarian dentists in the border region (Proximity/Cultural distance/Low level searching).

3. Refining the terminology

Trans-Border Access Seekers (TBASs)
TBASs choose high-end medical services which are planned; the patients arrive from distant destinations because of a lack of existing specialties in their home countries. They need to cover larger geographical distances and invest in greater seeking effort to find their optimal health solution. In this delivery of services the element of equity is absent (Connell, 2006). Supply side-driven promotional efforts are present (Crooks et al., 2011; Mainil et al., 2011) and regulation is still lacking (Turner, 2011). In most cases, patients have well-defined financial means. Waiting times, which translate into a lack of existing services, are an issue. This results in a different relationship with public and private access. For TBAS the price is often part of the sales pitch when you hear transitional countries, such as India, Thailand, and Singapore, promoting their transnational health care in relation to the prices in the US and the UK (Mainil, 2011). These patients will pay because they expect high-quality treatment. The level of out-of-pocket costs is well-represented for this type, although the use of health insurance also exists in the case of TBASs. They also find access to both public and private providers. However, transplant tourism (Anon., 2008) and reproductive tourism (Pennings et al., 2010) are practices which tend to display private delivery. Characteristics of destinations do play a role. In the case of TBAS, it matters how willing a distant region is to profile itself in such a way that the patient is not culturally-shocked, it would have an influence on the medical treatment process. Thus, in relation to this destination factor, cultural-
ism plays a role. Unattractive regions are those with looming cultural, religious, or political issues that will not be comfortable to these patients. Cultural distance, as opposed to cultural proximity, is how these patients are determined.

**Cross-border access searchers (CBASs)**

CBASs can be connected to distance (particularly in lowly populated areas), to familiarity (populations split in two countries), to financial incentives (i.e. dental care from Austria to Hungary) and access to highly specialised care (in particular for small countries such as Luxemburg or Malta). From a supply perspective, the practice of traditional European cross-border health care activities is mainly concerned with treatment, joint use of resources, training and prevention (Brand et al., 2008). From a demand perspective, regarding the practice of patient mobility, the social right to health can be an issue for the EU (Nys and Goffin, 2011). It is about planned treatments in neighbouring countries (Boffin and Baeten, 2005). Because of waiting times or perceived differences in service quality, the Dutch go to border medical institutions in Belgium (Brouwer, 2003). With regards to opting for public or private access being CBAS, the new EU directive on cross-border health care (Council of the European Union, 2011) will have the blended effect that levels of reimbursement and levels of out-of-pocket will both be present; not all surgical procedures are covered by the national health insurances if one crosses the border for health reasons. When health insurance cover is present, price is a non-significant variable for this type. In the case of CBASs, the chance of finding a proximal and/or related destination is much higher than in the case of TBASs (low searching effort). A country seen as a health care-delivering context would align much more with the cultural identity of this type (cultural proximity). Therefore the role of the destination as a context to be managed is of a different character.

**Receiving Context Actors (RCAs)**

RCAs need to be aware of their perceived quality in the eyes of TBASs and CBASs. They can influence their own perceived quality by showing evidence of the real quality of the medical institution and its services. Other RCAs, such as regional governments, could play a role in making this capacity visible to other parties, such as purchasers/payers and prospective patients. In observing private delivery, the different work carried out, products and legal conditions in different countries, such as Hungary (dental tourism) and Turkey (eye surgery), make the provision of health care services more cost-efficient for the international patient. This will enable patients who can less afford these procedures in their home countries to travel and undergo these procedures.
elsewhere. These travel requirements are not incorporated in the national funding scheme as most procedures are viewed as a luxury and out of the ordinary realm of health care. This also holds for more aesthetic surgical procedures. For these local producers of globalized health care, it is common to apply internet marketing (Mainil et al., 2011) to show the goods (in this case medical procedures) and to refer to health packages (Connell, 2010). Travelling to these RCAs also involves greater travel effort and cultural distance than what occurs in the case of CBASs. We would argue that the presence of these factors show that this type of patient mobility shows a connection with medical tourism as a sector and practice, with a large amount of marketed services, which is also indicated by (Laugesen and Vargas-Bustamente, 2010) as they define medical tourism as ‘where people take advantage of cost differentials on services like pharmaceutical goods, dental treatment, or elective surgery.’ This type of reasoning is only taken into account when thinking in terms of commercialized servicers and providers. With regard to public delivery, receiving context actors could also be public health institutions. In Europe one can observe public hospitals treating these patients (TBASs and CBASs). The recent developments in the EU debate and resultant legislations with national contact points for patients in view of cross-border information and the European reference networks between health care providers and centres of expertise (Council of the European Union, 2011) are showing movement on the public scale. As a counter effect, the Belgian government has installed the Observatory for patient mobility to monitor rising patient mobility in reference to the needs of their own population (De Mars et al., 2011), defending the objectives of the national health system.

**Sending context actors (SCA)**

It could be more affordable for a large institutional framework, such as a health insurance plan or national social security scheme, to send patients to another country to receive health care. Because it is more affordable for the health insurance plan, this means inherently that it is also more affordable for the patient. The reimbursement of the cost of the procedures, travel and accommodation is a joint cost-efficiency exercise between the patient and the institutional framework. In the EU situation the patient may have a choice to undergo health procedures in the home country or abroad (Glinos et al., 2011). However, a health insurance company should take into account possible larger stress factors for the patients when they have to travel and stay in other cultural settings with different medical traditions. Countries are certainly also in favour of making their health care systems more efficient. Public authorities (Glinos, 2011) are also a part of the SCAs. Transnational co-operation between these
SCAs could be linked to a specific future level of organization within the EU with respect to health policy. SCAs tend to be operating in a transnational manner. Health insurance schemes do not act in terms of countries, but in terms of transnational patient flows and rights: being insured as a patient, and being able to work in one country and to receive health care in another. This idea could be linked to the assumption that such hybrid patient and institutional transnationalism would urge for another EU health policy deployment: regional or context-controlled development and management to facilitate transnational movement of complete sets of health-related institutions, their professional workforce, and their patients. Following this logic, this would enhance purchasers/payers to act and perform more in view of the development of transnational patient mobility, and at the same time serve the public health cause by installing controlling and governance devices for those purchasers/payers.

4. Towards 12 types of transnational patient mobility

In combining the terminology of CBASs, TBASs, SCAs and RCAs (terms as described above) with public/private/no health cover on behalf of the demand side and public/private provision on behalf of the supply side, a typology has been developed, resulting in 12 types of transnational patient mobility. These 12 types will themselves develop in number according to how transnationalism will (not) expand in the coming years

Type 1A: Cross-border access searchers (proximity/cultural proximity/low searching effort), who search for public access to another health system by means of public health cover in using a public health insurance provider (SCA) and find access in the form of a public hospital provider.

Type 1B: Cross-border access searchers (proximity/cultural proximity/low searching effort) who search for public access to another health system by means of public health cover, in using a public health insurance provider (SCA) but find access in the form of a private hospital provider.

Type 2A: Cross-border access searchers (proximity/cultural proximity/low searching effort) who search for private access to another health system by means of private health cover in using a private health insurance provider (SCA) and find access in the form of a public hospital provider.
Type 2B: Cross-border access searchers (proximity/cultural proximity/low searching effort) who search for private access to another health system by means of private health cover, in using a private health insurance provider (SCA) and find access in the form of a private hospital provider.

Type 3A: Cross-border access searchers (proximity/cultural proximity/low searching effort) who don’t have access to reimbursement, and as such do not use an insurance scheme, but find access in the form of a public hospital provider.

Type 3B: Cross-border access searchers (proximity/cultural proximity/low searching effort) who don’t have access to reimbursement, and as such do not use an insurance scheme, but find access in the form of a private hospital provider.

Type 4A: Trans-border access seekers (distance/cultural distance/high seeking effort) who search for public access to another health system by means of public health cover in using a public health insurance provider (SCA) and find access in the form of a public hospital provider.

Type 4B: Trans-border access seekers (distance/cultural distance/high seeking effort) who search for public access to another health system by means of public health cover, in using a public health insurance provider (SCA) but find access in the form of a private hospital provider.

Type 5A: Trans-border access seekers (distance/cultural distance/high seeking effort) who search for private access to another health system by means of private health cover in using a private health insurance provider (SCA) and find access in the form of a public hospital provider.

Type 5B: Trans-border access seekers (distance/cultural distance/high seeking effort) who search for private access to another health system by means of private health cover, in using a private health insurance provider (SCA) and find access in the form of a private hospital provider.

Type 6A: Trans-border access seekers (distance/cultural distance/high seeking effort) who don’t have access to reimbursement, and as such do not use an insurance scheme, but find access in the form of a public hospital provider.
Type 6B: Trans-border access seekers (distance/cultural distance/high seeking effort) who don’t have access to reimbursement, and as such do not use an insurance scheme, but find access in the form of a private hospital provider.

<table>
<thead>
<tr>
<th>CBAS: cross-border access searchers</th>
<th>CBAS: trans-border access seekers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health cover TYPE 1</td>
<td>Public health cover TYPE 4</td>
</tr>
<tr>
<td>RCA PUBLIC* TYPE 1A</td>
<td>RCA PUBLIC* TYPE 4A</td>
</tr>
<tr>
<td>RCA PRIVATE TYPE 1B</td>
<td>RCA PRIVATE TYPE 4B</td>
</tr>
<tr>
<td>SCA</td>
<td>SCA</td>
</tr>
<tr>
<td>CBAS: cross-border access searchers</td>
<td></td>
</tr>
<tr>
<td>CBAS: trans-border access seekers</td>
<td></td>
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<tr>
<td>Private health cover TYPE 2</td>
<td>Private health cover TYPE 5</td>
</tr>
<tr>
<td>RCA PUBLIC* TYPE 2A</td>
<td>RCA PUBLIC* TYPE 5A</td>
</tr>
<tr>
<td>RCA PRIVATE TYPE 2B</td>
<td>RCA PRIVATE TYPE 5B</td>
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<tr>
<td>SCA</td>
<td>SCA</td>
</tr>
<tr>
<td>CBAS: cross-border access searchers</td>
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</tr>
<tr>
<td>CBAS: trans-border access seekers</td>
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<tr>
<td>No health cover TYPE 3</td>
<td>No health cover TYPE 6</td>
</tr>
<tr>
<td>RCA PUBLIC* TYPE 3A</td>
<td>RCA PUBLIC* TYPE 6A</td>
</tr>
<tr>
<td>RCA PRIVATE TYPE 3B</td>
<td>RCA PRIVATE TYPE 6B</td>
</tr>
<tr>
<td>NO SCA</td>
<td>NO SCA</td>
</tr>
</tbody>
</table>

* Public refers to hospitals providing care within a statutory healthcare system, but making a choice to develop strategies to attract patients from abroad.

Table 3: Twelve types of transnational patient mobility

Types 1A, 1B, 2A, 2B, 4A, 4B, 5A and 5B can develop further within the legal framework of the European Patient Rights Directive and its implementation by the member states. Types 3A, 3B, 6A and 6B are exemplifying the gap between EU regulations and individual health consumerism/citizenship. These types could enable governments to think more in terms of ‘context-controlled health regions’, where context-controlled refers to the role of regional and nationwide governments who could be more directive in installing strategies for creating networks and institutional devices for international patients. Making certain medical procedures more regional-specific would be one option to take. But how does this relate to the typology of transnational health care? At first, TBASs would be able to make more choices based on exact knowledge of the present expertise in a certain health region, as they are travelling a lot to make this choice. Secondly, in the case of CBASs, more geographic spread
would be created in this type because of the controlled regional specialties. Furthermore, this clarity would also be of use to health insurance schemes (SCAs), which need sound structure and the guarantee of quality for their clients. Finally, if RCAs were embedded in a larger nationwide or regional network they could benefit from branding and communication networks.

### 5. A role for the regions

For patients with decision-making freedom, the developments and characteristics of destination will tend to play a larger role in medical services. Medical stakeholders such as SCAs will be influenced by the destination image on national, regional, and municipal levels. Without a doubt the destination factor plays a larger role in developing countries and governments that want to attract international patients. The positive characteristics of a destination will play a role in how attractive a medical provider is for its international patients. If a medical institution is embedded in a rich cultural, instrumental and operational context, this can boost the medical institution. When receiving medical treatment extra stressors will have an effect on the willingness to travel for health care.

This can also be translated in the way medical providers such as RCAs are able to profit from the destination context and their embedding in the region. The region should be managed so that cross-border access searchers and TBASs are able to connect and feel comfortable in their treatment and/or in receiving additional services. This is a logic which could also be turned around. Cultural and ethical sensitivity will be necessary on these different levels (destination, region, and medical providers). In the same way Italy is conceived as a tourism destination, it could also be managed as a health destination. A critical question is, of course, whether or not different policy communities favour such an evolution. TBASs, CBASs, SCAs and RCAs demand additional services that cannot be classified as strictly health care services. An international patient will use airlines and other transport services and additional lodging, needs information on insurance and liability, may struggle to cope with cross-cultural issues, and may need additional support staff. These are all possible reasons why the number of such patients is still low. However, in view of future developments, the needs of these patients may offer an opportunity to develop specific health regions or health clusters which aim at delivering a specific range of services which are unavailable in proximal regions. Each ‘health region’ could enhance its specific
profile and expertise. If several specific health regions were developed, they could target specific patient types, removing the element of pure competition between national health systems. Regional governments, supported by (supra) national bodies, could steer this regional health development, and formalize the process through a sustainable health destination management (SHDM) approach. By investing in regional transnational capacity, this could transform the gap between domestic and transnational patients: domestic patients identify themselves with their region and as such SHDM could be a promotional and content vehicle that would make domestic patients see their region as a transnational one, attracting (trans)national patients because of its excellence. Currently domestic patients are often afraid of the possible effects of foreign patients entering their national health system. Could market segmentation - seen in tourism (Dolcinar, 2004) – be a valid tool for the development of transnational health care? With respect to the European Union, initiatives towards this approach are still in their infancy, but at least there are some developments, such as the regional government of Bavaria: it is using the slogan ‘Bavaria: a better state of Health,’ combining both trade and health departments. Hospitals in the region are being promoted on their website in combination with touristic characteristics of the region, involving spa and wellness. The border region between the Netherlands and Germany is subject to cross-border patient mobility, resulting in partnerships between Maastricht University Hospital and Aachen University Hospital. These initiatives are generating input from other service industries at several levels. The challenge would be how nation states would deal with access to its transnational health care. Is there only room for private initiatives to handle international patients or can the public health sector be involved? Are there ways to enhance governmental influence on transnational health care in view of the patient? What effect would developing health regions or health clusters have on public health care provision? In Europe, these questions obviously could be answered within EU policy debate and regulations.

6. Future perspectives: prospect

With respect to this typology and its regional consequences, it is clear that the positive opportunities have to be exploited consciously. If the transnational health care types could be explored and segmented further, then policy actions would be possible. Specific regions could serve as medical hubs focusing on specialized surgery. These centres of medical excellence would attract the
TBASs and CBASs if aligned with national and regional governments, allowing for several excellence centres to arise in different specialities. Furthermore, SCAs and RCAs could be embedded in this system. The terminology presented in this paper could serve as a conceptual argument towards the development of transnational health care in Europe or elsewhere.
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CHAPTER 4

Worldmaking

Diving into the contexts of in-between worlds: Worldmaking in medical tourism

Abstract

Alexis de Tocqueville, back in 1835, opened himself up with some nostalgic resistance for this new world of American democracy that he saw as the world of the future. A serious rupture in history took place of which he became a most relevant criticist. But ruptures multiplied since then: short periods in history of ‘in-between-worlds’ became more anchored in the Western world than ever.

Today, tourism as an expertise field of practice and knowledge is intertwined with several other networks of expertise. It is responsible for small ‘ruptures’ within these modern times. Mass tourism could be seen as a shift. Sustainable tourism and the attention for climate change would be another. An interesting case would be Medical tourism. It has a severe form of world making capacity, especially by means of the world wide web and international marketing tools. It arises in the interstices of the interacting networks of a global world. It crosses borders in line with emerging power-structures in a global network, but it also meets local resistances or regional obstacles which are related to other networks. In contexts from in-between-worlds various interactions of perspectives, for example, on the concept of health itself, come to the surface. Within the field of medical tourism different stakeholders play a role in a world making process. Medical tourism itself is responsible for a rupture in a global network society. Also a new hybrid (Hollinshead, 1998) medical paradigm seems to appear, which already exists in the world of tourism.

Key words:

World making – Rupture – In-between worlds – Medical tourism – In-between worlds – Network society

(concepts explained within the glossary of terms are marked with the symbol • at their first appearance in the paper)
1. Introduction: In-between-worlds

During the nineteenth century the French aristocrat de Tocqueville made a thorough analysis of the emerging democracy of the New World (1835; 1840; 1968). In his analysis it repeatedly appears that he situates himself in-between two historical eras, the old aristocratic and the new democratic one. This position seemed to be promising in its unique opportunities to analyse both worlds from ‘the other perspective’. Being raised in and impregnated by the values, convictions and conventions of an aristocratic, European old world, de Tocqueville opened himself up with some nostalgic resistance for this new world of American democracy that he saw as the world of the future. A serious rupture in history took place of which he became a most relevant criticist. But ruptures multiplied since then. Adapting Foucault’s framework in his histories of punishment (1975), madness (1961), the rise of a new [medical gaze] (1963), the history of sexuality (1976; 1984; 1984) or of knowledge itself (1969) to our network-society, short periods in history of ‘in-between-worlds’ became more anchored in the Western world than ever. After these short periods – according to (Foucault, 1975) – at the start of the nineteenth century a drastic process emerged of disciplining society in all these and more areas of everyday life. At schools, on the labour market and in tourism the same process of ‘disciplinisation’, that marked the new modern era, seemed to take place after this short period of rupture that preluded these revolutionary changes.

In the history of science, as it has been analysed by (Kuhn, 1962), (Lakatos, 1965), (Latour, 1987), (Bourdieu, 2004) inter alii, the same picture appears to the mind: in a short period of time the epistemological grid changes drastically during a revolutionary stage of abnormal science in which the social context plays an important role to understand the ‘growth of knowledge’. After it the grid took another turn: Newton’s theory that dominated physics for more than three hundred years was replaced by Einstein’s ( and Bohr’s) after this rupture. In this short period, too, the space of an [‘in-between-world’] plays a crucial role during these ruptures in power- and knowledge-constellations. It all seems to happen in a short period of time during which an enormous outbreak of uncertainty and creativity lies underneath the everyday life experiences of its participants. Tourism as a modern field of practice and knowledge could been seen as a creator of ruptures within a global market perspective.

Certainly in modern and post-modern life worldmaking – in its pure form, being the creative power to enhance new decisive ruptures (authors view) - constitutes an important part of this outburst of creativity from within these
‘in-between-worlds’. De Tocqueville referred to it in his analysis of the rise of American democracy. At the eve of world war one a famous and creative centre of art and philosophy in Vienna reflected on its position and created new forms

<table>
<thead>
<tr>
<th>Medical gaze:</th>
<th>the dominant medical perspective that came into existence around 1800 in the hospitals of Western society (Urry’s ‘tour-ism gaze’ has been based on this)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinisation:</td>
<td>according to Foucault the main principle that dominated in the Western system of punishment, hospitals, psychiatric institutions, schools and others. Through it people became controlled and ‘normalised’ in their behavior</td>
</tr>
<tr>
<td>In-between-worlds:</td>
<td>the place from where for example people within two cultures interpret each of the two cultures they are part of.</td>
</tr>
<tr>
<td>Third cultures:</td>
<td>cultures that emerge through a fusion of cultural elements from different cultures</td>
</tr>
<tr>
<td>Verstehen:</td>
<td>a method that tries to understand something as a meaningful element in its coherent context. As the method form the ‘geisteswissenschaften’ often opposed to the ‘explanations’ of the natural sciences.</td>
</tr>
<tr>
<td>Enunciated:</td>
<td>evoked, derived from the french ‘énoncé’ which is a core element of knowledge that has been evoked (enunciated) during the activities of the archeologist of knowledge, in casu Foucault himself</td>
</tr>
<tr>
<td>Episteme:</td>
<td>Greek for ‘knowledge’. According to Foucault the ‘in-depth’ structure of knowledge</td>
</tr>
<tr>
<td>Distanciates:</td>
<td>a crucial problem with ‘perspectivism’ is how to relate introspective perspectives with ones that are created from a (scientifific) distance or ‘distanciated’ (see Paul Ricoeur).</td>
</tr>
<tr>
<td>Perspectivation:</td>
<td>from positions in society people develop perspectives on the world. These perspectives interact in various manners and this process of interaction is called perspectivation (see Ulf Hannerz)</td>
</tr>
<tr>
<td>Doxas:</td>
<td>basic opinions that constitute the habitus of a field according to Bourdieu. For example: you do not talk about the price of a painting in the field (world) of art</td>
</tr>
<tr>
<td>Network society:</td>
<td>a new type of society that consists of diverse traditional, national, regional, transnational, global or virtual networks that interact all over the global village while crossing borders all the time (see Manuel Castells)</td>
</tr>
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Table 4: Glossary of terms
of thought and imagination. San Francisco (Hannerz, 1993) was such a centre during the sixties of the last century where ‘alternative’ forms of life were being tested as in Copenhagen, Paris, London or Amsterdam. More ruptures in various areas of everyday life seemed to emerge in a new era, that many started to call post-modernity. Post-modernity became synonymous with a chaotic world where different ‘worlds’ coexisted next to one another. This coexistence did not only take place in peace and harmony. Many interactions between these ‘worlds’ were possible. They could clash and end in serious conflicts like the ‘generation gap’ or the sexual revolution, they could merge into [‘third cultures’] (Featherstone, 1990) and they could take all the forms of hybrid interaction (Hollinshead, 1998) in-between these extremes. Characteristic of all these types of interaction is that the phenomenon of a rupture became a crucial element to be taken into consideration. This also implied that ‘in-between-worlds’ and the eruption of a process of worldmaking have been multiplied with it. The world of tourism is intertwined with several other global arena’s, it could be considered as a marker of interactional liaisons of multiple actors.

2. The proliferation of worldmaking in a networksociety

(Giddens, 1991) refers to modernity as a risk culture in which reflexivity and reskilling, based on local knowledge of day-to-day life are combined with systems of accumulated expertise with its disembedding and deskilling influences. These systems act to transform the content and nature of day-to-day social life while at the same time (late)modern people are getting used to reflect on the risks of this same social life. Nevertheless Giddens does not mean by this that social life is inherently more risky than it used to be (1991; 3):

“... for most people in the developed societies this is not the case”

In statements like this Giddens, just like Habermas and Foucault, makes clear that he does not involve the rest of the world, apart from the developed societies, in his thoughts. In an attempt to include the rest of the world a first point of reference must be the even bigger tension between the global and the local than Giddens, Habermas and Foucault have ever thought of. The abstract systems of Giddens penetrate in different ways into the local, regional and national lives of the non-Western world. Disembedding processes by the expansion of abstract systems, like money and power, do influence this rest of the world, but not in the same way. For a long time tourism has been seen as the appendix of a
neo-colonial plantation-economy in which the rich West once again dominates the poor Southern part of the world. Recently, however, Boissevain inter alii point to a reverse movement as well. Through this new interest of tourists in local cultures, modernisation through tourism does not only imply the subsequent destruction of these cultures. Often a revival of previously forgotten cultural elements, like local dances or food, follows this foreign attention to the local culture at the same time. From within the context of local cultures themselves always a reaction to globalising influences takes place that needs our understanding as well. People are not just passive recipients of globalisation, but react actively to it from within their local contexts. How strong this reaction can be, of course, depends also on the dominating discourses and counter-discourses in any region.

Bali has a long and strong local tradition of assimilating new elements in its rich culture. Therefore the disembedding process of touristification of Bali (Picard, 1996) is not self-evident because of the actual business influence of tourism interests. Is there, or not, boundary maintenance? – or more specifically, are the Balinese able to distinguish clearly between that which they sell to tourists and that which they reserve for themselves, between their religious ceremonies and the commercial performances derived from them?

Giddens especially knows that in late modernity ‘a plurality of choices prevails’ (Giddens, 1991, p. 219). The point here is that this Western plurality must be rethought of in a confrontation with the rest of the world whereby this plurality might be problematised in other, non-Western contexts when transmitted to the tension between the global and the local. In the work of Foucault this transmission did not take place either. The individualising disciplining of modern Western hospitals, prisons, schools, armies, labor markets, as described by Foucault cum suis, obviously does not take place in the same way in the rest of the world. It takes elaborate research into non-Western backgrounds to come to sophisticated conclusions on the various sorts of disciplining in other parts of the world. At the same time the expansion of these abstract systems ‘creates increasing quanta of power – the power of human beings to alter the material world and transform the conditions of their own actions’ (Giddens, p. 138).

Foucault, in a rather similar way although with much less attention to the human agency, refers to counter-discourses as present but not dominant enough in modern life. Here too, the analyses of Habermas, Foucault and Giddens do not suffice, because of the growing complexity in the tension between the global and the local, caused by many new voices, and the plural reactions in various
forms from diverse interfering networks all over the globe. For example oral traditions in Africa may change over time into a new orality of the post-colonial city (Allessandro Triulzi in Chambers and Curts, 1996, p. 78):

It were the pavements, the squares, the village neighbourhoods and the run-down fringes of the city that elaborated and transmitted this new form of orality that I shall term ‘urban’: the word inscribed, drawn, on the walls of Mogadishu, the word spread by pavement radio in Kinshasa, the satirical word, traded like goods, in the market place of Lomé. This return of orality and its shift from the country to the city is one of the new signs of contemporary Africa and its strategies of identity.

Where different encounters of Western and non-Western worlds have to be taken seriously, this proliferation of world making from within ‘in-between-worlds’ could provide us with an interesting and relevant source of information about how to understand these new circumstances. This implies that world-making within ‘in-between-worlds’ should be reviewed on the global scale of a [network-society] (Castells, 2000). More specifically, a reorientation of dominant Western perspectives draws the attention here.

For some decades anthropologists like Clifford Geertz (1983, 1993) have spoken about an ‘interpretive turn’ in anthropology. By this they turn again to the long tradition of ['Verstehen'] that has been marginalised too long in some main anthropological streams of thought. This turn also accentuated a change in the anthropological attitude from a distant professional who analysed cultures in terms of functions and dysfunctions to an involved interpreter who tried to understand meanings. (James Clifford, 1986) in his reaction to the ‘pastoral tendency’ amongst anthropologists wants to go even further. He feels that the professionalism of the – interpreting or not - fieldworker has to be relativised in view of the other relevant voices of a local culture. This relativising critique breaks with the original attitude of the mostly Western and logocentric, social scientist as the ultimate, neutral and objective assessor of local cultures as a whole. There is not one objective reseacher in control but many, often non-Western, voices need to be heard in order to generate better, objectified knowledge but also to include a more normative discussion on plural values and convictions that interfere with that knowledge.

Another example of this reorientation of Western perspectives from within in-between-worlds, stems from Spivak’s analysis (1999) of Marx ‘Asiatic mode of production’. Spivak relocates the intentions of this analytical category by infer-
ring the ‘native informant’s’ point of view. By this she creates a more diverse picture of what happened in this part of the non-Western world than Marx and his followers were able to. In the same way she criticizes the North-western European feminist who forcloes her Southern sister as a ‘native informant’ by sharing the male tendency to establish the North-western European subject as the same and dominating one. Gradually a more modest and refined kind of professionalism has been announced in our global village to which the answer of a proliferation of diverse local (counter) discourses seems more than logical alone. The exclusion of local perspectives that remain hidden in in-between worlds could be considered as one of the most threatening developments to a culturally diverse human existence, to be explored.

3. Post-colonial perspectivation in a new epistemological space?

This world is a complex network-society in which there is not one main and coherent, predominant discourse as a new totality, as has been illustrated in the books by Foucault, but diverse perspectives are [enunciated] in the same space of knowledge. Pluralism is a conditio sine qua non for an academic discussion on the new network society. In this sense, Foucault’s episteme still has a Western flavour that needs to be removed from it. Another important objection to the archeology or genealogy of Foucault is its relativism. In a network-society relativism is not an answer to the differences between perspectives. There is always a need to confront perspectives from a background of universal understanding. So, diverging perspectives will never be understood as isolated wholes that are not in need of critique from the outside.

Although there is some vagueness in the Foucaldean concept of episteme, the usefulness of the idea behind it for our purposes goes without saying. A post-colonial [‘episteme’], as circumscribed by (Stuart Hall and du Gay, 1996), makes sense, considering the often still hidden colonial influences in various forms of sociological, anthropological and philosophical thinking. Stuart Hall relate the resistance to these colonial influences in our globalizing world with its varying networks to this new discursive field, he calls ‘post-colonialism’.

In a post-colonial way of thinking all parties involved have gone through the phase of colonial relationships, are awakened from the frustrations and are supposed to build up a new way of understanding the emergent economic, political
and cultural networks around them. This new understanding [distanciates] itself from the former compulsion of the colonised to return a voyeuristic gaze upon Europe, away from the ‘Orient’s’ longing for its conquering other because this longing requires a simultaneous disowning of the world which has been colonised. In colonial education this same longing for the world of the conquerer has been institutionalized and this whole process should be understood by the post-colonisers and the post-colonised in order to recover from it. Still in our days Western observers tend to neglect their colonial past. This seems a logical reaction in view of what ‘selves’ do in late modernity:

“..avoidance of dissonance forms part of the protective cocoon which helps maintain ontological security” (Giddens, 1991, p. 188)

This also remains true for many Westerners in their relations with the non-Western world. Tourism offers good examples in this respect. Many Western visitors from the former colonies are travelling around in their ‘environmental bubble’ (Cohen, 1979) in which they want a secure and pampered treatment and certainly no harsh confrontations with their non-Western hosts.

As Homi K. Bhabha (1994) states, the culture of Western modernity with its carefully maintained ontological security must be relocated from a post-colonial perspective. The pastoral tendency in cultural anthropology has been unmasked as the projection of a so-called overcivilised Western society. Now the time has come to relocate this tendency by various post-colonial perspectives. In a comparable way Gayatri Spivak criticises the narcissism of the liberal-feminist investigator who gazes at the silenced third-world women without hearing them represent themselves (Spivak, 1987, p.41). It all ends according to Spivak with a solipsistic confirmation of the investigator’s discursive privilege. In criticizing the French feminist writer Julia Kristeva, Spivak (1987, p.137) states:

“Her question, in the face of those silent women, is about her own identity rather than theirs …”

This, of course, does not imply the preconceived rightness of a so-called ‘third-world’ perspective. In the words of Castells, in feminist literature the end of patriarchalism has been proclaimed and the nuclear family from modern times is partly replaced by a proliferation of various types of households. But there has also emerged a huge literature on the position of women from the Southern part of the world, written by themselves. In this literature various perspectives
are demonstrated in diverse circumstances of power relations from different parts of the world.

The fundamental task of feminism, says Castells, remains here to de/reconstruct woman’s identity by degendering the institutions of society through struggles and discourses. It leads to the construction of many identities that seize micropowers in the worldwide web of life experiences. This also implies the voices of women from various contexts, other than the dominating liberal-Western voice presented as a universal one. The question therefore emerges how the legitimating narratives of cultural domination can be displaced to reveal a ‘third space’ (Bhabha, 1994). According to Bhabha, in this third space there is a need for a theory of hybridity (Bhabha 1994; Hollinshead 1998), in which room will be made for new, emergent voices, and the translation of social differences that goes beyond the polarities of Self and Other, East and West. In a post-colonial order this also implies that previously silenced or silent voices enter the academic and professional discourses from their local perspectives in-between the global and the local, from many in-between-worlds. In a third space, therefore, different traditions meet with their fusing, clashing or interacting visions on moral and existential themes that are often excluded from official discourses.

From within worlds that have been constituted by these various interactions of local, regional, national, global deterriorialised or virtual networks – social structures – in one and the same place such as an international tourism destination, [perspectivation] is produced in the sense (Hannerz,1993, p.68) mentioned. People, according to Hannerz, ‘manage meanings from where they are in the social structure’ and perspectivation is the social organisation of meaning in a network of perspectives. The perspectivation of meaning is ‘a powerful engine in creating a diversity of culture within the complex society. Call the network a polyphony, as the perspectives are at the same time voices; term it a conversation, if it appears fairly low-key and consensual; refer to it all as a debate, if you wish to emphasize contestation; or describe it as a cacophony, if you find mostly disorder.’(Hannerz, 1993, p.68). And exactly this perspectivation reminds us of the process of worldmaking from within in-between-worlds in networks on a global scale.
4. Pluralistic worldmaking in a network society

Worldmaking is a discursive practice in the first place. As Foucault stated in his Surveiller et punir (1975, 24) in relation to a new, discursive world of punishment around 1800:

An entire whole of appreciative, diagnostique, prognostic and normative judgements about the criminal individual came to live in the shell of the penal laws. Another truth has penetrated the one that was demanded by the judicial mechanisms: a truth that, confusedly mixed at first, promoted the confirmation of guilt to a strange scientific, juridical complexe. (Translated out of French)

Two worlds meet in this passage, the old and the new. The new one is rising in a newly discovered discourse, while the old discourse is fading away. Or, a few pages before (Foucault, 22):

important instant. the old partners of the juridical frame of punishment, body and blood, left their positions. A new figure entered the scene, masked. Finished a certain tragedy: a comedy starts with silhouettes of shadow, voices without face, meticulous entities. The machinery of punitive justice must get hold now on that reality without body. (Translated out of French)

This type of confrontation between discourses that constitute real worlds in everyday life (in casu of punishment) has been multiplied in this network-society. For a good understanding of the process of worldmaking (holding for the definition of Hollinshead (2007) as well as for Mainil & Platenkamp, p5), a discursive analysis of what happens in the context of such confrontations seems highly recommendable. A main problem with this context is that many voices seem to remain silent, but not necessarily so, as counter-discourses that do not enter the official, often Western and even Anglo-Saxon dominated discourse. And there are many voices from within the contexts of many in-between-worlds that seem to be involved in a constant process of perspectivation that spans the globe. Too many ‘worlds’ remain hidden for the insecure lenses produced by academic or professional discourses in tourism as elsewhere.

This is where world making might enter the game, in the field of medical tourism. Medical tourism has the power to apply worldmaking in the sense of (Hollinshead, 2007) as a false imaginative process, but has also the chance of being a changing agent in how countries need to deal with global health care provision.
and globalization tout court. This is worldmaking in the positive sense of the word. The question, therefore, arises how to reach to these perspectives that remain hidden in the contexts of this type of discourse. And next to this, how do these perspectives interact in-between the global and the local? How does the concept of rupture play a role within the process of medical tourism?

5. Medical tourism, before and during the ‘process de rupture’

To travel for health reasons has always existed since the old ages, but you speak of a time before medical tourism became global and the momentum of today where multiple stakeholders are working towards a global network of health-related services. As we know the rooted idea of patients and their loved ones was to receive health in nearest medical institution and close-by general practitioner or medical specialist. This is a medical paradigm which has evolved in the choice of the health user to seek his health needs on a broader basis. We have to acknowledge that medical and health care are globalizing. The global network society has touched the medical field and this will not change anymore. Health care was built out of national health systems, today we see other perspectives arise for the supply and demand side.

Medical tourism is an interesting case. It arises in the interstices of the interacting networks of a global world. It crosses borders in line with global power-structures in a global network, but it also meets local resistances or regional obstacles which are related to other networks. Because of the relation between the local and global networks, in the case of medical tourism, the positive worldmaking capacity could come into play, whereas the false imaginative process could become prominent or turned down. Within this complex situation puzzling contexts merge that need the closest attention possible. In these contexts from in-between-worlds various interactions of perspectives, for example, on the concept of health itself, come to the surface.

6. Medical tourism: characteristics and background

Medical tourism could be considered as a boundary between health care provision and other business and knowledge fields:
Medical tourism as a niche has emerged from the rapid growth of what has become an industry, where people travel often long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense. It has grown dramatically in recent years primarily because of the high costs of treatment in rich world countries, long waiting lists (for what is not always seen institutionally as priority surgery), the relative affordability of international air travel and favourable economic exchange rates, and the ageing of the often affluent post-war baby-boom generation. (Connell, 2005)

As this example suggests, we consider medical tourism as a process: The health user makes the argumentative choice to receive health care in a medical facility in another distant location. At that illustrative point – if the international patient does allow guidance – a process starts: medical tourism companies facilitate the travel journey and guide the trip throughout its touristic and medical character. Two different worlds come together: the high technological and expertise-based medical world and the quality service-based tourism field:

Ultimately ‘tourism’ is rather more than just a cosmetic noun for an activity that otherwise has little to do with conventional notions of tourism, since most visitors and certainly those who accompany them, find some time for tourism. Moreover, at the same time, the whole infrastructure of the tourist industry (travel agents, airlines, hotels, taxis etc) all benefit considerably from this new niche. Indeed, since for a significant proportion of patients there may be a lengthy period of recuperation, the rewards to the tourist industry, and especially the hotel sector, are considerable. (Connell, 2005)

The stakeholders in this field (Bourdieu, 2004) will have to cope with new doxas, typically present in the in-between world reality. A doxa is implicit and self-evident. It is what people in a particular life world or culture share and which goes without saying, it is a ‘adhesion to the presuppositions of the game’ (Bourdieu, 2004, p.111). When two distant knowledge fields fall into collision with their own world-making capacities a new balance needs to be found. Out of the rupture new world making scripts arise, which enlarge the fields of uncertainty in the in-between vacuum of globalized citizens today.

Medical tourism is one form within globalizing health movements. Today it is ascertained that health care is globalizing and that global health issues should be taken care in a worldwide integrated approach. However many boundaries
exist within the field of global health. A large agenda is based on providing (medical) aid to deprived areas, but still out of an international mode (WHO, United Nations, NGO’s). This movement exists since a long period and developed in a mature practice (WHO, 2002) with its own dynamics and issues. Within this reality a lot of different political measures are taken, whose analysis falls outside the scope of this article. Another boundary is the young existence of cross-border health care: patients travel short distances to neighbouring countries because positive factors related to the health system of that country. A large difference with medical tourism is that the idea of tourism production is lacking. The medical aspect is the largest important factor. Health tourism could also be connected to global health. However one could speak then more of global well-being – referring to the provision of spa facilities and accompanying limited medical treatments. One could state that all globalizing health-related delivery could be put under the umbrella of transnational healthcare services (THS), with in the centre the transnational health user (THU). Medical tourism does fit in this terminology, which seeks to develop into a blended taxonomy, appropriate for several knowledge and business fields.

7. Stakeholder perspective within medical tourism

Medical tourism needs a stakeholder perspective. Considering medical tourism as a process also presupposes the idea that several gatekeepers play a role into the field. In the first place the patient traveller himself. He/she wants to finish his/her medical tourism tale with a positive and healthy vibe. However in his quest for health, he will find himself in an in-between world, travelling between his own cultural values and beliefs and those of the medical tourism destination. Next, we have the medical institution, the medical tourism facilitator and the homeland insurance company. They are the ones who are responsible for the world making capacity of medical tourism as a process. Finally we must not forget a third party who also has to deal with the reality of medical tourism: the local population who sees that the patients from out of the more developed countries are profiting from the services provided. In what way do local citizens benefit or suffer from the reality of medical tourism?! Globalizing health is causing ‘des ruptures’, because of the fact that the idea of receiving health care only in your neighbourhood has been abandoned by parts of the world population:
In less than a decade the rise of medical tourism has demonstrated that a form of service provision, the provision of health care, so labour intensive that it was assumed to be highly localised can now be globalised like so many other service activities. (Connell, 2005)

But in which way are the stakeholders involved in different aspects of this rupture?

Future patients of medical tourism enter the in between worlds by diving into the internet. Multiple websites on medical tourism show how great the possibilities are of visiting another country for medical purposes. They show the different operative procedures, together with pictures of facilities, hotels, sceneries. Via these websites the patient enters the field of medical tourism. It is in this way that the first contact is being made between medical tourism facilitators, medical institutions and the future patient. The process starts:

The health care travel packages typically include air and ground transportation, travel visas, hotel accommodations, assistance from a local company representative in the destination country, transfer of medical records to treating physicians, and negotiated rates for whatever medical procedures clients decide to purchase. (Turner, 2007)

In the best case scenario he will have pre-consultations in the home-country, after he will visit this new created world, where he will balance between a medical tourism facilitator spokesperson and the medical staff of the treating institution, in-between two worlds. In this way also a new world is created. The world making capacity of medical tourism websites, facilitator companies and medical institutions overseas goes without saying. Medical tourism advocates indicate however the unlimited opportunities for the individual seeking medical treatment:

With self-selected medical tourism the individual has control over his health care program. (Bies, 2006)

The internet could be seen as a world making entity or as mean to accomplish this. Within the context of medical tourism this is certainly the case because of the gatekeeper function of the medical tourism websites (Lunt, 2010). The first step to professional medical tourism practice will be these websites. Because these websites are linked to companies - medical tourism facilitators - they
should be made as attractive as possible to gain future health users. There is no
type way to show this world-making force by throwing some significant exam-
plars into the ring. There is a prominent body of knowledge on quality criteria of
medical websites. Development of criteria for medical tourism websites could
be an enrichment to professionalize this booming sector. Promoting its own
capacities is one of the main world making issues within these websites:
Cost Comparison – India Vs United States Of America (USA). Significant cost
differences exist between U.K. and India also when it comes to medical treat-
ment. India is not only cheaper but the waiting time is almost nil. This is due to
the outburst of the private sector which comprises of hospitals and clinics with
the latest technology and best practitioners. (website1, consulted 7/08/08)
The most prestigious medical centers that focus on medical tourism are state-
of-the-art facilities. These medical centers have invested in the latest technology
in laboratory, diagnostic and surgical facilities. The level of service in terms of
nursing care is second to none with nurse-to-patient ratios approaching one-
to-one. Leading overseas medical centers are run by highly proficient managers
with international experience.(website 2, consulted 7/08/08)

Next to this promotional and marketing content these websites show also an
array of medical info which is very descriptive, and often does not show alterna-
tive ways of dealing with disease management, in other words the future patient
gets only one possible side of the medical story. Proof for certain information is
very difficult to check for the patient, how can she or he know that this informa-
tion is true:
Example for gastric banding; advantages: • Lowest mortality rate • Least inva-
sive surgical approach • No stomach stapling or cutting, or intestinal re-routing
• Adjustable • Reversible • Lowest operative complication rate • Low malnutri-
tion risk (website 3, consulted 7/08/08)

This is just a small fraction of what is portrayed on medical tourism websites.
However, it is clear that future patients are subject to a whole new world. They
are becoming the masters of their own medical behaviour, but are making
choices on information that is coloured by its creators.
The supply of medical tourism is becoming a global phenomenon none the least
because of the urge of many national governments. They see medical tourism
as a solution, among others, for the economical prosperity and development of
their country. Medical tourism as a national solution has many aspects within
its reality:

Countries that actively promote medical tourism do so for self-serving rea-
sons. Investing in the medical industry is a way to increase gross domestic
product, upgrade services, generate foreign exchange and create a more favourable balance-of-trade situation, and boost tourism. Other more subtle benefits include stemming a brain drain of health professionals and buying goodwill. (Ramirez de Arellano, 2007)

Garud (2005) reported of governments of Singapore, Thailand and India as being the countries which were busy on the national policy level with regards to medical tourism initiatives:

In many countries, it is being actively promoted as an official government policy. The governments of Singapore and Thailand have been in the forefront in Southeast Asia and the Government of India is trying hard to catch up. (Garud, 2005)

However today, this national supply governmental policy is a global phenomenon in which already other countries play a role, like other Asian, South and Central America and European countries. This means that the public policies interfere or cooperate with private corporate companies which makes medical tourism a public-private global alliance.

Medical tourism can only become a real global health solution if also the local population of the specific medical tourism countries will benefit from the facilities and medical services provided. If this is not the case and you obtain a situation where citizens from western countries are the only ones who can reach for this kind of services, than this could have its effect on the perception of medical tourism as being a medical colonisation, which is not to wish for in the forum of global health discussions. Already in India (Garud, 2005; Hazarika, 2010), this rupture between an international based medical expertise and a more limited access for the local population could harm the global medical health discussion. However if national governments see medical tourism a means of developing their national health care systems this would weaken ‘la rupture’. A significant case of this idea could be perceived in Thailand (Cohen, 2008). Further research needs to be developed on the local perspective in relation to medical tourism. In a first phase, this would need to have the character of research with an ethnographic turn. Analysis of how patients and local populations deal and cope with this new cluster of services should be researched with qualitative research methods. It is unlikely to gather useful information into the minds and drivers of these stakeholders from out a quantitative reflex. The limitations of survey methodology have been ascertained many times. Also the concept that
health behaviour experiences are culturally determined, would instigate us to adapt an applied anthropological research design. This first phase should be executed by social scientists with attention and sensitivity for the life-world of the local citizen and health user.

8. Globalization, medical tourism and a new cross-cultural view on Health

The effects of globalization and the network society are present today without a doubt in many areas of expertise and human contexts. Medical tourism beholds the global dimension as no other realism, which of course has its geographical consequences. With multiple stakeholders in its toolbox medical tourism will continue to expand:

Despite the risks, medical tourism is expected to continue. Patients may no longer give a second thought to traveling halfway around the world for a procedure that is either not affordable or not available at home—especially if it might save their lives. And shopping for a surgical procedure could eventually become as routine as trying to find the best deal in airfare. (Newman, 2006)

However the combination of bringing the distant geographies to each-other by the different products medical tourism has to offer, could also lead to see the medical expertise as a field very much open for marketeers and business opportunities. One could speak of a brave new world, although offering health care initially followed other definitions. So an important relation between global health and medical tourism initiatives should be ascertained at the least, and worked through at the most. The geographical omnipresence of medical tourism could be seen as a tool for in tackling equity issues, to attain joint public and private goals.

Medical tourism as being a global entity within a network society also changes the idea of getting your health care in your own cultural setting. Your own cultural field will enhance your own values and beliefs concerning health and care settings. However when you change the home setting of health care into a global one, new cross-cultural experiences and skills come into play, for patients and relatives, as well as for medical staff and supporting services. This also will create – certainly in the beginning – a rupture for patients and the supply side. However, out of this cultural struggle the new cross-cultural patient-citizen will arise, who will acknowledge that global health care and medical tourism
need a new cross-cultural way of thought for medical care. American citizens who travel to Singapore for their health have to deal with cultural specificities of that country. Europeans who travel to Turkey for health reasons have to do the same. However, medical tourism medical staff and supporting services also need to make a cultural shift. This mutual cultural exercise is a form of world making where at the bottom end a new global network society setting starts. A shift which has already occurred in the tourism field among others.

9. Conclusions

This moment in time is showing us that the local notion of health care provision is slowly left behind. A new global form of health care perception is moving up, which has already occurred in the tourism field. Different stakeholders within medical tourism are responsible for its world making capacity. We keep in mind that the tourism industry is playing a decisive market role here. Before this could take a turn, a rupture had to take place where the local health care notion struggles with medical tourism’s global aspirations. The era of the medical institution in your neighbourhood or own country is still being present, however little shifts and ‘petites ruptures’ are shown within the media and in everyday life of worldly citizens. This new field of knowledge which covers elements of health care, tourism, cultural studies and social sciences is open for production. Tourism as a field of production for practice and knowledge is entering an era of standardization and professionalization because of the reactive boundaries with other areas of expertise. We should be aware of its capacity to shape and create worlds, both in an unethical (Hollinshead, 2007) as in a progressing, positive mode, introduced in this paper.
References

CHAPTER 5

Culturalism

1. Introduction

Transnational health care (THC) is a futuristic, coordinated and professionalised provision of cross-border health care and medical tourism services. It is an emergent field (OECD, 2011) with a lot of opportunities, but also has risks. A conceptual basis is lacking, therefore the application of an established thought model (Habermas’ action theory) would be beneficial for understanding the nature and dynamics of THC. The purpose of this chapter is to introduce the legacy of Jürgen Habermas and adapt it to the context of THC, in order to show the complex cross-cultural dynamics that play a role in transnational health care. Therefore we introduce the basics of Habermas’ general action theory (communicative and strategic actions/life-world and system). Then we link his theory to the dynamics present in THC (market/consumer/ethical/professional perspectives). Furthermore, we focus on a case study in THC, showing at a micro-level how there are tensions between communicative and strategic actions. The role of cross-cultural management is introduced to solve these tensions. Finally, the relationship between cultural management, THC and Habermas’ framework is discussed.

2. Basic concepts of Habermas’ theoretical framework

In the globalising world of, transnational health care, new areas of (intercultural) communication emerge that lead to particular directions in the discourses about THC. To understand these new directions it seems to be relevant to use the theoretical framework of the German philosopher, Jürgen Habermas (Habermas, 1982). Habermas tried to find an answer to the question of why so many things have gone wrong with the process of rationalisation that has accompanied the emergence of modern Western societies. Since we entered the era of globalisation, this question seems to have become relevant for the whole, interconnected globe, in many situations of everyday life, with a tension between the global and the local. A characteristic of the Western situation Habermas reacted to, is the modernisation of the whole of society. A new instrumental rationality that made many things in life more efficient and effective, replaced the old coordination mechanisms of, for example, religious resources in pre-modern times. On the
one hand, this new situation provides more welfare based on this type of instrumental rationality. On the other hand, it goes along with what Habermas calls various ‘pathologies’ in late-capitalist societies, such as alienation, fragmented identities, materialism, consumerism, the replacement of citizens by consumers, and the impressive influence of a massive culture industry. In order to analyse the ambivalence in modern society, Habermas distinguished two types of actions in his general action theory, which enables a strong characterisation of the situation that can be extended to the global–local nexus in THC.

First, there is communicative action. One of the basic questions of sociology has always been ‘how is social order possible?’ Through communicative action, one can answer by reference to the common definitions of the situation (reality) that are made in everyday communication. These common definitions not only refer to the objective situation of the actors, but also to the norms that are obligatory to them and to the truthfulness of their utterances. In their daily communication, people come to agreements by bringing frames of interpretation into discussion that are criticisable. Through argumentation that is free of power and oppression, agreements will emerge, according to Habermas, with this type of communicative action. The life-world, another crucial concept of Habermas, constitutes the horizon against which these communicative processes take place. It consists of non-problematic, mostly diffuse, background convictions that are the source of the attainment of common definitions of situations of communicative actions. Life-worlds contain a stock of experiences of previous generations in the form of interpretations of reality, constraining norms and fixed interpretations of needs. From within these life-worlds an argumentative type of discourse takes place that gives meaning to the everyday life of its participants, and constitutes a coordination mechanism for their actions because of their shared reality by common definition.

This, of course, is an ideal situation that is simultaneously challenged by a second type of action, strategic action. Everyone knows that he or she will sometimes be forced to accept a definition of the situation. This can be the consequence of strategic action, which is not oriented towards shared understanding but to results. Now, on the one hand this strategic action has brought about, in particular for Western society, a great deal of progress, strong political power and a flourishing economy. The reason is easy to understand: based on efficiency and effectiveness strategic action creates a much stronger coordinated type of action that speeds up and replaces the argumentative type of action by communication. The type of instrumental rationality that results from it has
created a money-based, interdependent world economy, as we have learned to understand it through the concept of a global village. The same goes for the power mechanisms that go with this type of rationality and that have created our global political system, with its divisions worldwide. This economic and political system is another crucial concept in Habermas’ theory, introduced in opposition to his life-world. Although many good things originate from the efficient and effective coordination of this system, it also has caused a crucial tension with the much more vulnerable, argumentative, processes of the life-world.

Colonisation and fragmentation of the life-world in-between the global and the local

Life-worlds can only be maintained by communicative action. When this is not functioning well, as in modern society, we witness the colonisation and fragmentation of life-worlds. Maintenance by communicative action should result in common frames of interpretation, solidary group formation and responsible individuals. Ideally speaking, the identity of a society would become, then, completely dependent on argumentatively steered processes of interpretation by its actors. There is a development in this direction, according to Habermas. But there are disturbances of these processes that can be very serious, because of the destructive influences they have on the processes of interpretation. On the one hand, life-world processes enable systems that are based on efficiency and effectiveness. And as long as they stay within the control of these interpretations, they are the basis of progress in our modern society. At the same time, however, this systemic influence becomes independent and starts to replace the interpretive coordination in modern life-worlds. States and markets deliver other dominant coordination mechanisms in the life-worlds of people, and cause a fragmentation and colonisation of these life-worlds through the growing importance of money and power over communicative interpretation. Markets and bureaucracy start to dictate the coordination of life-worlds to an unacceptable degree. For example, in higher education the knowledge economy often seems to have become the defining factor of its success. International rankings are followed, and the discussion about, amongst others, what education should imply for responsible world citizens seems to be replaced by them. Managers decide the costs and benefits of education and research, and are less interested in the academic mentality of doing careful research for the long term. This is unacceptable, because in their life-worlds humans should remain in control through their own frames of interpretation of what their world (of higher education) looks like or should look like, instead of being outvoted by the market.
mechanisms of the day. When this happens in a systematic way, life-worlds will be colonised by this systemic influence of money and power and their frames of interpretation will become fragmented and will lose their meaning and power for coordination.

This type of phenomenon has been analysed and extended by many theorists who follow Habermas in his explanation of the modernisation of the Western world. In this study his basic concepts, as explained earlier, will be applied to the situation of THC on a global scale, far beyond the Western world. In a globalising world this seems to be a logical next step. In-between the global and the local, new areas of communication have come into existence in the globalising world of THC, especially related to the media and the Internet. It seems challenging to explore the tension between the system and life-world in these new areas of communicative and strategic action.

3. Making a bridge between the rationale of THC and Habermas’ framework

In a globalising THC, the intermediary organisations in-between the system and life-world seem to form the place where the tension between communicative and strategic actions is mostly felt. For Bourdieu (1984), the stakeholders that are committed to this relatively new field constitute the ‘new petite bourgeoisie’ that emerges in a post-modern market situation (Featherstone, 1991). They are situated in-between production and consumption, and symbolic production is central to their activities, which frequently means the use of advertising imagery, marketing and promotional techniques. Translated to Habermas’ concepts, this would refer to an intensified struggle between the system and life-world, in which the human values from within their life-worlds are coming under the pressure of the demanding wishes of highly efficient and effective markets. One of the given facts in the medical tourism market is this drive to be highly efficient, leaving the gate open for severe strategic action. Therefore, let us observe the perspectives present in THC (Mainil, Platenkamp & Meulemans, 2010) and link them to Habermas’ action theory.

One can detect several perspectives present in the system of THC. First of all there is a specific ethical perspective present in THC. Stakeholders are offering (medical) services but do have to take into account the ethical perspective of treating a patient, which is of a different nature compared with selling a hotel package to a prospective tourist. Although this is clear, the existence of bro-
kers in the field (such as medical tourism facilitators and traders in the organ market) does not always allow this means of ethical reasoning, as the market perspective has an established tradition in the developing sector of medical tourism. Businesses and hospitals see ways of making profit on the basis of prospective streams of international patients, and translate these into marketing and business plans. The medical tourism sector is built on the generation of magical numbers of international patients: no real quantifiable data exist. The websites of the brokers show content that is not always built on truthful medical quality (Lunt, 2010). There is a perseverance to develop an international health care market: a market perspective that is known as the trade in health services (Smith, 2009). International patients are seen by the sector as consumers of health services. It is known that development of health literacy skills leads to more empowerment (Nutbeam, 2000). This could result in the development of pro-active searching skills on the Internet, searching for health information, along with developing another relationship with the medical professionals. This image is partially true, because in many cases patients do not have much choice in deciphering what health options they have. However, on the assumption that a THC sector will arise that is transparent, professional and based on a skilled network, health consumers will get the chance to make appropriate choices and decisions: a health consumer perspective. Consumerism is seen here as having almost the same connotation as citizenship, where patient rights do have a large part to play in the empowerment of patients. Finally a specific professional perspective is also developing. Professional elements from different sectors are combined and intertwined in THC: the tourism industry and medical sector. One cannot deny that a certain touristification takes place in the medical sector by means of medical tourism. How can the professional medic stay responsive in a sector ruled by packages, Internet marketing and a striving for commercial accreditation?

In order to make these four perspectives, prevalent and deterministic in THC, of use within the framework of Habermas, one needs to position them as strategic action and/or communicative action. Therefore we want to form the thesis that being ethical and being a knowledgeable consumer/citizen as a patient are forms of communicative action. On the other hand, marketing and professionalising the services would be seen as forms of strategic action. One could argue that it is possible to see a sustainable consumerism as a form of communicative action, without breaking the rules of Habermas’ view on the development of consumerism. It is the life-world in which the patient operates, based on a set of communicative rules: his or her patient rights. If you inform yourself as a
responsible user of health services abroad, you hope that the information you receive is based on common understandings regarding how to communicate truthfully with the consumer as an organisation within THC. Strategic action in this case would be to market your services in such a way that your organisation benefits from it, but, in order to do so, you should abandon the equal bond between doctor and patient, and let commercialisation of health services rule. Systemic occurrences are instigating a medical tourism market, but one based on strategic actions: the market is creating itself with a view to monetary and business objectives. Also, what one considers as ethical in health matters should be seen as a joint exercise of communication within a health community with democratic rules of engagement. The way an organisation professionalises itself could be determined fully by strategic action. Again this is based on non-democratic processes that are efficient in making profit but could be dysfunctional for the patient as a global consumer. Apart from this, but not of relevance in the context of this chapter, it excludes the perspectives of the patients and other stakeholders of the local health care systems around the globe.

4. The case of the international office (IO) in the UKE Hamburg

The intent now is to show a combination of Habermas’ action theory and THC perspectives in a single case study of a hospital. The Universitätsklinikum Eppendorf hospital (UKE) has been attracting international patients for more than a decade. Its service-oriented style suggested that an approach on behalf of the patient was necessary. Therefore a department of non-medical services was created: the International Office (IO).

As an intermediary between the patient and the medical staff, the IO is seen as operating between producers and consumers of medical services, from a service-oriented perspective. One can observe a combination of strategic and communicative actions: on the one hand, the strategic perspective of the functionalities of a hospital (professionalism), on the other hand, the mutual understanding between international patients and the members of the IO:

“we consider ourselves as a service point or link between the patient and the clinic ... we function as a link between patient and the departments, we often speak to both of them, we always try to do the best we can in the interest of the patient, but also try to do our best in the interest of the clinic. That is not always easy.” (Management IO)
As an organisational unit within the hospital, its members are mediators and have to show instances of agency on behalf of the international patient, while at the same time they have to take into account the medical authority of the medical staff and departments, with regard to the rules of practice in a professional German university hospital (strategic action). But by working with the patient as an equal partner, the IO installs communicative actions, while also making efforts to include professional codes of practice. The IO tries to help patients by reducing waiting times; international patients do expect this sometimes, although the hospital needs to treat every German and international patient equally (Management IO).

With regards to this mediating function, there are several professional roles present in the UKE department. They serve as an example of how other professions can contribute to the guidance of a patient. First of all there are interpreters, who have a critical role in the process. They are the human face of the hospital, and the liaison between the international patient and every service that is provided. Mutual cross-cultural understanding between patient and interpreter inserts a gap in the system of the hospital; a life-world is created in the view of the patient, a consumer with citizen rights:

"The role of the IO is to function as a link between the patient and treatment facility/doctor. Because of the special circumstances the patient is in and the sometimes delicate topics that have to be translated, often a bond is developed between the patient and the translator. The patient mostly fully trusts the translator and sees him as a true friend abroad. Sometimes even after the patient has already got back home, letters are written or visits are scheduled. This is then of a totally private nature and has nothing to do with the professional relationship when they started to know each other." (Translator 1)

This close relationship with the patient sometimes results in a non-professional relationship that of course is related to the specific character of the international patient; frictions between strategic and communicative actions are inherent to the professional role of the interpreter.

With the medical facilitator as an agent of commercialised health-related services, the UKE department at some point shows its capacity to dispute. It is critical in using the services of the facilitators, who sometimes try to indulge their own agency by interfering in the process between interpreter and patient:
“the relationship is sometimes difficult, because some facilitators try to get involved in the process too much, they try to change things in the clinics, they speak to doctors directly, which we don’t like at all. They sometimes function as interpreters, which we really don’t like at all; we have medical translators, they know what they are doing, they know the medical terminology, while the facilitators have little knowledge of medicine. So we don’t like them to interact too much, which sometimes they do” (Management IO)

Next to the interpreters, the role of the case manager is decisive for the mediating role between hospital and patient. The case managers are the regulators of the system. They are there from the early stages of contact to ending the services. Additional services are less common in a health care setting: departures from selected hotels, contracts with air lines, special oriental food needs, and more specialised tourism possibilities. This indicates the relevance of other market-driven services for a sector such as THC.

“If the patient asks us to do that, we do it, we have a website which shows the hotels which we have contracts with. We also have a contract with Lufthansa for special rates. Usually patients do this by themselves, or their facilitators do it for them; if they ask us to do it, we do it. We have some external partners who we work with … Mainly travel and lodging, sometimes people want to do a tour around the town; we can organize that for them, or tell them where they can get it easily, or they want to rent a car, or something special, where they can go shopping … Yes there is, but we offer that here, we have special Arabic food for our patients that we offer, we can provide Kosher food, not done at the hospital but we can order that, if they ask for that it is not a problem; we also have special foods for the Russian patients, they sometimes like special Russian food, so we can offer that.” (interview Management IO)

Sometimes the opposite occurs: patients are consumers in the strategic sense, forcing the hospital and the IO to focus on efficiency, by speaking about their shopping behaviour to international hospitals and the experiences they have had:

“Yes, most of the time they tell us where they have already been, they compare us with other hospitals in Germany or in other countries and tell us immediately what they like about this hospital. They try to describe it as if they heard that it was better somewhere else. They try to compare anyway.” (Translator 2)
Patients also show themselves as owners of their own health by asking for information that is sometimes difficult to get. Again this seems to be a collision of market (strategic) and consumer (communicative) forces: in order to be efficient as an organisation, clarity of the risks needs to be provided to create a field of trust with the patient:

“Patients ask for success rates of treatments, but is very difficult, because it is based on the health reports of patients, which is not the same as the current status of the patient, which is not known to us” (Case Manager)

The agency character of the department is enhanced by its capacity to offer non-medical services, which do play a role in its mediation between patient and hospital. The department is confronted with the otherness of some of its patients, therefore the agency also includes guarding the cross-cultural identity of its hospital while maintaining relations with other patients and medical staff:

“Arabic patients in particular do bring a lot of people with them, they sometimes have 3, 4 or 5 people accompanying them, and those people like to hang out with the patient, they think it is their duty to stay with the patient all the time, and they can be very loud and this is challenging for the staff and other patients who are close to those patients. And we try to mediate – and this is done by the interpreters – who then explain that they should be a little more quiet or go inside, because all the patients need to have a good stay in the hospital.” (interview Management IO)

By interviewing the management, it became obvious that a different ethical standpoint is needed for THC, especially in terms of marketing the services of the department and its hospital:

“Yes, you need to think about the morals and the ethics: this always needs to be considered, in all the marketing efforts we do; what we do not do is offer something we cannot hold to, what I said about the discrepancy between the ideal world of marketing and practice, we are not saying ‘when you come here everything will be perfect and you will be healed’ … you need to be very careful, because you are dealing with very ill people and you always have to consider that.” (interview Management IO)

In conclusion, we can state that a service department in a medical environment does need a different dynamic than other commodified service areas. Differ-
ent ethical standpoints are needed, inherent to the community action-based medical life-world. A market perspective is possible, but it is about mediating between two or more other agency groups. The consumer perspective is present with the nature of the international patient, because of the larger risks and efforts that are in place. Finally the professional roles are specifically linked to these other agency groups, such as the medical staff, medical facilitators and international patients, and suffer from a larger complexity and cross-cultural capacity than present in other sectors. All the narratives from the IO suggest, at this micro-level, that the unit needs to balance at an ethical level between the medical life-world and a more commercial strategic action model. This balance also needs to be maintained when looking at the patients as consumers: every patient needs to be treated with equity, but because of the large effort needed to treat these patients, a combination of strategic and communicative frames is present. This is intertwined with the professional role of the IO: designed to service international patients and to be efficient (strategic), but nested within a European concept of how to secure the rights of patients (citizenship). The market perspective requires the organisation to move into and to act in a commodified business arena, but at the same time it is part of a university hospital with a rich tradition based on a communicative, historic life-world.

By applying a form of cultural sensitivity and adaptation (source), internalised by the staff of the IO, this could be a tool for the THC sector to overcome the gap between strategic action and the life-worlds of communicative action. Being culturally aware of the other, in this case the international patient, can align the patient as a citizen with the more strategic targets of the organisations present in THC. This alignment would be the acceptance of the differences in cultural norms and thought frames between patient and professional in an international context. To accept that an Arabian patient is different in a German cultural context, and to adapt your supply of services according to this cultural awareness, is a way of creating a new globalised life-world on the basis of developing an intercultural identity (source): it aligns your efficiency as an organisation towards the rules of a clash of life-worlds, a culturally defined concept of healthcare provision. Could it be that different cultures have other means of perception regarding how they are treated by the medical profession?
5. Discussion

As an important actor in the THC system, we distinguish between a medically based mediator and an international patient department that work in direct proximity in a reputable hospital. One can see that the department has developed its own professional profile and means of communicating and dealing with international patients, in-between these patients and the medical professionals. Being very close to the medical provision of the medical services, it has to balance market-driven perspectives and higher standards of ethics and professionalism. This makes it unique but shows a case for renewal within the THC sector, close to the medical paradigm.

In the IO, a combination of strategic and communicative actions occurs: on the one hand, the strategic perspective of the functionalities of a hospital (professionalism); on the other hand, a mutual understanding between international patients and the members of the IO. In its mediating function, it has to fulfil several professional roles, in which the tension between communicative and strategic actions becomes obvious. As interpreters with a critical role, it provides the human face of the hospital and the liaison between all hospital services and the international patient. As owners of their health, patients also want the organisation to create a field of trust with them. The patient trusts the interpreter in his or her emergent life-world as a patient with citizen rights. It may become a close relationship that extends beyond the non-professional aspects of it, which can lead to tensions between strategic and communicative actions within the professional role of the interpreter. A medical facilitator in close contact with the patient can demonstrate some capacity for dispute. Sometimes he or she may speak to doctors directly and interfere with medical actions that he or she has little knowledge of. Other more market-driven services, additional to the health care setting, show their relevance for THC as well, where the role as case manager between hospital and patient is concerned. Non-medical services include confrontation with the otherness of its international (for example Arabic) patients compared with other patients, which points to the cross-cultural identity of the hospital and the relationships with other patients and the medical staff.

The professional roles mentioned are all specifically linked to the other agency groups involved, such as the medical staff, medical facilitators and international patients. Their professional character suffers from a larger complexity and cross-cultural capacity than present in other sectors. From a cultural perspective, our world is a hybrid world, with many interacting life-worlds all over the
globe. The situation within THC is not different in this respect and the international patient department has to handle this hybrid complexity. Different agency groups create a new dialogue with many cross-cultural constraints. In this field of communicative action some basic cross-cultural skills could be of great help to facilitate the necessary coordination for this type of action. In their different life-worlds, participants make use of different cultural and other sources. An example of such skills, therefore, could be the empathic capacity to change perspectives, which means that one should listen carefully and try to take the role of the other while listening. This capacity can be trained to a certain degree and its cross-cultural application would provide much more serious coordination in the field of communicative action. Other concepts of cross-cultural management could help in facilitating this coordination, which seems to be so crucial in this world of hybrid complexity. Particularly in the much debated area of ethical discussions, norms and values may originate from various religious and culturally related sources. Here too, there is still too little attention to the cross-cultural aspects of this type of normative discourse in THC. This is true in spite of the quickly developing influence of strategic forms of action that take place at the same time. In this chapter we have also looked at the expanding market discourse in the field, based on efficiency and effectiveness as criteria of coordination. Mainil et al. (2010) refer to a break down in global discourse on THC in this respect. After an initial stage of domination by an ethical type of discourse, there was a sort of break down in this global discourse towards a marketing discourse. Such a break down always seems to suggest the emergence of more strategic actions in the field of THC. The market-driven constraints become stronger in the field of health care, which will always remain sensitive to a certain degree to that other type of (communicative) action. In this new development there is a hidden threat of replacement of a communicative coordination mechanism, with its complex cross-cultural constraints, by a seemingly more efficient and effective coordination mechanism that originates in strategic action. This does not mean that, where strategic action is needed, it should not be accepted. It means that where communicative action is needed it should not be colonised by strategic action, as meant by Habermas’ concepts.

6. Conclusive remarks

The IO, as an intermediary, shapes the cross-cultural relationship between international patients and the hospital. Therefore, it looks as if two scenarios for professionalism are occurring in the context of THC. Firstly there is a sce-
nario with a sustainable professional context-controlled model, where market, quality and sustainability meet each other, offering intermediaries that have a quality-oriented mediating role. In this scenario there is a sophisticated balance between communicative and strategic actions. Secondly, there is a model where there is only a market-driven sector, close to tourism, where each of the intermediaries has its own market drivers, with unrestricted production of uncontrolled mediating sources. According to this model, the life-worlds of the participants of THC will be colonised, with the consequences referred to in this chapter.
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CHAPTER 6

Discourse

The evolving discourse of medical tourism in the media

Abstract

Purpose Non-discursive practices such as the economy and political constellations have always caused shifts in history. However in the network-society of today these shifts have become omni-present. Globalization of health and medical tourism have created a shift or rupture in the history of healthcare provision and into the lives of different stakeholders. The objective of this study is the detection and assessment of the rupture caused by global health care or medical tourism within the field of the written media in order to define the reality of medical tourism as a trans-historical field (Bourdieu, 1993).

Design/methodology/approach The methodology of this study comprised an extensive discourse analysis of written and new media performed over a time frame of more than a decade. Market, medical, ethical and patient discourses were detected along scientific sources, international and local newspapers.

Findings Results indicate that a change in the market discourse has caused a shift in the attitude towards medical tourism, where ethical voices are seen as submissive to the market logic. In the current time perspective medical tourism has become more mature with the development of non-ethical counterparts such as organ tourism and reproductive tourism as a consequence.

Originality/value The research framework shows that the general public receives a normative message from the medical tourism sector.

Keywords: Medical Tourism – Media – Discourse – Rupture – Market – Ethics

“These,” he said gravely, “are unpleasant facts; I know it. But then most historical facts are unpleasant.”

Aldous Huxley
1. Medical tourism: a brave new world

Medical tourism or the provision of international health services is an emerging sector with its own issues, but also with promising facts and figures. Different actors fit in a multi-cluster services system – for instance the governments of developing countries, specialized medical services (Moe, Pappas & Murray, 2007), adjacent services (logistics, hotel, hospitality and tourism services), E-health companies and transport services. The way the different media report about this phenomenon has changed immensely during the past years. Therefore an examination of the different media streams using a discourse analysis approach enhances a better understanding of medical tourism, from a noise over an emerging practice to a sector with its own dysfunctions.

Because of the several lines of industries providing services we can acknowledge that what started in a medical context has transformed itself into a cross-disciplinary stakeholder-driven sector. How medical tourism is portrayed in the media has its effect how the sector is seen by the general public, both locally and internationally. An analysis of these several lines of media enables us to detect where a rupture (Foucault, 1969) has taken place: an invasion of a new reality realizing a change in the worldviews about how to receive and search for health care. ‘Rupture’ is used here in a sense adapted from that of Foucault (1966, 1976, 1977, 1977), a radical cleavage in discourses about punishment, madness or medical care around 1900. Here, the growing complexity in the tension between the global and the local has been taken as a point of departure, caused among other things by many ‘new voices’ and the plural reactions from diverse interacting networks all over the world. ‘Ruptures’ have become more familiar in a less radical way, but produce the same type of incommensurable frameworks as their consequences in this network society (Castells, 2000). An interesting case of a rupture in this sense can be found in the area of medical tourism. A first step is to undertake an exploration of the scientific literature and its link with the underlying discourse which originated in Europe and the United States. This first step is necessary to assess the indicators at stake at this very moment, for there are many gaps and histories in the provision of health care services.

2. Towards the different world views of medical tourism

As we want to analyze the historic value of the phenomenon of medical tourism or international provision of health care services, we may begin by looking at
what has been produced in academic circles. In other words, how is the scientific community changing its thoughts and presuppositions on our topic? After this short but necessary exploration a more substantive analysis is possible. The relationship between health and tourism has been addressed before, but more in reference to well-being and tourism. (Hall, 1992) related health to spa tourism and retreats and (Goodrich, 1987, 1993) and his concept of health-care tourism brought him to the application of the concept in the Caribbean. This paper puts even more tension on the medical world and on the users of these services, in relation to tourism. There are older sources published in the twentieth century (Anon., 1953; Bugyi, 1963), but they are no indication of a underlying discourse at that time. As a way of getting a grasp on the scientific discourse we opted for a narrative approach.

If one examines the database Web of Science with the keywords ‘medical’ and ‘tourism’ together (281 hits), one sees an evolution in the scarce scientific reporting on medical tourism. Early publications examine the relation between tourism, travel and health care. Examples one finds in World Health Statistics Quaterly (Pasinii,1989) and Health Policy (Sheaff, 1997). Around 2000, as medical tourism is beginning to increase, critical ethical voices are heard in the authoritative medical camp by means of the leading British Medical Journal. (Bishop, 2000) and Wilderness Medicine (Bezruchka, 2000). From 2003 the debate and the volume around medical tourism intensify in context. First we read of the perspective in India, which is a large stakeholder and a pioneer in the field, in the national medical Journal of India (George, 2003 – Garud, 2005). From 2005-2006 onwards there are more articles on the US perspective in Health Affairs ( Carrera, 2006) and the first reports on less reputable offshoots such as transplant tourism and reproductive tourism in Human Reproduction (Heng, 2006) and Transplantation (Canales, 2006). No tourism studies journals are in the picture until Tourism Management enters the debate with the roaring title ‘Sun, Sea, Sand and Surgery’ (Connell, 2006). In 2007 both The Lancet (Macready, 2007) and the WHO Bulletin report (Chinai, 2007) on the phenomenon. In 2009 another by-product appears in the literature: stem cell tourism, again in The Lancet (Barclay, 2009). The relation between health reform in the United States and the sector of medical tourism is discussed in Mod Health (Rhea, 2009). Also the first evidence case studies are published to compare national health care and medical tourism health care provision, represented by the German journal Gefasschirurgie (Kleinhans, 2009). New countries are reported to be engaged in medical tourism, such as reported in the Journal of the Korea Medical Association (Woo, 2009). The relation between
public or primary care and medical tourism is an emerging object of interest, especially in Asian regions (2009). The scientific discourse about medical tourism has as such been changing drastically in the past several years. One could link this to the field concept of Bourdieu: the further the field is established the more existing frameworks are opposed to each other in fixed places, with lesser possibility of free movement. Medical tourism is installing itself within existing national, international and local frameworks. However, it is possible to have a look what lies behind this field of change.

3. A framework for discourse, the rupture and medical tourism

Medical tourism could be approached from different angles or by examining the different forces that play in a field that is establishing itself. First of all, the oldest stakeholder is the medical sector which now has to endure the presence of other participants, but still has the strongest authenticity. This sector has its own dynamics which consist of a drive to excel both in innovative treatments as in technological advances. Its role in society is well established and was rarely under dispute in the past. Its attitude towards the patient/health user has changed due to recent developments in patient rights law and patient advocacy. Therefore we choose to use the medical discourse as one of the ways to analyze and approach the ongoing evolution of medical tourism.

Medical tourism, as a sector which represents financial streams and economical drivers in addition to the provision of health care to international patients, is also subject to the non-discursive reality of market principles and the presence of national, international and local markets. Recent events in the global economy have shown that the influence of the economy on our daily lives is undisputed. It is however interesting to see how the entity and emerging sector of medical tourism is moving into the market: therefore we speak of a market discourse into our analysis of the selected media.

On the basis of a value system, the ethics which are connected to the provision of health care, the access to health resources, the way medical tourism is approached from an ethical perspective by the different stakeholders in the field, result in the development of ethical perspectives which undergo changes under the laws of other discourses and worldviews regarding how one should deal with public health, access to healthcare and resources, and views on what tour-
ism could or should contribute to populations. An analysis of the ethical voices in the media concerning the position of medical tourism is necessary because it involves a relationship with the other discourses listed above.

One further discourse could be traced through the different timelines. The changing role of the patient from an object of study and practice into a being with a voice and decision power deserves exploration. The relationship between the role of the patient and medical tourism is clear: without patients or health users who take their own health destiny into their own hands, we would not be speaking of medical tourism or an international provision of health care services. The same holds for health tourism where tourists opt for healthcare-related spa services. Therefore, the way the different media report about the patient and his changing role is decisive for our discourse analysis and is seen as a part of the concept of medical tourism: the medical tourist as a force, a partner in this emerging sector. Table 1 serves as a clarification of the main discourses we identified:

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical discourse</td>
<td>This discourse stands for the medical profession which has its own characteristics: high-end solutions; awareness of superior medical services; helping the patient; being a live-saving entity; an important decision-making power; a certain attitude towards medical tourism; medical quality; medical and management standards, medical technology.</td>
</tr>
<tr>
<td>Market discourse</td>
<td>The essence is business – medical related business; relation with ethics; trade and medicine; globalizing economy; business values; patient as a consumer who needs to be made comfortable.</td>
</tr>
<tr>
<td>Ethical discourse</td>
<td>Moves between medical standards and caregivers more towards patients. What are the ethical voices towards medical tourism and global health, what is the relation between public health? National health and medical tourism and private health care; local population; how to behave as a doctor; ethics and tourism.</td>
</tr>
<tr>
<td>Patient discourse</td>
<td>Moves from a submissive patient perspective to a patient as user/decision-maker. New roles for the patient as joint decision maker; health literacy; communication; empowerment; choices for their health. Choices in consuming health destinations; position of the patient.</td>
</tr>
</tbody>
</table>

Table 5: Description of the main discourses for analysis of medical tourism in the media

All of these discourses are elements within a discursive battle. Together they have the character of being responsible for ruptures. ‘Ruptures’ (Foucault,
1969) are massive changes in the discourse and worldviews in how populations see their world and its dynamics. The tensions between them provide a logic of world-making capacity, which is translated through international, national, local, scientific and internet media.

4. Methodology

Concerning the selection of media, we opted in the first phase to analyze international English-language high-end newspapers, three from the UK (The Financial Times, The Guardian – The Independent) and two from the US (The New York Times and The Washington Post). A first selection criterion for these international UK and US newspapers was obvious: these media are accepted as references in reporting international news, and their international audience is also large and widespread. As such the New York Times and the Washington Post have a reputation in winning Pulitzer Prizes (104 - 26). The Financial Times has a worldwide readership of 1.3 million. The Guardian and Independent are widely accepted as UK high-end newspapers. A second selection criterion is also seen as a limitation: LexisNexis search engine was used to generate these articles: the selected newspapers reported on medical tourism and were present in this reputable database. 119 articles were found with the search engine LexisNexis by using the search terms ‘medical tourism’ and ‘medical travel’. Other search terms were also considered but were less effective in generating the desired content. The aim was to look at the dominant discourses by reading international newspapers first. We confronted our frame of analysis to the articles and were able to detect several signifiers in the data. In a second phase, local newspapers (The Bangkok Post – Thailand, Straits Times – Singapore; The Hindu – India) were the object of analysis to address the confrontation or rupture between these assumed separate discourses. The researchers needed to limit themselves to English-language local newspapers. In the selection of the available local newspapers in English, again we opted for the most accepted and widespread sources. The Hindu, for example, proclaims to have a readership of 4.03 million people. As a limitation, a selection of local newspapers, in the local language would have potentially generated additional discourses. 395 articles were selected with the same keywords and on the basis of the filed pages of these newspapers. The chosen time period to select articles was limited by the access provided to older articles (time frame 1997-2009/2003-2009/2002-2009). The authors were impressed by the large number of articles present in the Straits Times, a newspaper with both an international and local character,
but also operating in a region where medical tourism is seen as an economic driving force.

<table>
<thead>
<tr>
<th>Nature</th>
<th>Time period</th>
<th>Selected articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Financial Times</td>
<td>International</td>
<td>1993-2009</td>
</tr>
<tr>
<td>The Guardian</td>
<td>International</td>
<td>1994-2009</td>
</tr>
<tr>
<td>The Independent</td>
<td>International</td>
<td>1996-2009</td>
</tr>
<tr>
<td>The Washington Post</td>
<td>International</td>
<td>2002-2009</td>
</tr>
<tr>
<td>The Straits Times</td>
<td>Local</td>
<td>1997-2009</td>
</tr>
<tr>
<td>The Hindu</td>
<td>Local</td>
<td>2003-2009</td>
</tr>
<tr>
<td>The Bangkok Post</td>
<td>Local</td>
<td>2002-2009</td>
</tr>
</tbody>
</table>

* The Straits Times is divided in two newspapers: Singapore (108 articles) and Malaysia (217 articles)

**Table 6:** Selection of articles in international and local media sources (newspapers)

As a first exploration – before starting the analysis of these media – we traced the evolution of themes addressed in scientific journals, social sciences and medical sciences. The time frame for the first phase of analysis stretched from 1989 to 2008 using the search terms ‘Medical Tourism’ and ‘Medical Travel’. This search was performed in Web of Science, linked to the Social Sciences Citation Index. We note, however, that the SSCI only contains three journals related to the tourism field: Tourism Management, Annals of Tourism and Travel Medicine (Jamal, Smith & Watson, 2008). Web of Science has its limits for the academic field of tourism. However, as the relation between tourism and health is quite important in this paper, we could not exclude the relationship with the health field present in Web of Science. Out of 281 articles the selection of analysed media was based on relevance to the main topic or object of research. According to Richardson (2007), “language ought to be analyzed in relation to the social context in which it is being used and the social consequences of its use; and more specifically, the relationship(s) between discourse and its social conditions, ideologies and power relations needs to be examined”. The different observed discourses could be placed within these power relations. A market discourse built up in a newspaper, is related – as language – to the existing power relations in specific countries and contexts. In relation to existing critical discourse analysis (CDA) methods (Fairclough, 1995) we choose the concep-
tual framework of Laclau & Mouffe (Laclau, 2005; Laclau & Mouffe, 2001) as a guide- line of methodological thought. We opted for this framework because of the close relation with the concept of rupture: Laclau & Mouffe established the concept of a discursive battle between underlying discourses. In a sense, the medical discourse could be in opposition to market thought; the market wants to make medical tourism profitable whereas medical doctors want to cure the patient. The language used in those newspapers could be seen as in relation with existing social and power dynamics around the rupturing world of medical tourism. This ‘discursive battle’ is very close to the concepts of changing world-views and the preparation and breakthrough of a rupture. Media texts were analysed by means of ‘key signifiers’, a piece of text as a unit of analysis which is seen as representing one of the four main discourses described in the previous chapter. A part of a sentence as a unit of analysis could indicate the market or ethical language that is used and which is in relation to the existing social conditions and power structures, for example: an ethical standpoint towards medical tourism from the Western perspective, contrasting with a market perspective with a view to developing economies in transitional countries. These societal realities are also represented in newspapers.

5. Results

Several lines of complexity could be detected in the following material. First of all there were four constructed discourses: market, medical, patient and ethical discourses. Secondly, we made a distinction between global and local contexts. We assume that global discourses – as reflected in international UK and US newspapers - differ from local discourses (Thai, Malaysian, Singapore and Indian newspapers). Lastly, the third level of complexity is the focus on country-specific analysis: the United Kingdom, the United States, Thailand, Malaysia, Singapore and India as countries of analysis. The discourses are constructed with the axis of local and international contexts and the divide between Western and developing or transitional countries.


An obvious turning point, or ‘rupture’ in terms of this article, appeared around 2001 and 2002. Before this rupture the market – in its related function as a non-discursive practice – was considered to be emergent or in its initial stage,
which indicated the promise of becoming more dominant. In terms of the four discourses the accent was on the ethical and medical discourse. Popular descriptions of medical tourism portrayed it as a hedonistic illustration of global supply and demand with many risks for underdeveloped countries. These risks were identified as being related to language problems, poor facilities and painful outcomes ‘when things go wrong’. For example, going to Africa for liposuction was built up as a low-cost option with the opportunity to see great wildlife (the market discourse) but a heavy accent was placed on the problems surrounding patient protection (ethical discourse). Sometimes medical tourism was said to be strongly rejected (Halpern, 1995) because of the emergent health staff in developing countries, where medical workers who have worked in developing countries were penalised for having ‘long holidays’ and irrelevant experiences for their future career.(the medical discourse) The New York Times already reports in 1994 about a small portion of wealthy infertile women seeking artificial fertilization and an urge to make rules in the EU (Anon., 1994)

In the treatment new health tourists were looking for, cosmetic surgery and health checks were described as ‘get your tummy tucked, your nose jobbed and eyesight corrected’. The image is of private hospitals dominated by rich foreigners combining surgery with a holiday – a hedonistic vacation in private hospital-cum-hotel. The adjective ‘hedonistic’ for this type of medical tourism was used in many articles and always had a moral undertone of rejection. An example is the article in The Independent (Bennett, 1996) where ‘miracle destinations’ are compared with the sanatoria visited by aristocrats in Victorian times. Here, too, the message was a rejectionist reaction to an up-and-coming market with different legal systems and risks because of the supposedly inferior quality of the standard of care as compared to the UK. Like Fatima and Lourdes, the other destinations also seemed to have miraculous characteristics: Vichy was good for the circulation, Hungary was known for its radium-rich waters and in Switzerland, Northern Italy and Austria the adage was ‘ski ‘n spa’.

An impressive exception was an article in The Guardian (Carroll, 1998), in which a holiday package in Florida was evaluated for the British market. In this analytical article three main categories in medical tourism are distinguished and evaluated. The holiday could be spent enjoying the attractions of Disney World, Universal Studios, Sea World, Magic Kingdom and Daytona Beach. The second category, medical service, reviewed bone marrow transplants, chemotherapy, physiotherapy and gynaecology: a broader scope of medical activities than the usual plastic surgery. The third category related to other stakeholders
– hotels, British Airways, insurance companies (home and overseas) and travel companies.

This exception could be seen as foreshadowing a rupture in this discourse. From 2001 on the accent on medical tourism as a hedonistic illustration of global supply and demand and the ethical rejection this implied, seemed on the wane. A more positive mainly market discourse emerged in which, for example, cardiac work or hip replacements were treated along with fertility tourism in private hospital chains in which low costs went together with high quality service and a nice holiday in India. There were no queues or long waits like in Britain and there was an enormous potential for growth, although a gap was identified in the market for insurance firms, when there was no cover if complications arose. The rupture in the discourse goes from the general moral rejection of hedonistic medical tourism to a challenge for development in this high potential market. The Washington Post reports on the South African solution to hedonism: “First Liposuction, Then Lions” (Jeter, 2002) The moral discourse often became focused on practical questions. For example, British dental care was characterised as the most expensive in Europe, which seemed to be a good reason for dental care abroad. But what do you do when something goes wrong? Also the New York Times challenges medical tourism, but not before it pictures a case study on the evolving industry in Bangkok and Thailand (Talbot, 2001)

The ethical discourse in the rich countries seemed to revolve more around money issues from a growing patient discourse. When travel for dentistry in lower-cost Budapest is discussed in The Guardian (Shaw, 2008), the main topics are cost savings, different legal systems when things go wrong and the quality standards of the medical treatment. Before the rupture a general rejection of this type of ‘hedonism’ prevailed. Now it is about cost savings, good quality service, and hospitality in high-quality hotels for post-operative relaxation (Davies, 2008) and (Smithers, 2007). Apart from the basic principle of ‘sending our overflow to foreign hospitals’ it mentions the growing well-being market from the UK and Germany going abroad for weight-loss treatment, detox diets, mineral and thermal face lifts, skin treatments, massage and cosmetic surgery. Therefore, here too a more pragmatic approach has been chosen of medical tourism in which the ethical discourse is reduced to a mainly patient discourse with implications for the medical discourse. The same logic holds for the US sphere, resulting in articles from the Washington Post which portray the facts of medical tourism (Loose, 2007). The quality of care towards the medical procedures is formulated out of a critical approach: “How can one judge the quality
of care by anecdote? One can’t, and that’s a real issue” (Redfearn, 2008) (the medical discourse)

However, some moral implications for locals are taken into consideration. An article in The Guardian (Ramesh, 2005) mentions the poor people in India who have no access to healthcare, but in this case most attention has been paid to medical tourism as a booming industry with its high service, low costs and beautiful combination with tourism in countries like India. The market discourse is rising since the rupture.

But at the same time there seems to be more attention for some opposition between that market discourse and the ethical one. In this booming market for consumers of highly developed technologies, there is also a growing concern about children’s emotional well-being (fertility treatment in India for a British market), about human rights and racial identities. Very sharply worded this ethical counter-discourse sounded: ‘healthy young women – super-ovulated exclusively for you!’ (Prasad, 2008). These sharp formulations about highly controversial issues seemed to be relatively exceptional after the rupture, such as when the medical risks of India’s donors are taken into consideration or when IVF was depicted as a completely commercialised industry in India. More generally speaking one may justifiably conclude that after the rupture, in the global medical tourism discourse of the West, the market discourse prevails in the poor healthcare countries whereas the ethical discourse in rich patients’ countries concentrates most on the patients’ rights from within a growing patient discourse. An article (Kurlantzick, 2007) in The New Yorke Times shows this direction: the author indicates the relation between the medical situation in a country such as Thailand, with regards to the supply of medical staff: a understaffing of doctors in national hospitals (medical discourse). Where the discourse before the rupture over-accentuated the hedonistic lifestyle that was supposed to go with global healthcare, this element almost disappeared from the discourse after the rupture.

In the global discourse of the Financial Times after the rupture the accent lies on a market discourse in which the potential of tourism for countries like India, Mauritius or Dubai has been related to their low ranking as tourist destinations due to various reasons, terrorism being one of them. Tourism in India, for example, is said to suffer from poor infrastructure, inadequate connectivity and high hotel tariffs (Leahy, 2008) but India has recorded above average growth in international visitor arrivals in recent times. The slogan ‘incredible India’ by the
Ministry of Tourism has further increased foreign curiosity. However, India’s potential is much bigger than this. Apart from the intent to improve the infrastructure and logistics and the like, tourism plans must lay their accent on the diversification of tourism products. Medical tourism is one of these new, promising products that are expected to boom in the nearby future. ‘The boom will be helped by new industries, such as medical tourism...’ (Lamont, 2008). Connected to medical tourism are wellness tourism and health tourism. In the Financial Times (Erixon, 2008) a plea for free trade in healthcare urges Europe to give up its protectionism. Many developing countries, it is said, want to liberalise trade in healthcare. Countries as diverse as India, Cuba, China, Thailand, Jordan, South Africa and the Philippines have all developed export strategies to supply health services to foreign markets. ‘Free trade in healthcare is no panacea, but it would certainly help European governments use resources more efficiently and improve accessibility and affordability of healthcare. Substantial liberalisation is unlikely to emerge from WTO trade negotiations, at least in the foreseeable future. Governments should therefore opt for autonomous reforms, tailored to their needs, and stronger regional trade and investment co-operation’, says Fredrik Erixon, director and co-founder of the Europe Centre for International Political Economy (Erixon, 2008).

**Local medical tourism discourses** (based on The Hindu, The Straits Times Singapore, The Times Malaysia and Bangkok Post)

This local discourse has been derived from English-language newspapers in Thailand, Singapore, Malaysia and India. This, of course, has important implications for the type of audience amongst which this discourse has been generated. Except maybe for Thailand, there are many native speakers of English in these countries and English is clearly present in local public life. Nonetheless, it would be advisable to repeat this same analysis with newspapers in local languages, especially to elaborate on the ethical discourse after the rupture among the local populations in their own languages.

**Thailand**

The main discourse in all these local (English) newspapers after the rupture is the market discourse. The discourse in Thailand could be formulated as such: ‘with expertise and Thailand’s fame in the hospitality industry, the country has now become a favourite destination for cosmetic surgery and it is especially sought after for gender reassignment (Russell, 2006)
In the Bangkok Post (Anon., 2005) Thailand was now also well positioned to extend its spa and holiday services to complement medical care services at affiliated hospitals. Service mindedness scores high in Thai health care and hospitality business. The market discourse prevails here even with regard to the local healthcare system. The country’s public health system should be improved alongside medical tourism ‘to give foreigners more confidence in the Thai health care services.’

Promotion is also treated in detail. Especially internet and word of mouth are considered to be the main promotion channels. Overall, not only in Bangkok but also in Phuket, medical and health tourism is seen as a new niche market. According to the managing director of Bangkok Phuket Hospital ‘it adds value to its tourism industry.’ A short excursion into the medical discourse in order to categorise patients who check into hospitals or clinics for treatment or surgery is once again closed with a renewed reference to the dominating market discourse.

Obviously, the market discourse is overwhelmingly dominant. Examples are abundant in the Bangkok Post as elsewhere after the rupture. Philips’ investments in the medical systems business in Thailand have been highlighted several times (Kittikanya, 2005, Kittikanya, 2005, Pandey, 2006, Kittikanya, 2007). Also the financial protection is imagined as the main goal for insurance policies to reach and should lead to a removal of the main obstacles so that the medical care is top quality, the standard of hotel services is high and the insurance covers the costs worldwide. Ms. Carter, managing director of Bupa Health Insurance is ‘very impressed with hospitals here’, though she hopes that ‘the time never comes when they are unaffordable for Thai citizens’. All articles point to the fact that Thailand is cashing in on the medical tourism boom, that state help is needed to fulfil the ambition of becoming a hub in the region and that fixing foreigners can create a win-win situation for Thailand. Mapping the market for medical travel draws the attention with discrete segments such as those who seek better care than they can find in their home countries, those who want quicker access to medically necessary procedures delayed by long wait times at home, or those who seek lower costs for necessary medical procedures. But the high potential for growth in medical tourism, clear strategies for care providers and implications for medical travel players are also treated again and again in detail (Mango, 2008). However, Dr. Damras from Siriraj Hotel notes: ‘there will be a brain drain due to the fact that doctors treating foreigners will get more money than those treating Thais. Unless we have effective measures to manage this problem there will soon be a shortage of doctors at hospitals serving only
the locals’ (Anon., 2006). A solution, however, is immediately proposed. It is to offer incentives to professionals in government hospitals so that this opportunity will be used to raise medical standards throughout Thailand.

**Singapore and Malaysia**

In other countries the local discourse in English-language newspapers does not differ substantially. In Singapore and Malaysia the market discourse shows a comparable tendency to dominate. Although especially in Singapore costs seem to be a bit higher than in Thailand or India, globally the situation is comparable and more specifically the high quality of medical care is thought of as a unique selling point in the region. Singapore also attracts dentists working at top institutions in India and elsewhere to work in Singapore after having passed a series of qualifying exams. This has been arranged in an agreement between Asian countries and starts in January 2010. In Singapore only the ‘qualifications from some foreign dental schools, mostly in the United States and Britain’ (Chong, 2009) are recognised. The rest will ‘have to sit for the same exams taken by local candidates’. Also in medical aesthetics in Malaysia quality is promoted as a key element through ‘the blog, which is linked to the company’s (MJ Aesthetics in Shah Alam) Facebook page’ (Sani, 2009).

Competition beats the drum in this dominating market discourse. Proton therapy as a new cancer therapy could boost Singapore’s reputation and ‘help its medical tourism’ (Tan, 2009). Singapore’s biggest competitors? ‘If India manages to engage the technology before us, then they would benefit from patients coming from the Middle East. For Thailand, it is the South-east Asian region’, Soo Khee Chee, director of the National Cancer Centre, said. Then follows an extensive medical discourse on the new technology and its profitability; Chee observes, ‘At the same time, it will boost our clinical standing in the international playing field and in the area of medical tourism.’

In Singapore and Malaysia there is a growing awareness of the competitive advantages of Asia in the growing field of medical tourism. For Westerners, again, the reasons are: ‘cost factor, little or no waiting time, a higher and better quality of care not available at home, and an exotic tourism package thrown in’ (Ng, 2009). Then follows an extensive analysis of the profitability of this new industry, especially because of the growing ‘market of more than 220 million “baby boomers” who will be medical tourists by 2015’ but also because ‘the industry players are looking at the 50 million uninsured as the jackpot’. In Asia all these people will find ‘medical excellence with a human touch’. And coming
back to the growing competition in the region, ‘South Korea is known for plastic surgery, while Singapore is well-promoted for its clinical outcome. Malaysia needs to highlight its own speciality’, says Simranjit Singh, director healthcare for Asia Pacific of Frost & Sullivan (Adam, 2009) and he suggests the National Heart Institute and Nilai Cancer Centre as the two ‘medical landmarks that Malaysia could promote’.

In the Straits Times of Singapore and the New Straits Times of Malaysia this market discourse is overwhelmingly repeated in various wordings. There are articles on the promotion of medical tourism (Anon., 2009), high service and low costs as the best medicine for global success (Cruez, 2009), higher income (Darmodaran, 2009), boost for medical tourism (Anon., 2009), services to play key role (Arulampalam, 2009), big bucks in medical tourism (Cruez, 2009), healthcare arm inks deal to promote medical tourism (Anon., 2009), far-sighted step towards excellence (Phuoc, 2009), new firefly gives city a boost (Anon., 2009), foreigners generate RM300m medical tourism revenue (Yunus, 2009), race for better healthcare (Elis, 2009), state on medical tourism map (Kaur, 2009), promoting efficient, cost-effective healthcare through ICT (David, 2009), nation well-positioned to draw medical tourists (Hamid, 2009), clinics can link up to offer 24-hour help (Hua, 2009), step into Berjaya U-C world of hospitality (Anon., 2009), PCMC receives international accreditation (Anon., 2009) and Prince Court expects healthy revenue (Hamsawi, 2009). The dominance of the market discourse in this overview goes without saying.

Apparently the patient discourse draws much less attention. A rare exception is the patient perspective of Tom Watson, a British senior, in “New hip gives Tom a fresh lease of life” (Hughes, 2009). At the same time some hesitant counter arguments emerge as well. In ‘This is not a role for the ministry’ (Idris, 2009) Mohamed Idris, on behalf of Consumers Association for Penang, argues for a clear separation between public and private healthcare in Malaysia.

India

In India the line of argumentation seems to mirror that of Thailand and Singapore. Nevertheless, our main source, the newspaper The Hindu, also seems to put some more question marks by the road towards more medical or health tourism in India. Here, too, the market discourse is dominating without any doubt. Earnings from foreign medical tourists are combined with incentives for doctors. Indian therapies like ayurveda, sidha, yoga and naturopathy are promoted (Anon., 2000). Kerala is presented as a centre for medical tourism
and not only because of ayurvedic therapy. Low cost treatment and high service
is promoted. The resistance of insurance companies is mentioned just like the
need for infrastructure (Anon., 2003). Over and over again the bright scope for
medical tourism is underlined (Anon., 2004; Anon., 2004) with its high market
potential in Gujarat, Kerala and Mumbai. Quality and accreditation (Anon.,
2005), again, are important fields of interest, as are plans to develop medical
tourism (Anon., 2004; Radhakishnan, 2006). India (Anon., 2005), too, is seen
as a medical hub, just like Chennai (Anon., 2007). Health care, combined with
tourism, will cause multiplier effects and medical tourism is presented as a high
potential industry (Anon., 2005). Obviously the market discourse dominates
again.

However, more than in the other local discourses, some voices of caution
emerge (Anon., 2006; Anon., 2006; Anon., 2005). On the one hand it is ‘boom
time for medicare’, but ‘national weaknesses start with one of the lowest rates of
expenditure on public health’ (Anon., 2006). The general undertone is optimis-
tic but a ‘cautious approach to medical tourism is advocated’ (Anon., 2006). In
an article of (Anon., 2005) readers are asked: ‘are we ready for medical tour-
ism?’ Private sector healthcare facilities are depicted ‘as gleaming “islands of
excellence”, all too often surrounded by seas of medical neglect’. Much depends
on government support, is the conclusion of this article.

6. Discussion

Medical tourism is a magical new market and, of course, a well-defined cam-
paign strategy is in the interest of many developing countries. The overwhelm-
ing presence of the market discourse, therefore, is no surprise. Some criticism
is offered, but generally speaking this criticism is overshadowed by the expected
profits in the sector.

However, it is possible to identify a small but persistent counter-discourse,
in the sense Foucault understood it (Foucault, 1961). A clear example can be
found in the Phuket Gazette 01/02/03. On Phuket there is a tourism industry
that is highly dependent on big global and local economic interests. Therefore,
criticism of medical tourism from an ethical perspective is not always welcome
in many official discourses. Because of this it also will be necessary to become
sensitized to these relations of power in non-discursive practice and their
discursive legitimations in order to understand this criticism by local voices.
In the Phuket Gazette a local journalist, Somchai Huasaikul, wrote an article on the life-cycle of medical tourism in the post-colonial context on Phuket. The journalist comments on the marketing plans of Phuket that wants to become a ‘rejuvenation paradise’ with the catchy slogan “Come to Phuket for your health”. In a sublime ironical way the journalist suggests developing some new forms of (immoral) ‘cycle of life’ tourism. It implies many more casinos so that Phuket will be the ‘Reno-by-the-sea’, spas and therapies for the middle-aged and more serious forms of medical treatment for the elderly – high-quality, low-cost medical and plastic surgery procedures.

In a decade medical tourism has appeared on the agenda of the media, both international and local sources. We developed a way to deal with the communication spread over the various media sources. We wished to explore the concept that these media spread the message about the phenomenon and product of medical tourism. This is the message that potential health users get if they are actively searching through information sources. It is the image that is given by decision makers and practitioners. To analyse these sources by discourse enabled us to use a frame of reference which offers perspectives on projected messages. We used the concept of a rupture (Foucault, 1969) to show the shift in the general discourse on medical tourism. As such the paper became a confrontation between scientific arguments, international perspectives and local counter-discourses.

7. Conclusions

Ethical discourses changed and evolved into an upgraded market discourse on medical tourism, an emergent industry which involves a multiplicity of stakeholders and beneficiaries. A serious gap in our knowledge about medical tourism or global health care is what drives patients to go abroad, their decision-making behaviour. What happens when they enter another cultural context? These are issues we cannot solve here.

However, the way the discourse on medical tourism is portrayed in the media we examined has to do with the message health users get when they search for information and want to learn about the phenomenon. This paper is a contribution to the understanding of the short-term history of medical tourism, a history in which local and global discourses give us the chance to analyse an industry which should give more attention to local populations, contextual destination
characteristics and the importance of cross-cultural aspects within this provision of health-related services.
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CHAPTER 7

Quality management

Framing and measuring international patient management

Structured abstract

**Purpose:** Hospitals need to determine if an international patient department is a necessity to communicate with and manage international patients.

**Methodology:** A benchmarking instrument was created to assess the level of professionalism in managing international patients, including reviewing and validating processes by two university hospitals, professionals and an expert panel.

**Findings:** First, the differences between the hospitals depended on the will of the hospital to engage in such activities. Second, the differences depended on the embedding national context in which the hospital was situated. Further validation revealed the importance of other supportive services, such as cultural sensitivity and language. Finally the micro-level phenomenon of international patient departments is placed within a macro-level transnational health region development scheme.

**Originality:** This study focused on the supply of services with respect to international patient departments, which could be related to efficiency and sustainability on a public health and health systems level.

**Keywords:**

Delivery of Health Care – Standards – Quality improvement – Surveys
1. A brief review of international patient management

Managing international patients through international patient departments is a micro-contextual practice which has effects on macro-developments such as the reforming of health systems. Furthermore, policies concerning these health systems should take into account such micro-contextual developments. International patient departments could be seen as change strategies in medical organizations. However, these strategies are part of a larger development of health care as being a health care industry. This global transformation has its influence on how health systems and governments need to act strategically, still in view of public health goals but in a forced relationship with market forces and extended mobility of medical professionals and patients.

The multi-dimensionality inherent to international patient management results in several academic disciplines touching upon this knowledge field. First of all, the relation with migrant health is observed (Gonzalez-Block and de la Sierra-de la Vega , 2011; Nielsen, Krasnik and Rosano , 2009; Priebe et al., 2011). Secondly, the connection with quality management is guaranteed by focusing on TQM and benchmarking (Oakland, 2007; Philips, 2007; Dale, van der Wiele and van Waarden, 2007), but also quality in the relationship between hospitals and patient safety (Groene et al., 2009; Makai, Klazinga, Wagner, Boncz and Gulacsi, 2009; Milisen, Abraham, Siebens, Darras and Dierckx de Casterle, 2006; Ovreveit, 2009; Robertson and Valadez, 2006; van Harten, Casparie and Fisscher, 2002) and patient satisfaction (Sitzia and Wood ,1997; Stevens, Reininga, Boss and van Horn, 2006). Finally, the patient mobility dimension is translated through the demand side (Legido-Quigley, Glinos, Baeten and McKee, 2006; Mainil et al., 2012) and the supply side (Ormond, 2011; Glinos, Baeten and Maarse, 2010; Turner, 2011) of the phenomenon.

Hospitals can choose to take care of international patients in a more coordinated way by establishing an international patient department. In the EU (Glinos et al., 2010) and Asia (Ormond, 2011; Pocock and Hong Phua, 2011), international patient settings are in development. An analysis of international patient departments or departments within hospitals which engage this target group would be of interest in view of the implementation of quality assurance.

It was therefore decided to perform an exploratory pilot study with a benchmarking design for comparing hospitals regarding how they manage international patients. This pilot study aimed at defining a measurement instrument which takes various aspects of the management services available in hospitals.
into account in relation to this specific target group of patients. This instrument could serve as a benchmarking tool for comparing hospitals regarding their capacity for handling and managing international patients.

2. Towards the development of a benchmark

In critical studies, a vast amount of consideration is devoted to the use of a survey as an instrument for collecting data within a health care context (Twigg, 2002; Minvielle, Sicotte and Champagne, 2008; Robertson, and Valadez, 2006); however, these surveys are often related to patients themselves as an object of data collection (Stevens et al., 2006; Hekkert, Cihangir, Kleefstra, Van Den Berg and Kool, 2009), or applied to a group of health professionals (Twigg, 2002; Milisen et al., 2006; Ratcliffe, Bekker, Dolan and Edlin, 2009). With respect to quality management for hospitals, there are a considerable number of studies available (van Harten et al., 2002; Minvielle et al., 2008; Robertson and Valadez, 2006, Ovreveit, 2009) which are mainly focused on the quality of medical treatment processes. Furthermore, an international patient department is subject to a continuous process of quality assurance, which is often denoted in the literature as Total Quality Management (TQM) (Oakland, 2007; Dale et al., 2007). We could see our benchmarking efforts as part of this TQM process. The aim of our instrument was to give an overview of the practice or non-practice of international patient departments. Good practices of these international patient departments are already available within the spectrum of global health care, as exist in Singapore (Bumrungrad hospital, 2009) and Germany (Bosscher, 2009). The UKE Hamburg university hospital provides services which could be characterized in 4 main framing fields: Treatment, Facilitation, Financing and Quality. These fields serve as the four main categories in the survey. In this way the practices of the UKE become a benchmark for other hospitals worldwide. The process changes in the fields of treatment, facilitation, finances and quality guarantee the success of the TQM cycle in international patient departments as supportive services to medical units in a hospital. These 4 main fields are indirectly linked to components of satisfaction, introduced by Ware (1983) in (Sitzia and Wood, 1997): technical quality of care: competence of providers and adherence to high standards of diagnosis and treatment (Treatment), accessibility/convenience: factors involved in arranging to receive medical care (Facilitation), finances: factors involved in paying for medical services (Finances) and interpersonal manner: features of the way in which providers interact personally with patients (Quality). Fur-
thermore, these 4 main fields could be related to problems and good practices involved in provision of health care to migrants, such as language barriers, lack of familiarity with the health care system, cultural differences, lack of access to medical history, interpreting services and cultural awareness of staff, indicated by (Priebe et al., 2011). The pilot study is designed as consisting the first phase of a bench marking methodology (Oakland, 2007:p. 154), the planning phase, where two hospitals have contributed to the fine tuning of the instrument, as well as with interviews with the international office of the UKE and experts in the field. This relates to this essence of market research, identified by Phillips in van Hamersveld and de Bont (2007) as to provide reliable evidence which will help managers take better decisions.

<table>
<thead>
<tr>
<th>1. Treatment:</th>
<th>How many international patients does the hospital treat and how are these patients managed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Facilitation:</td>
<td>How are international patients facilitated with regards to accommodation and travel arrangements?</td>
</tr>
<tr>
<td>3. Financing:</td>
<td>How are the financial aspects, such as costs and insurance matters managed for international patients?</td>
</tr>
<tr>
<td>4. Quality:</td>
<td>What quality measures are taken on the fields of culturalism, communication, patient satisfaction for international patients?</td>
</tr>
</tbody>
</table>

**Table 7:** the four main categories present in the instrument

The treatment of international patients concerns the process of medical treatment from the start of care through to the post-treatment follow-up, which is a complex situation to manage, not only for the hospital, but also for the patient (Okkels and Onsberg Henriksen, 2006). Facilitation takes into account the fact that these patients also have specific concerns regarding their travel behaviour, alongside other services. Next, the financial specificity of these patients with respect to insurance policies and payment issues must be considered. Finally, it is important to know how the hospital identifies itself in benchmarking quality measures for international patients. On this issue, several quality management systems can be found in the literature (Makai et al., 2009). It is of utmost importance to understand that an international patient department often deals with issues other than the surgical success for the patient. A link could be said to exist with multi-national companies and how they deal with complex organization towards international customers and clients in a global dimension (Fallah and Lechler, 2008).
Within the four different main categories of the survey, several points of attention were taken into account to assess a hospital on its capacity and willingness to focus on the target group of international patients. These different points of attention serve as indicators to determine the level of internationalization of patient health care services. These several items/questions of the instrument are represented in the Table 2. Most questions/items are constructed on a nominal/ordinal scale and room is provided for open questioning to enhance effectiveness within the respondents: the target group of the hospital manager. The items are constructed in relation to the good working practices, present in the UKE Hamburg International Office:

<table>
<thead>
<tr>
<th>1. TREATMENT</th>
<th>2. FACILITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amount of international patients</td>
<td>• Travel opportunities by air</td>
</tr>
<tr>
<td>• Physical exam and patient history</td>
<td>• Travel opportunities by ground</td>
</tr>
<tr>
<td>• Formalized service coordination</td>
<td>• Accommodation visiting companions</td>
</tr>
<tr>
<td>• Types of follow-up care</td>
<td>• VISA arrangements</td>
</tr>
<tr>
<td></td>
<td>• Suggesting hotel/lodging</td>
</tr>
<tr>
<td></td>
<td>• Arranging hotel/lodging</td>
</tr>
<tr>
<td></td>
<td>• Costs separately booked</td>
</tr>
<tr>
<td></td>
<td>• Vaccination opportunities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. FINANCES</th>
<th>4. QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Information insurance coverage</td>
<td>• Training doctor/patient communication</td>
</tr>
<tr>
<td>• Identification insurance plans</td>
<td>• Religious/cultural needs of the patient</td>
</tr>
<tr>
<td>• Detailed costs pre-operatively</td>
<td>• Training cross-cultural soft skills</td>
</tr>
<tr>
<td>• Detailed costs post-operatively</td>
<td>• Cultural distance patient/hospital</td>
</tr>
<tr>
<td>• Credit cards services</td>
<td>• Staff complaints regarding patients</td>
</tr>
<tr>
<td></td>
<td>• Patient satisfaction data</td>
</tr>
<tr>
<td></td>
<td>• Transfer of medical records</td>
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<tr>
<td></td>
<td>• Language assistance</td>
</tr>
<tr>
<td></td>
<td>• Accreditation</td>
</tr>
<tr>
<td></td>
<td>• Physician credentials</td>
</tr>
</tbody>
</table>

Table 8: Topics and items present in the instrument

3. Methods

In developing the planning phase of the benchmarking instrument, the four main topical categories were considered, which all concern the hospital’s capacity for interacting with international patients. A first draft was drawn up in
which the research team considered the existing literature on survey design and
the insights and knowledge provided by current good practices of the UKE. The
University Hospital of Antwerp in Belgium and the UKE Hamburg Eppendorf
University Hospital participated in the research.
As a quality check the for the instrument the UKE Hamburg international
office was interviewed on its practices. The interpreters and other employees
of the UKE Hamburg international office (with a workforce of 9 employees)
were questioned to capture the perspective of the patient (wants and needs).
Qualitative interviews were performed, which resulted in the adaptation of the
instrument. These interviews were analysed according to practices inherent to
grounded theory with thematic analysis.
Finally, a small panel of medical experts reviewed the final version of the survey
to check for the present validity and sensitivity. Furthermore, the feasibility of
every question was discussed with the experts to formulate further recommenda-
tions. Doing so would prepare the benchmarking tool for the next phase in
the process: the actual data collection in a larger sample of hospitals (1), com-
paring them with each-other, analysing the data in how they perform (2) and
developing strategies for better practice.(3) (Oakland, 2007)

4. Results

Observing the difference between two hospitals
In this pilot phase it was considered important to compare two hospitals in
different stages of the international servicing and with regards to the 4 main
categories.
1. Treatment: The Hamburg Eppendorf University Hospital (UKE) has a for-
ormalized international patient department. The Antwerp University Hospital
(UZA) is in a different stage. The UZA is sensitive to the presence of other
cultures and international patients, but no formalized managing entity exists
and promotion is not seen as a necessity, although the hospital is part of a
central promotion organization (Health Care Belgium). This lack of formal-
ization is related to the main target group of Dutch cross-border patients. The
hospital only has a limited staff capacity to handle the coordination of care of
international patients. The hospital’s tasks are limited to assigning patients to
departments, not to handling other facilitation requests or services. In both
hospitals follow-up procedures are common.
2. Facilitation: For the Antwerp University Hospital, the only facilitation
services are an ambulance at the airport and referrals to possible hotels. VISA
arrangements are not the duty of the hospital. In the case of the UKE, there is much more attention given to these services.

3. **Finance:** In the UKE there is some assistance provided with respect to health insurance agents/plans. Also, detailed cost/service reports are provided pre-operatively.

4. **Quality:** Both hospitals offer possibilities for religious counselling. In the UZA the staff are not provided with cross-cultural skills because 8% of the patients are international, but 6% of the patients are from neighbouring countries (specifically the Netherlands, where fewer language and cultural differences exist). The UKE provides training through their training centre. In both hospitals, medical records can be transferred by email for international patients. Translating services are also available, however, in the UKE translating services are undertaken by permanent employees belonging to the international department.

In the future, the registration of international patients with different cultures or religious backgrounds might not be carried out because of specific legal restrictions involving such indicators. The lack of available registry data on health care utilization of migrants in the EU has been ascertained by (Nielsen, Krasnik and Rosano, 2009). Furthermore, the lack of migration history in hospital records is also acknowledged by Gonzalez-Block et al. (2011) for migrants and their hospital utilization. This could be an indication of the limits imposed on international patients by the national contexts in which these hospitals currently operate. If the two hospitals selected already have differences on a limited number of criteria, it would seem to indicate that international patient departments in hospitals worldwide are in different stages of standardization and professionalism.

**Validation of the instrument through the employees of the UKE Hamburg International office (IO)**

In this phase we have consulted the international office (IO) of the UKE. Through interviews with the employees of the department we have sought to capture how they operate. The interpreters are a bridge between the medical staff and the patients. This alternative relationship is formulated as follows:

*The role of the IO is to function as a link between the patient and treatment facility/physician. Because of the special circumstances the patient is in and the sometimes delicate topics that have to be translated, a bond is often developed between the patient and the interpreter. The patient fully trusts the interpreter and considers the interpreter as a true friend abroad. Some-
times, even after the patient has returned home, letters are written or visits are scheduled. This is of a totally private nature and has nothing to do with the professional relationship they developed. (interview interpreter 1)

This results in a relationship which refers to normalizing the everyday life situation in a very specific case (being away in a far-away European nation):

My patients are not used to turning to a psychiatrist when they suffer from psychological problems or go to a psychologist to have a consultation. They speak and talk with their family, their friends, and their colleagues about their problems. If they are not there, we are the ones who need to listen to their stories. (interview interpreter 2)

Even the professional role of the interpreter is sometimes challenged, as the patient expects him/her to choose sides:

It starts with the language, but not limited to it; they are dependent on it, they need it, and one needs to give them the feeling that they can trust us, otherwise it will not work. A lot of times a front is formed against the MDs, because MDs and patients are not always on the same side, and then the patient tries to get the interpreter on his side. (interview interpreter 2)

To develop further insight in the life world of the international patient, it is imperative to understand the process which the international office initiates in view of the patient:

When the patients arrive, most have decided to make use of the services of the international office (IO). Thus, the patients are picked up by an employee of the IO or a taxi service at the airport. They will be taken to the accommodation IO first, or they make arrangements beforehand. Some patients stay in a hotel, but a large number of the patients rent a fully furnished and well-equipped flat. The flats are rented out day-to-day, so as soon as treatment is finished they can leave without having to pay a full month’s rent. The day of arrival is mainly used to move in the new accommodations and completing administrative matters. The next day there is a first appointment at the hospital, which is accompanied by a talk that is part of the services of the IO. Patients check-in at the hospital and get to know more details about their treatment plan and how things are going to be handled while undergoing treatment. (interview interpreter 1)
They see us as quite close to them, and especially the interpreters, they see them as their friends, this is not supposed to be this way of course:

*It should be a professional relationship and that is sometimes very hard to differentiate for the interpreters. To stay on the professional side and getting not to close to the patient. Because the patient will always try to use the interpreter for all kind of things and all kinds of questions, they want the interpreter to be there 24/7 days a week, which is not possible (interview marketing manager)*

What is also ascertained by the interpreters is the differences in the international patients in terms of culture and religion. It is possible to act upon these human traits and install services, as follows:

*The patients, as well as their families, can come together for praying and worshipping. If a patient is in the middle of praying and the physician is making rounds for medical examinations, the physician comes back later and sees another patient first, so as not to interfere with the rituals the patients are used to. (interview interpreter 1)*

The start of the process by the case manager is considered as important, in the sense of patients enquiring about the hospital’s services:

*What they really need, when they write us, is an email, a very quick reply, that they know that someone read their email. Then I reply that I got the email and that I will forward the information to the specialist, emailing that I will get back to them. It is important that they get feedback within the week. (interview case manager)*

If one observes the character and nature of these narratives one sees that a lot of the issues are focused on everyday life matters, such as religion and cultural needs. Thus, communication is needed between different actors. Interpreters should guide and support the patients. A certain cultural sensitivity is needed. Issues on the basis of food and lodging are also present. The whole process of arranging administrative matters from the beginning and arranging services of the hospital towards the patient must be placed within the perspective of the relationship between the patient and the IO, which needs to be based upon trust and comfort. As a constant, one considers the treatment process by the medical staff. However, around this most important criterion, one could situate
the other additional services in view of the patient. The IO needs to work with
the medical staff, but has no other choice than to make sure that the additional
services are of good service quality in an international patient environment.

Having explored the personnel in the IO, it seems that matters regarding treat-
ment and quality are not the only fields to consider for the survey. One could
state that medical affairs are a constant in hospital practice. Service levels
have been described in the literature. Monitoring medical quality is not a new
phenomenon. The installation of additional services within a hospital context,
however, is quite recent.

**Evaluation by a medical expert panel**

After the final revision of the survey, the experts (UZA/University of Maas-
tricht/UKE Hamburg) were asked to reflect on the nature and purpose of each
individual question in the survey. Furthermore, the experts needed to deliver
an overall assessment of the instrument.

From the beginning of the interviews it became clear that the experts’ com-
ments on the survey instrument were strongly influenced by the context of each
hospital. The UZA expert indicated the high prevalence of one type of inter-
national patient (the Dutch patient crossing the border near Belgium because
of easy access). Other international patients were less common. This made
some cultural, language, and facilitation questions in the survey less relevant.
Consequently, the need for an international patient office becomes less urgent
because of the familiarity between the Belgians and Dutch. One could observe
a difference in the comments provided by the German UKE experts; a lot of
effort has been expended to support the international patients, especially those
patients who travel greater distances. The UKE sometimes works with medical
tourism companies (Turner, 2011) (profit organizations who guide the pa-
tient through the travel process), indicating the challenges presented by these
patients. The UKE is more focused on delivering additional services. The UZA
expert called this the hotel-function of a hospital as opposed to a broader sense
of the solidarity principle (every patient is treated in the same way, whether
foreign- or home-based). Furthermore, this expert questioned whether or not
local populations would be ready for the new enhanced patient mobility. In
the UZA as a family member of a patient, you have one possibility to stay in
a facility near the hospital with a nominal fee. In the UKE, more options are
provided, but from a different business model. It is acknowledged by all experts
that religious facilities for patients should be provided at the hospital. The UKE
expert indicates that the translation of transfer of medical records with respect to international patients is being outsourced to a Russian company. The UKE expert emphasised the importance of patient satisfaction data for international patients. Notwithstanding different strategic positions of the hospitals, the experts see an augmented role for the US-based Joint Commission International (JCI) hospital accreditation in Europe. The third expert (Maastricht University) indicated the importance of translating the survey into the native language of the hospital managers (e.g., German).

The UZA expert mentioned the marginal character of specific types of international patients in the Belgian context based on a social solidarity principle when considering the efficacy of the survey as a whole. This was not the case in the German situation in which international patients are seen as a source of extra revenue for the hospitals (on top of the budget), according to another expert (Maastricht University). The UZA expert appreciated the value and sensitivity of the survey instrument, and saw it as distributable to a larger sample of hospitals. The UKE expert suggested some extra attention in the survey questions with respect to the hospital’s strategy surrounding international patients. A regional or national strategy could be developed which focuses on pro-active policies of hospital management with respect to internationalization.

4. Discussion

The model of an international patient is, in fact, comprised of a diverse array of patients who have overlapping features. Cultural differences between staff and patients could encourage the hospital management to appoint staff in relation to these matters. The provision of facilitating services is another way of offering support to international patients. Understanding the needs and desires of international patients could be a goal for many medical institutions worldwide. This benchmarking instrument is intended to record and measure the state or stage that hospitals are in coping with international patients. Private and public hospitals which are already focusing on these target groups will have developed their staff and services more towards this goal. It is still unclear at this stage how these hospitals are performing on a comparative level. However, previous studies have shown that hospitals are in different stages of maturity with respect to patient centeredness and quality improvement (Groene et al., 2009). Patient centeredness is an important issue with respect to international patients. Differences will occur between hospitals, some of which are due to national health systems and their legislations. At this stage academic knowledge
concerning the methods used in international patient departments are still lacking and therefore there many theoretical issues regarding these practices such as the usage of the concept of cultural sensitivity by the staff, and the theoretical stages in the customer process between patients and an international office. Globalization is present in many arenas (World Health Organization, 2007), and most definitely in the medical sector. Because one observes many parties in a patient mobility health setting, a context-controlled regional policy framework could be introduced. For example, if a region is allowed to have one medical excellence centre of cardio-vascular surgery, by means of a regulatory initiative of a regional and/or national government, then this centre could develop itself as a unique centre for a particular group of patients. Another proximal region could specialize in another medical discipline and attract other types of international patients, thus eliminating pure competition between regions, hospitals, and other stakeholders. This would also allow a sustainable health destination management approach (SHDM) (Mainil et al., 2012) to promote regions and their specialized centres of excellence, a role which would be possible for (supra-)national governments (i.e., medical nation branding). Such a sustainable scenario would radically change the medical tourism perspective, and would have its effect on the national health systems delivery and use of care, thus allowing for transnational streams of patients and leaving behind the divide between national and international patients. From a public health perspective, this could also enhance more cost-efficiency, and opportunities for transnational public-private partnerships. This line of reasoning indicates the relationship between micro-level developments, such as the rise in international patient departments, and changes in health system and public health policy perspectives. If one allows the concept of SHDM as an intermediary level and a tool for regional governments to evaluate, to steer and embed hospitals in a larger regional framework, based on stakeholder and ethical theory principles, a SHDM could change the role of developing and BRIC countries in attracting international patients and the relationship with public health provision. We speak of sustainable because it should enhance the public health of local and international patient groups, and it should also enhance a mutual understanding and better functioning between private and public stakeholders, and between regions, nation states, and supra-national bodies. Transnational organizations working on the field of international health care could participate in this form of regional planning and management because it augments control and certainty of delivery of demand. Governments are able to provide the same factors to their populations. One could argue that the development of a typology for international patient departments is possible and the effective management of
international patients will have internal institutional benefits, as well as external macro-effects on health systems and their future.

5. Conclusions

A benchmarking pilot study was performed which included interviewing the workforce in the UKE Hamburg and reviewing phases with medical experts and the UKE and UZA hospitals. This resulted in a greater level of validation of the instrument, along with some initial observations on behalf of the hospitals included in the survey. Furthermore, this pilot study has identified the necessity of the next benchmarking phase of data collection to fully assess the level of international patient management. In the next step of the research, a larger sample of European hospitals will therefore be selected. In the past, a vast amount of research has been conducted regarding quality management and patient safety. In contrast, the current study has focused on the supply aspects of medical and additional services with respect to international patient departments, which has proved to be a topic that deserves further examination based on the local context of the hospital, the strategy towards international patients, and embedding in developing health systems. The study of patients as health users of services should be more developed towards the future, especially for international patients. Flows of these patients have recently been researched, but the decision-making processes by patients and by institutions should become a future research field.
References

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Cross-border mobility within the European Union: From international to transnational health systems?

Summary

- In this chapter, we attempt to provide a deeper explanation for why the EU patient in cross-border care is not only a consumer but a citizen. By providing a more thorough explanation of how and why the EU context is unique, we hope to contribute to the theoretical foundation for discussion and debate of policy alternatives for structuring cross-border care internationally and in the EU in the coming years.
- We attempt to provide a typology of cross-border care that builds on existing ideas but incorporates the dimensions raised above. The analysis of the regulatory history of cross-border care in Europe also raises a number of important policy and political questions.
- We explore a number of scenarios for the future evolution of cross-border care in the European context.
- A context-controlled steering mechanism such as the EU patient rights directive cannot stop this globalization movement, but it can insert an equity balance for both national as well as international patients, if properly applied by the EU member states. Therefore as a future research agenda, the monitoring of this application by the EU members onto the European patient rights directive, as well as the monitoring of transnational health care development, will become an important necessity.

1. Introduction

In total, the quantity of “medical travel”, “medical tourism” or cross-border “patient mobility” and service provision is still limited, e.g. in relation to total health expenditures and service provision. Currently, issues of cross-border social security, cross-border mobility of patients and services are of special relevance for tourist regions, regions attracting retired persons, and border regions. However, the question of how economic and political dynamics will shape these kinds of cross-border affairs remains open.
Our chapter in many ways takes its starting point from a recent article by Carrera and Lunt (2010) which provides a European perspective on “medical tourism” (Snyder, 2011; Crooks, 2011), “medical travel” (Ormond, 2011; Turner, 2011) and “patient mobility”. Carrera and Lunt have suggested that the EU patient in cross-border care can be characterized as not only a consumer—as with cross-border care patients around the world—but also to a significant extent as a citizen. We agree with this characterization.

While we see great value in Carrera and Lunt’s article, we believe in general that their focus on the specific arena of “medical tourism” implies the need for a broader perspective. We believe that the discussion and analysis of the patient as both citizen and consumer in the EU needs to be related to the patient perspective rather than to the industry perspective of medical tourism. This is because most of the regulations that make the EU patient unique in this regard (i.e. the reasons that make the EU patient as much a citizen as a consumer) have to do with those who become patients while abroad (e.g. those permanently residing in countries other than the country of affiliation, those living in border regions) and not with medical tourism (i.e. tourism for the sake of medical consumption) as such.

In this chapter, we attempt to provide a deeper explanation for why the EU patient in cross-border care is not only a consumer but a citizen. By providing a more thorough explanation of how and why the EU context is unique, we hope to contribute to the theoretical foundation for discussion and debate of policy alternatives for structuring cross-border care internationally and in the EU in the coming years. This means that we want to establish a link between “medical travel”, “medical tourism”, “patient mobility” and its consequences for EU populations and the provision of health services. As a limitation, we primarily focus on the ways that health care is consumed by EU citizens within the EU and the legal context that surrounds that consumption. We do not extensively address issues relating to the mobility of European patients who seek care outside of the EU or the mobility of non-European patients who obtain care within the EU.

The chapter starts with references to the regulations framing medical travel, medical tourism and patient mobility within the EU, to illustrate the dual character of patients as citizens and consumers. On the one hand, cross-border affairs are regulated by mechanisms of social coordination. On the other hand, they are regulated by various aspects of European law, most notably the Directive on the Application of Patients’ Rights in Cross-Border Healthcare, also
known as the ‘Patient’s Rights Directive’ (2011/24/EU). These two sides should complement each other. As these two regulatory lines reveal, there are many ways in which European citizens are not only consumers but citizens when they obtain care in countries other than their own. This analysis suggests a few meaningful ways in which existing typologies of cross-border care can be further refined. In Section 3, we attempt to provide a typology of cross-border care that builds on existing ideas but incorporates the dimensions raised above. The analysis of the regulatory history of cross-border care in Europe also raises a number of important policy and political questions. In Section 4, we explore a number of scenarios for the future evolution of cross-border care in the European context.

2. European Cross-Border Patient as Citizen and Consumer: the regulatory framework for cross-border health care consumption and provision in the European Union

Arguably, the legal context in which cross-border health care in Europe takes place has primarily been given form over time more by economic interests, legislation and jurisprudence than health policies at EU or member state level. In some sense, therefore, it is a paradox that cross-border care within the EU is defined as much by citizens’ rights as consumer forces.

In many ways, EU citizens consuming health care in a member state other than their own are no different than any patient travelling for care throughout the world. The European patient may indeed travel to another member state as a consumer—as many do—to obtain services that are cheaper, better, or more accessible in a member state other than their own. Laugesen and Vargas-Bustamente (2010) have called EU citizens’ consumption of cheaper dental care abroad an example of “complementary exit”, and specific cases (e.g. such as the landmark ECJ cases Peerbooms and Watts) in which Europeans have sought better or more accessible care abroad as examples of “duplicative exit”.

This process is arguably highly consistent with the original economic intentions and treaty agreements at the heart of the European Union and the process of integration that the Union embodies. The European Union was founded to secure the free flow across borders of people, money, goods and services (O.J. 1992 C 191 1, 31 I.L.M. 253). Article 119 of the TFEU guarantees EU citizens “an
economic policy...conducted in accordance with the principle of an open market economy with free competition” (O.J. 2008 C 115/47).

It seems to be not particularly surprising, therefore, that the legal context for cross-border care in Europe was primarily given form by decisions—political but also jurisprudential—taken for economic reasons. Yet it might at a first look be surprising that, given that economic forces have given the EU context of cross-border care the majority of its form, rights based on citizenship—rather than ability to pay as a consumer—define the lion’s share of the possibilities and limitations of that context. There are two major regulatory threads that have given rise to this uniqueness in the European context of cross-border healthcare. In this section, we provide a brief history of the evolution of policies and laws that provide a unique landscape for the consumption of cross-border healthcare in Europe.

2a. The Mechanisms of Social Coordination

As a consequence of European integration, policymakers were confronted with the dilemmas created by the fact that two major groups of European citizens were seeking healthcare in countries other than their own. The first group was workers—at all levels, from professional- to working-class—who were employed in a member state other than their own, as well as their families who at times relocated to accommodate that employment abroad. The second group was comprised of pensioners who relocated after retirement for part or all of the year from their member state of origin to another EU member state.

In 1957, the Treaty of Rome (1957) (EEC 25 March 1957, 298 U.N.T.S. 3.) established the European Economic Community (EEC). Increased movement of persons from one state within the EEC to another soon became the target of European regulation. Regulations 1408/71 and 574/72 as well as revisions 883/2004 and 987/09 secured the rights of workers, their family members as well as pensioners to contribute to and draw from social security systems in member states other than their own. Also, these regulations established and over time have clarified and strengthened the ability of EU citizens to receive reimbursement for planned healthcare in member states other than the one in which they pay social security contributions. They are treated in line with the statutory system of the EU Member State in which the services are delivered, at the expense of the EU Member State in which they are insured (Palm/Glinos 2010: 515). But the situations in which reimbursement was regulated have been specified, and e.g. for elective hospital services patients have had to ask their
health insurances in advance for permission, while the insurer had the right to withhold the permission.

Here the situation of EU member states differs significantly, for example, from the United States. US citizens do not accrue US Social Security benefits when living and working abroad, nor can foreign earnings ever be applied back to an individual’s accrued balance within US Social Security. Medicare, with extremely limited exceptions, does not reimburse care provided outside of the United States (CMS, 2010). Hence, the US consumer of cross-border care does so most often exclusively as a consumer—one who is privately insured or pays out of pocket. He enjoys no ‘right’ to this care as a citizen of the United States or Medicare insuree. This contrasts with European cross-border healthcare consumers, some of whom could—even from the early 1970s—base their claim to reimbursement in their rights as a citizen of a European member state in a professional field of social security schemes.

2b. Path to the Directive on the Application of Patients’ Rights in Cross-Border Health Care

The process of establishing and clarifying the rights of migrant workers and their families and pensioners to cross-border healthcare occurred relatively early after—and on the basis of the competencies established at EU level by—the Treaty of Rome. However, a second line of establishing the right of EU citizens to obtain health care in member states other than their own developed. This line of regulation ultimately led to the quite recent passage in 2011 of the Directive on the Application of Patients’ Rights in Cross-Border Healthcare (2011/24/EU).

One of the early and most important milestones in the history of this development took place in the mid-1990s. At that time, at least two citizens of Luxembourg, Kohll and Decker, made healthcare expenditures outside of Luxembourg and declared those costs to their domestic insurer. When the claims were rejected because they were related to expenditures outside of Luxembourg, each gentleman sued the insurer. Each claimed that under European treaty law, he should be entitled to full reimbursement for expenditures made anywhere within the European Union. Ultimately the European Court of Justice, which heard the cases together, decided in favor of the plaintiffs (Judgments Kohll and Decker, 28 April 1998, cases C-120/95 and C-158/96 (1998).
These and other cases soon led the European Commission to propose a Directive on Health Services within the Internal Market (Commission of the European Communities, 2008). The Commission’s stated purpose in proposing this Directive was to clarify many aspects of cross-border healthcare in Europe—not only the patient’s rights, but rights relating to providers, insurers and others as well. However, the proposal of a directive with such a broad scope proved impossible to implement. Instead of new law, a new round of reflection was the result. Robert Madelin chaired a high level group starting in 2004 to discuss a wide variety of issues related to cross-border healthcare in Europe. This in turn fed into an open consultation of the Member States that took place in 2006.

Directive 2011/24/EU, which took force on April 4, 2011, provides a number of new and important assurances to citizens seeking cross-border care within the EU. Generally, under the Directive citizens of the European Union are now guaranteed that care they consume in a member state other than their own will be reimbursed at the rate that it would have been reimbursed in their own member state (i.e. the member state of affiliation; this is an important difference to mechanism of social coordination, see above). This reimbursement may be paid directly by the member state of affiliation to the care provider. Member States do retain the right to pre-authorize care consumed outside the member state of affiliation, though these circumstances are quite limited – much more limited than under the mechanisms of social security coordination. The Directive is expected to complement the rights established in Directive 993/2004.

The Patients’ Rights Directive entails some regulations which have to be implemented by the Member States within the next years, addressing e.g. national contact points, information by healthcare providers, transparent complaints procedures and mechanisms, systems of professional liability assurance, data protection, pricing issues and reimbursements (Art. 4). The Member States are asked for mutual assistance and cooperation in setting standards and developing guidelines on quality and safety and the exchange of information. They shall facilitate cooperation in cross-border healthcare provision at regional and local level as well as through ICT and other forms of cross-border cooperation, and deliver information about the right to practice (Art. 10). Further issues address the recognition of prescriptions issued in another Member State (Art. 11), the establishment of European reference networks (Art. 12), health services for rare diseases (Art. 13), voluntary networks connecting national authorities responsible for eHealth (Art. 14) and Health Technology Assessments (Art. 15).
It has also been decided that the Commission will produce reports (patient flows, financial dimensions of patient mobility, implementation of Article 7 (9) and article 8, and on the functioning of the European reference networks and national contact points. The Member States shall provide assistance and information (Art. 20).

With passage of Directive 2011/24/EU, citizens of European Union Members States have become further distinguished from citizens of countries outside the European Union when it comes to the consumption of cross-border health care. The European Union is now at least 40 years into a process of continual expansion of citizens’ rights when it comes to the consumption of such care. It is now roughly accurate to assert that the rights of EU citizens to obtain care in EU Member States other than their own is quite similar to the rights applying for citizens within their own country’s health care system. But at the same time, it is still an open question if or what kinds of dynamics in cross-border mobility will follow the implementation of the regulation. The required reporting activities will hopefully deliver more systematic information and knowledge about cross-border mobility and respective developments in coming years.

3. Types of patient mobility in the EU

The described EU regulations have been taken into account in the following development of a typology for medical travel, medical tourism and patient mobility. The development of this constructed typology (based on several authors) originates in the fact that Carrera/Lunt’s consumer/citizen typology does not capture the full complexity of patient mobility, and that in our opinion, the terminology (medical travel, medical tourism and patient mobility) itself needs further clarification. Building on this line of reasoning, this would also include an assessment of policies to implement the right services to support patients and services providers in cross-border issues.

It is perhaps consistent with the complexity of the patient mobility phenomenon that different scholars have suggested several typologies to describe and categorize it. Carrera and Lunt, and their concept of combined citizenship and consumerism incorporated by the EU patient, is a unique contribution but does add to the work of others. One of the more complete typologies is that of Glinos et al. (2010). This typology was originally conceived from a demand driven impetus: The motivations of patients (familiarity, perceived quality, affordabil-
ity and availability) were combined with the question of whether services would be covered by social security or health insurance systems or not. However, the focus on patient mobility limits the radius of this typology. Instead, we like to think in terms of mobile settings, where there is an integration of the situation in which the patient resides and how the professional constellation reacts to this situation. Evidence seems to support the idea that cross-border health care can function if every stakeholder is integrated, but that there is a gap between the reality and the ideal situation, which raises challenges for the future.

A second contribution to the proposed integrated framework we would like to suggest the exit patient mobility typology of Laugesen and Bustamante (2010) which also seeks to be wanting to argue in global terms rather than on a EU or US level. They derived types of international patients and the reasons why they want to exit their home country (sending context): They formulate it as follows: “Four types of patient mobility are defined: primary, complementary, duplicative, and institutionalized. Primary exit occurs when people without comprehensive insurance travel because they cannot afford to pay for health insurance or directly finance care, as in the United States and Mexico. Second, people will exit to buy complementary services not covered, or partially covered by domestic health insurance, in both the United States and Europe. Third, in Europe, patient mobility for duplicative services provides faster or better quality treatment. Finally, governments and insurers can encourage institutionalized exit through expanded delivery options and financing. Institutionalized exit is developing in Europe, but uncoordinated and geographically limited in the United States.”. Although this typology also takes a global perspective on patient mobility, it does not start from a mobile setting; rather, it argues for patient perspectives.

Mainil, Van Loon, Dinnie, Botterill, Platenkamp and Meulemans (Forthcoming), taking a global perspective, aligning cross-border health care and medical tourism following a logic of access to health care, link the patient motivations of availability and familiarity with their own criteria to typify international patients. As such, the geographical proximity/distance to be covered by the patient is related to how available a medical service abroad is, by taking (relative) proximities and distances into account. Cultural proximity/distance of the foreign health system can be linked with how familiar that system is for the patient. Finally, the searching efforts that are deployed by the patients are based on a mix of both familiarity and availability: high levels of availability and familiarity decrease searching effort. These criteria offer the possibility of rea-
soning in terms of a duality of patient types. The two types represent (1) high levels of the criteria and (2) low levels of the criteria.

In order to create an integrated typology, taking the different settings and dimensions of proximity and distance into account, one could combine the mind sets of Glinos et al., Laugesen and Bustamente, Carrera and Lunt and Mainil et al. The latter show that if EU patients cross national borders, this phenomenon is often referred to as cross-border patient mobility, described by Glinos et al. as: ‘at a minimum involves a patient who travels to another country for the purpose of receiving planned health care.’ A clear focus on the demand side of health care occurs here. In other parts of the world, such as the Asian and American continent, medical tourism is the term which is mostly used, as defined by Snyder et al., to describe: ‘a growing industry that involves patients intentionally travelling abroad for non-emergency medical services. Here a supply-side logic seems to be the semantic focus. Medical travel as a term is preferred by some scholars (Ormond, 2011; Turner, 2011) above medical tourism, probably because it is excluding the nature of tourism, as being a purely supply-driven, leisure-based, commercialized sector, far away from the basics of pain, healing and providing care to patients, characteristics present in the health care sector. Patient mobility incorporates types of patients which are not classical international patients, sketched by the medical travel industry. An example can be found in the retired senior citizens from the UK, residing in Spain, and in need of health care services (Legido-Quigley et al., 2012)

The term transnational health care (THC) could be used to better reflect patient mobility as a time when coordinated actions and enhanced structure and formality take place in cross-border care and medical tourism services. Transnational health care can be recognized, therefore, by the existence of extended global and local professional as well as provider – third party payer networks within the provision of health care services. Within established transnational health care structures, patients would have to possess the possibility to make an appropriate and knowledgeable choice on the basis of the provided services within these networks to go abroad and to receive health care.

In this framework, we distinguish two types of patient settings: cross-border access searcher settings (CBASs) and trans-border access seeker settings (TBASs). CBASs are a prototype of patients who do not have to cope with large distances or cultural shifts. CBASs search for access in a regulated health care system in a proximal country (e.g., the Dutch using the Belgian health care system). Or if no
reimbursement is possible, they estimate if it is still worthwhile to pursue their treatment. CBASs have the possibility to be embedded in a safe social or private security system. This means that CBASs are centered around three criteria which makes them specific as a type:
1. the proximity and the limited travel distance inherent to this proximity (hence cross-border).
2. The cultural proximity (Bell et alii, 2011): the medical culture they are encountering in the other health system is no different from their own, with medical staff who are recognizable.
3. The challenge of searching for health care in another proximal country are perceived to be of a reasonable scale: in the case that insurance schemes are a provider, they can offer information to their clients. If this is not the case it still reasonable to search for information in a proximal country (hence access searchers). On the basis of these criteria, we estimate that availability (Glinos, 2010) and familiarity are perceived as high.

In contrast, TBASs are patients who have to travel more, more regularly pay out-of-pocket, and encounter cultural differences within the context of the host (hospital) and guest (patient). TBASs are motivated to find alternative health care options, including how they can be treated abroad (e.g., patients from Arab states seeking health care in Germany - Private), but also covered specialized treatments for EU patients are part of this type (e.g. an Italian patient to be treated in Belgium - Public). This means that TBAS is also characterized around by criteria:
1. The larger distance to travel makes it harder and more risky to undertake such health-related travel (hence trans-border).
2. There is also cultural distance (as opposed to cultural proximity (Bell et allii, 2011) between the mindset of the patient and the receiving (medical) context.
3. It involves for the patient a seeking exercise in stipulating which receiving context or health system they are going to choose (hence access seeking).

Taking into account these criteria, we estimate that availability and familiarity are experienced as lower, as in in the case of CBASs.

The duality between TBASs and CBASs, on the basis of the three criteria of geographical distance, cultural distance and searching effort, is based on their different needs for supportive services; as such, the criteria position CBASs and TBASs at either end of a continuum, one end representing high ranges of the criteria and the other end low ranges of the criteria, respectively, with a full range between them. The supportive need for services is much higher in the
case of TBASs than it is in the case of CBASs. The fact that these two types are at both ends of this continuum obviously means that other combinations of the criteria are present, but for didactical reasons they are not elaborated upon. Supportive services could be defined as cultural, informational, financial and logistic services, as opposed to medical services.

The added value of this typology is that it tries to connect on a meta-level several author-based conceptual exercises. The typology combines them in order to grasp the complexity inherent to patient mobility. In typifying two types of international patients (CBAS and TBAS), one could link them to the concept of public and private health care delivery. At the same time, public health care delivery relates to the practice of CBHC and citizenship, whereas private health care delivery refers more to medical tourism and consumerism. Finally, this public/private divide can be coupled to patient strategies to choose for another health system: an institutionalized exit (supported by governments and insurance schemes) is related to the public domain, a primary exit (having no insurance) is related to the private domain.

<table>
<thead>
<tr>
<th>EXIT STRATEGIES OF PATIENT MOBILITY (Laugesen and Vargas-Bustamente)</th>
<th>TRANSNATIONAL SETTINGS (Mainil et al.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized exit</td>
<td>CBAS</td>
</tr>
<tr>
<td>Primary exit</td>
<td>PRIVATE (Type 2)</td>
</tr>
</tbody>
</table>

**Table 9:** Typology Mainil et al.

The suggested typology can be interpreted further as follows: Citizenship is defined by the mechanisms of social coordination and the patient rights directive (Council of the European Union, 2011), as such citizenship is the core of EU cross-border health care. This also means that one should ascertain that the two archetypes (CBAS and TBAS) are different in kind by means of their cross-cultural and travel distance. It is now possible to reveal four types of patient mobility on the basis of the meta-model:
1. CBAS Public (Type 1): making public use of a proximal health system through a public insurance scheme, the patient is a citizen, in the framework of cross-border health care, which incorporates an institutionalized exit, other criteria are cultural proximity and access to information on behalf of the patient. As a case we could observe the Dutch crossing the border to receive health care in Belgium.

2. CBAS Private (Type 2): making private use of a proximal health system through their own financial means, the patient is a consumer, a medical tourist, which incorporates a primary exit, other criteria are cultural proximity and access to information on behalf of the patient. As a case we could observe patients from the UK opting to receive treatment in Belgium which is not covered by any health insurance scheme.

3. TBAS Public (Type 3): making public use of a distant health system through a public insurance scheme, the patient is a citizen, in the framework of cross-border health care, which incorporates an institutionalized exit, other criteria are cultural distance and extensive seeking behavior on behalf of the patient. As a case we could observe Arabic patients for who travel for cancer treatment to Germany with insurance coverage.

4. TBAS Private (Type 4): making private use of a distant health system through their own financial means, the patient is a consumer, a medical tourist, which incorporates a primary exit, other criteria are cultural distance and extensive seeking behavior on behalf of the patient. As a case we observe Russian patients receiving stem cell treatment in Germany, paying out-of-pocket.

Concerning the other types of patient mobility: 1) the temporary movement of individuals (e.g. tourists) who seek care outside their own country; 2) the permanent relocation of individuals who seek care outside their own country; 3) individuals living in border regions who cross borders largely as a matter of geographical convenience or cross-border care planning, it is not an issue: they fall easily in the public framework of cross-border health care. But from the moment patients start moving from a sending context (country A) to a receiving context (country B) with as a primary reason to receive health care, which is not or not yet available in the sending context, then a tension breaks out between what is considered as the public and the private domain. Therefore cultural and travel distance, incorporated by CBASs and TBASs serve a tool to conceptualize transnational health care. Finally, Laugesen and Bustamente typology shows us the private and public divide, and its differences between the US and the EU. It is about having no insurance (private)(1-primary exit), or the exit is institu-
tionalized and supported by governments and insurance schemes (2-institutional exit), which can be perfectly linked to the Glinos’ typology (having cover/having no cover). Two other categories have been observed by Laugesen and Bustamente: searching for better and faster treatment abroad (private/public) (duplicative exit), having insurance coverage, but a service is not or partially covered (complementary exit). They are seen as less relevant at this moment for the typology, but it would be interesting for the development of the model to include them in the future. Especially complementary exit - when only partial cover is available – is highly relevant in the light of the Patient’s Rights Directive (co-payments): if the health care costs are higher than what the country of residence is providing to its international patients.

The typology makes a clear distinction between the public and private provision and use of health care services. This is necessary to keep the categories clear and transparent. However in the clash between the patient rights directive and the mechanism of social coordination one could observe a tendency which needs to be elaborated upon in the next part considering further developments. There are and will be cases in the future which are partially public and partially private in nature: if an international patient gets only partial coverage, and a part of the medical bill needs to be paid out-of-pocket, then the divide between citizenship and consumerism becomes even more complex and diverse. Our estimation of these developments can be observed in next part.

4. Towards transnational patients and services?

As in Europe, patients themselves are becoming a mix of citizen and consumer, due to the recent European legislations, it becomes necessary and urgent to formulate in the first place considerations in the current European policy field: how willing are Europeans to travel abroad? What about socio-economic differences between the member states? What about the economic climate in Europe? Secondly, some scenarios can be developed to describe how—while taking such considerations into account—the direction of European patient mobility will evolve. The four types of the typology are branded on these scenarios. Finally, challenges for health systems are linked with these scenarios.

Considerations regarding further developments (dynamics, drivers)
The typology introduced in the previous chapter can be linked with EU regulations. They offer also a framework for reflections about further developments. Major questions are:

- What are the major motivations of EU citizens to travel for medical services across borders?
- How will the volume (financial volume, number of patients) of cross-border mobility develop, in total, under the regulations of the mechanism of social coordination, and under the mechanisms of the Patient Rights Directive?
- Will there be differences between European countries?
- How will health systems adapt to these developments?
- What are positive developments, and what could be more critical issues?

For reflections on these questions, a couple of considerations should be taken into account. A first consideration concerns the theoretical willingness of the population to consume health services abroad. Approximately half of the EU population is in principle willing to travel abroad to receive medical services (Eurobarometer 2007). Major motivations are a hypothesized unavailability of necessary treatment, a perceived better quality and access to renowned specialists, quicker access and a cheaper treatment. At the same time, 42% are not willing to travel. Major reasons are convenience, satisfaction with health care, language reasons, affordability, but also a lack in information. The non-willingness to travel abroad to receive medical treatment differs between EU Member States, due to the size of the countries, but especially also due to the socioeconomic circumstances. In countries with a comparatively high socioeconomic standard, citizens do often not see a reason to travel abroad. In countries with a comparatively low socioeconomic standard, many citizens are discouraged by the affordability. There are also differences between socioeconomic and cultural groups within countries. Younger people and people with higher education, inhabitants of urban areas and the self-employed are more often willing to travel abroad to receive medical services than others (Eurobarometer, 2007).

A second consideration is also linked with socioeconomic differences across the EU and addresses especially the differences in the costs of medical services with regard to third party payers. They can also either be attracted by lower prices, disengaged or even overburdened by high prices in other countries.

The third consideration concerns the economic climate. The health policies within the Member States emphasize cost containment strategies. Private delivery of patient mobility or transnational health care is much larger in other
regions of the world (Asian and American continent), but it could also become larger in Europe, considering the stronger health system budgeting in the European crisis debate (Garel and Lombardi, 2011). Some services have been excluded from a reimbursement by social security systems, and also within social security systems, out-of-pocket payments have been raised. These developments might raise incentives for an extension of cross-border mobility for patients as well as for third party payers. At the same time, health service providers, confronted with cost-containment strategies and limited budgets, might develop a strong interest in attracting patients from abroad to create additional revenue. These considerations can be used to reflect upon the probability of four scenarios. In a first scenario, based on the assumption that the current regulations will not create the dynamics for more cross-border mobility, the status quo remains. The access to social security systems and health services will be preliminary be organized by and within EU Member States. That means that citizenship will dominate and in its material dimensions preliminary be organized within EU Member States. The cross-border mobility of patients as well as the role of patients as consumers will stay limited. The same holds for cross-border cooperation between third party payers and providers. Some contracts between third party payers and health service providers will exist, but they will stay exceptions of the rule. In this scenario only the first type of the public CBASs citizen travel to a proximal country (type 1) will be still in place. It is the type which is the less difficult to execute for a patient and the oldest form of the phenomenon.

In a second scenario, based on the assumption that the current regulations are implemented, a strengthening of citizenship, based on a amalgamation of social rights and limited consumerism, could push cross-border mobility forward. Social security systems will be extended and include access to health services abroad. Quality and safety issues as well as payments will be based on international or EU agreements. But the organization of social security systems and health systems stays mainly in the competencies of the EU Member States. In this scenario type 1 (CBASs/public/proximic/citizenship) and type 2 (TBAS/public/distant/citizenship) will tend to expand, based on the larger public and social security dimension.

In a third scenario, based on the assumption that the implementation of current regulations will create a dynamic with impacts on citizens, patients, health care service providers and third party payers, the material dimensions of citizenship and health systems (patients, third party payers, health services) become “transnational”. They will not be primarily organized within the boundaries
of Member States any more. Social rights are fully linked with EU citizenship, and third party payers as well as health service providers operate and develop structures across borders. In this scenario all four types will evolve and expand. The public/private divide will probably not fully disappear, but a transnational system of social security will dominate. This scenario is the most beneficial for the development of patient mobility in Europe and beyond. This means if transnational health care is matured practice, the types of CBAS and TBAS could vaporize in one category or status of 'broad availability', generated from transnational networks and used by transnational patients.

The fourth scenario offers an alternative to the extension of citizenship by taking into account that also the consumer role of the patient could be strengthened, going hand in hand with a limitation of social rights. Health policies will emphasize cost containment strategies and private expenditures (private health insurances and out-of-pocket payments) will go hand in hand with deficits in the dimensions access, availability, affordability, quality and safety. Health policy makers will downsize the public character of health systems, strengthen private markets, and accept cross-border supply of and demand for health services as private or market solutions. The patient acts (or is forced to act) as a homo economicus, looking for private solutions. Health service providers compete to attract patients from abroad. In this scenario types 2 (CBASs/private/proximic/consumerism) and type 4 (TBASs/private/distant/consumerism) will tend to become the main types, creating a departure from the European social security model.

The discussion of the scenarios can be combined with a reflection on the impact on the performance of health systems. The overarching goals of health systems have been defined as health, responsiveness, and risk protection (and the instrumental goal efficiency). The main functions of health systems - steering, service provision, resource generation and financing – should contribute to the realization of the overarching goals. An assessment of the consequences of cross-border mobility, addressing the overarching goals and main functions of health systems, can be organized around the Health System Performance Assessment (HSPA)-dimensions.

With regard to the health of populations, cross-border mobility might have positive effects on the access to health services (at least for certain patient groups), either to closer services (border regions), specialized services (also with regard to rare diseases), to services of a better quality or to cheaper treatments (afford-
ability). Positive impacts on the responsiveness (familiarity, meeting standards of perceived quality) can be expected, especially in a more competitive environment.

The continuity of the treatment (the management of interfaces in the process of treatment across borders), the assurance of safety and quality standards and liability rights might be challenging, but they are addressed by the Patient’s Rights Directive and in principle manageable on the basis of EU wide regulations. This holds also for the appropriateness of treatments. Major challenges are not so much based on medical services being delivered within the framework of regulations with regard to cross-border mobility. They are linked with services being offered beside the regulated system (e.g. aesthetical surgery or services with questionable need or quality). A further challenge is linked with access to services with are not offered in a country due to political reasons (e.g. PID, abortion, euthanasia etc.).

The most relevant challenges concern challenges being linked with equity, fairness and sustainability. There is a high probability that the benefits and costs of cross border mobility will not be equally distributed. It is not clear yet who will be the winners and the losers. Countries with a comparatively low GDP per head and low wages in the health sector might create additional revenues, also being beneficial for their balance of trade. On the other hand, the inflow of money might be counteracted by payments based on the Mechanisms of Social Coordination (social security mechanisms have to cover the prices of the country where services are delivered) or on the Patients’ Right Directive (especially wealthy patients decide to consume and pay for services abroad). Therefore, and in the light of EU health policy aims, objectives and values, it is a critical economic as well as ethical question whether cross-border mobility is mainly an opportunity for countries with a comparatively high socioeconomic standard (cost containment at home and access and availability of health services abroad), while the stimulation of the development of the access to and availability of health services is not so favorable in countries with somewhat lower socioeconomic standards.

In the light of citizenship vs. consumer, the mechanisms of social coordination and the Patients’ Rights Directive might develop as complementary regulations. But the Patient’s Right Directive strengthens also the consumer role. It can be linked with the political idea of a transformation of encompassing welfare states to three tier systems, with a social security system covering basic services, pri-
vate insurance covering additional services (like costs to services offered abroad and not fully covered under the Patients’ Right Directive) and a higher amount of out-of-pocket payments.

5. Concluding remarks

Taking into account the several mixed roles a patient can take, the construction of citizen’s rights is determined by a divide between a conceptual difference in the roles of citizens and consumers, and the (political) reality: policies addressing citizen’s rights can and have been linked with the idea to strengthen consumer roles. On the one hand this depends on the development of health policies in EU Member States, described in the 4 scenarios in this paper. On the other hand, European citizens, following the findings of the Eurobarometer, will take initiative in order to preserve their own well-being. If more conservative health policies will be the future in the EU, there will be more social spill-over effects. The (supra-)national governments will still have to take ad hoc decisions on the basis of a more decisive international patient. The EU patient rights directive offers a chance to European nation states to act more in favour of a European public health strategy. This means that patient mobility in Europe could be seen as a driver for change, both from a patient as from an institutional perspective. The constructed typology offers an understanding of the complex reality of patient mobility, furthermore it can be linked to the 4 scenarios. Globally a process of globalization in health care has taken place. Transnational organizations in the form of insurance schemes or hospital chains are a given reality. A context-controlled steering mechanism such as the EU patient rights directive cannot stop this globalization movement, but it can insert an equity balance for both national as well as international patients, if properly applied by the EU member states. Therefore as a future research agenda, the monitoring of this application by the EU members onto the European patient rights directive, as well as the monitoring of transnational health care development, will become an important necessity.
References

CHAPTER 9

Towards a sustainable framework of transnational health care

Towards a model of sustainable health destination management based on health regions

This chapter:

• Introduces the idea of a destination management framework for transnational health care.
• Considers the definitions and concepts that inform an analysis of transnational health care, governance and sustainability
• Presents the building blocks of destination management, specifically stakeholder, ethical and branding theories.
• Demonstrates how the linkages between destination management and transnational health care are constructed.
• Demonstrates how regional development in relation to health and health care is an active practice in the EU.
1. Transnational health care, cross-border health care, governance and sustainability

Health care is subject to the processes of both globalization and commodification (Pelligrino, 1999; Relman, 1980). Related to these phenomena is the movement of international patients across regions and around the globe. In the European Union a large part of this patient mobility is being regulated by the European Directive on patient rights (Council of the European Union, 2011). It is from this perspective that the term cross-border health care (CBHC) should be considered. In Europe there is a regional approach towards patient mobility (Brand et al., 2008). Border regions have been and are examples of good practice where cross-border health care, the provision side of patient mobility, takes place within the EU. Cross-border health care has always been pursued from a patient-driven perspective (Glinos et al., 2010). It also incorporates other forms of patient mobility, such as tourist accidents that require immediate treatment and senior citizens residing in southern destinations (Legido-Quigley, 2012) who need health care.

In contrast to the EU, in other parts of the world commodification has made a more decisive impact on the daily practices of patient mobility. From an Anglophone (Snyder et al., 2011) and Asian (Ormond, 2011) perspective, the tendency is to refer to medical tourism (industry-based) and medical travel (scholarly accepted). These terms originate from an industry which is based on a different, much more supply-driven business model. Or as I. Glinos explains: ‘rather than focusing on the suppliers of health care and their interests in patient mobility ... the industry-driven term “medical tourism” insinuates leisurely travelling and does not capture the seriousness of most patient mobility’.

The term ‘transnational health care’ (Mainil et al., 2012) originates from the notion that transnational organizations in health care such as private and public insurance schemes are working across borders and in national health systems. Just like large corporate hospital chains, insurance schemes are also active globally. This transnationalism could be professionalized further and networks could be developed further, but in close coordination with public health authorities or governments. Such transnational activities could create a more visible presence within health care that could better serve the interests of the international patient, with proper surveillance by public health authorities. Therefore we see transnational health care as a future, developed, globalized practice where integration could take
place between EU examples of cross-border health care and Anglophone medical tourism practices, bringing together industry and public health perspectives. With regard to setting the institutional frameworks and legal governance in relation to patient mobility in the EU, the EU directive on patient rights (Council of the European Union, 2011) provides patients with more opportunities for mobility, for health and economic reasons, but at the same time offers and reserves an important role for the member states in guiding patient mobility. This includes the installment of reference centers, measures of quality, and information infrastructure. In the light of these developments one could also ask the question: “is there room for regional steering?” Could regional governments, governing a health region where a large part of the workforce is active in the health care and wellbeing market, where there is a motivation to attain an identity as being a health region, where there are enough stakeholders present to steer this identity and where there is a joint concern for the local and transnational community, obtain more authority to decide which centers of excellence are being installed in their region, so that these initiatives are made accountable as part of a whole health region? Regions could then choose which specific medical (and wellbeing) areas to focus on, with a specific set of providers and facilities, based on the needs of (trans)national populations and the wants of public health authorities, creating regions with a specific set of medical (and wellbeing) expertise. Other nearby regions could create another set of expertise. This means that health region development becomes a driver for the management of the medical supply side in the EU taking into account the needs of the patient and resident community. Such a strategy is not without its critics, as indicated by previous practices in countries such as the UK and its National Health Service (NHS). Its impact on travel time for both patients and their families within such a specialized model of health care provision, and the perceived loss of local services affected during its development phase, are both difficult, and unresolved, political issues. Similar developments can be found in the logic and effects of mergers of hospitals (Gaynor et al., 2012; Fulop et al., 2002)

However, using this model, steering power is given to regional governments by a (supra-) national authority and regional development for patient mobility becomes a sustainable element of public health provision. We propose that both national and international patient groups will benefit from these health regions, because the regions can provide a better pool of medical expertise and organizational efficiency and thus be promoted more adequately, both nationally and internationally. This regional approach is in line with more transnational corpo-
rate organizations (Dicken, 2009), who could partake in the regional activities as stakeholders. Sustainability is therefore approached here as a consequence of governmental intervention. If the measures benefit the populations as patients present in the EU, then it is a sustainable practice, as opposed to a more commodified approach, subject to privatization and based on profit. Sustainability as such is seen here in a similar way as ‘sustainable tourism’ (van der Duim & Caalders, 2008; Gössling, Hall & Weaver, 2008) has been conceived: tourism activity with a view of the local community. Sustainable health destination management should serve the public health goals and targets of EU (supra) national governments.

So far, we have explored several concepts important for patient mobility and have introduced a regional approach for this phenomenon. We will now explain ‘destination management’ as an instrument for patient mobility governance, and show how some EU regions are developing practices that refer to this instrument. Finally, we will relate the current debates on EU patient mobility to our proposed framework.

2. Destination management and transnational health care

Destination management may be conceptualized as a practice operating at four geographic levels: city, domestic region, country, and international region (Table 1). For example, Hospers (2011) has described the city-level strategies undertaken by Helsinki and Barcelona; Barrutia and Echebarria (2010) have studied domestic region-level efforts in Spain and Italy to build their social capital, research and development, and innovation capacities; Baker (2011) has shown how at nation-level the destination management organization (DMO) of Australia has sought to integrate cultural expression in the form of film into the branding of the country; and at international region-level, Ilbery and Saxena (2011) have analyzed the strategic, administrative and personal challenges inherent in managing integrated rural tourism approaches in the English-Welsh cross-border region.
Table 10: Levels of destination management

<table>
<thead>
<tr>
<th>DESTINATION LEVEL</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>- Helsinki, Barcelona (Hospers, 2011)</td>
</tr>
<tr>
<td>Domestic region</td>
<td>- Spanish (17) and Italian regions (19) (Barrutia and Echebarria, 2010)</td>
</tr>
<tr>
<td>Country</td>
<td>- Australia (Baker, 2011)</td>
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<tr>
<td>International region</td>
<td>- English-Welsh cross-border region (Ilbery and Saxena, 2011)</td>
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Although the destination management literature has focused primarily on leisure-based tourism (Dwyer et al., 2009; Mistilis and Daniele, 2004; Pike, 2004), in recent years there has been increasing interest in the field of medical tourism (Bies and Zacharia, 2007; Cohen, 2008; Connell, 2005; Hazarika, 2010; Turner, 2007). With the steady rise in the number of individuals travelling abroad for medical services (Keckley, 2008), over 50 countries now promote themselves as international destinations for medical services (Gahlinger, 2008; Woodman, 2008). As Mainil et al. (2010: 753) have stated for a part of globalized populations, “...the notion of local health care provision is slowly being left behind. A new global form of health care perception is on the rise and the shift has already occurred in the tourism field”. This has led to an increased interest in patient mobility from both policy makers and citizens. It therefore seems timely to examine the theoretical foundations of destination management in order to gain insights into how and to what extent destination management techniques may be applicable - or are actually already in use (Ormond, 2012) - to the domain of transnational health care.

Figure 1: Theoretical foundations of destination management
Stakeholder Theory

Destination management entails the participation of multiple stakeholders in the pursuit of achieving shared goals. In the context of corporate organizations, stakeholders have been defined as “groups that are themselves affected by the operations of the organization, but can equally affect the organization, its operations and performance” (Cornelissen, 2004: 59). One can question, following the framework of patient mobility, whether citizens/patients would be included in this definition of stakeholders. Within the general management literature, several studies have attested to the importance for organizations to develop and maintain a stakeholder orientation (Greenley and Foxall, 1997; Christensen, 2002; van Woerkum and Aarts, 2008).

Given the perceived importance of stakeholders, organizations of all kinds need to identify and then engage with their various stakeholder groups and individuals. Mitchell et al. (1997) have suggested that organizations may grade the salience of their stakeholders in terms of the power, legitimacy and urgency of each group. In an examination of Mitchell et al.’s power, legitimacy and urgency framework, Parent and Deephouse (2007) found that power has the most important effect on salience, followed by urgency and legitimacy. In the context of sustainable tourism development, it has been argued that “in order to produce equitable and environmentally sustainable tourism developments multiple stakeholders must be involved in the process of planning and implementing the project” (Currie, Seaton and Wesley, 2009: 41). This indicates the scope of the challenge inherent in adopting an inclusive approach to stakeholders – not only do multiple stakeholders need to be included in the initial planning phase of a project, they also need to be engaged in the project’s implementation. Policy makers need to ensure that adequate resources are allocated to manage such a wide ranging, inclusive process.

Cross-border health care and medical tourism are moving towards transnational health care as a future professional field, involving more professional structures and networks, for example providing information to prospective transnational patients and creating transnational follow-up care structures, which would benefit from greater attention using a stakeholder approach. Governments could play an important role in organizing a set of stakeholders to address patient mobility from a holistic, meaning inclusive/integrative, perspective. In setting the region as a framework within which different stakeholders interact, medical (hospital providers) and non-medical stakeholders (insurance
providers and intermediaries) could benefit. As an example, we have observed that in Malaysia the government plays an important strategic role in positioning the country and its domestic regions with regard to patient mobility, alongside the role of the private sector in this endeavor (Ormond, 2012).

**Ethical Theory**

Ethical theory contributes to our understanding of destination management by drawing attention to two key concerns – the need to address the issue of ‘commodification’ and the importance of ensuring that the development of the destination is conducted in a sustainable manner. The question of commodification revolves around concerns over how appropriate it is to ‘package’ and promote a destination using techniques similar to those employed by companies for their products. Arguing beyond commodification leads to the distribution of resources to different social classes in society. Health as a resource or social good is also commodified (Pelligrino, 1999). The risk is that commodification will reduce the perceived authenticity and value of a place as a destination (Klieger, 1990; Dearden and Harron, 1992). However, this view has been challenged by other researchers who contend that commodification of a place can play a positive role in the local community. For example, Abram (1996: 198) suggests viewing commodification as “part of a very positive process by which people are beginning to re-evaluate their history and shake off the shame of peasantry”. A more contemporary view is expressed by Cole (2007: 945-6), who suggests that “understood from the perspective of the local people, cultural commodification can be positive... it needs also to be recognized as part of a process of empowerment”. Commodification is not without controversy in many arenas (including health care), it can lead not only to empowerment but also to disempowerment of citizens within the spectrum of the development. Particular sensitivity needs to be displayed towards the issue of commodification when the focus of attention is a phenomenon as integral to well-being as is transnational health care.

Developing a destination in a sustainable manner is key to the advancement of successful transnational health care. Tourism researchers have established a perspective according to which “... the success of area-based sustainable tourism development... largely lies in providing local actors with the means to engage in a process of managing complex and potentially risky situations; the collective learning of stakeholders, supporting multiple-loop learning, is a key mechanism for arriving at more desirable (sustainable) futures”, (Kout-
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The increasing awareness of environmental issues has led to sustainability becoming an important component of destination management (Chang, 2009). Building on this recognition of the centrality of sustainability in destination management, Insch (2009) has conceptualized green destination brands in terms of the manner in which destinations emphasize the green dimensions of their brand identity. It should be made clear that sustainability in the context of this paper and regarding patient mobility is not so much concerned with acting ‘green’, but more to do with good population public health, activated by several levels of governmental policy.

Commodification is present in transnational health care. This means that destination management could counterbalance the excesses of commodification by installing control by governments on the development of global health care initiatives and ensuring an equitable relationship with the public health care systems serving local populations. Transnational health care would benefit from sustainable solutions with regards to the resident populations and communities. As an example, Health care Belgium is representing a framework for patient and professional mobility for Belgium, but needs to take into account the Belgian government and possible reactions of the public opinion. The general issue, if enhanced patient mobility and the flow of more foreign patients into the Belgian health system is wished for, is still under debate.

**Branding Theory**

The increasing level of competition between destinations to attract medical tourists has heightened the importance of DMOs’ attempts to differentiate themselves from the competition through the development of distinctive place branding strategies. As an academic discipline, place branding has relatively recent roots (Gertner, 2011). The application of branding techniques to places is grounded upon three key concepts in the branding literature – brand identity, brand image, and brand equity.

The first of these concepts, brand identity, has been defined as “a set of aspects that convey what a brand stands for: its background, its principles, its purpose and ambitions” (van Gelder, 2003: 35). Brand image, on the other hand, refers to the mental perceptions that people hold of the brand, regardless of how accurately those perceptions reflect the reality of the brand. In the field of tourism, destination image has been the focus of considerable research (Pike, 2002). Im-
age is considered to be central to tourists’ destination evaluation and selection process (Echtner and Ritchie, 1993). The third of these concepts, brand equity, is well established in the marketing and branding literature and frequently transferred to the tourism literature. It is treated from a consumer perspective as customer-based brand equity, defined as “the differential effect that brand knowledge has on consumer response to the marketing of that brand” (Keller, Apéria and Georgson, 2012: 54). The customer-based brand equity concept has been applied to destinations by Konecnik and Gartner (2007), who emphasize that in addition to image, other important dimensions include awareness, quality, and loyalty.

Regions and governments, engaged in transnational health care, would be able to create awareness as health regions, by branding them as sustainable health regions, where a balance is present between commodification and the public good of the population. If regional governments get the chance to choose the global health care initiatives they visualize for their regional development, this would mean they could also promote their region as a healthy one for (trans) national populations, with a well-balanced supply, based on access to health care, of medical and wellbeing providers. This would provide better integration between nearby regions, installing regional development as a tool for enhanced patient mobility and further developing transnational health care. As an example, Bavaria, in Germany, is promoting itself as ‘Bavaria, a better state of health’, combining health and environmental policy, and promoting itself as a health region: a combination of medical and wellbeing facilities.

3. Case-studies: Health care Belgium, Maas-Rhine region, the Veneto region and Bavaria

Each of the cases is examined against the triad of stakeholder, ethical, and branding theories, identified above as inherent to destination management. This will indicate the differences in character of the regions and assess which regions are closer to the concept of sustainable health destination management. These regions were selected on the basis of their involvement in patient mobility developments.

Health care Belgium, Belgium
Stakeholder perspective: Health care Belgium is a private non-profit organization, sponsored by stakeholders (such as university and private hospitals, and
medical suppliers), but in combination with influential governance required by the Belgian government. On the basis of these characteristics we can say that they are adopting a stakeholder approach: working together with governments/health insurance providers/employers and hospitals. The organization is engaged in delivering secondary and tertiary health care on the basis of bilateral contracts with other regions and nations. This involves outsourcing Belgian medical expertise to these regions/nations and taking care of specialized patient cases in Belgium. A similar recent development could be observed when Belgium offered aid to those wounded in the war in Libya. However, at the present time stakeholders are not fully committed to a joint governance model; they are still very much competitors, inherent to the traditions and practices of the distribution of resources within the medical sector.

Ethical/local community perspective: The Belgian citizens’ cultural experience of their health system makes patient mobility still a difficult exercise. Among local populations there exists fear regarding the quality and capacity of Belgian hospitals. Because Belgium is a country that follows the continental European social model, it takes a persistent political standpoint which means that opening the borders to foreign patients is sensitive, and that a two-speed health care system must at all times be resisted in favor of the Belgian population.

Branding/promotional perspective: From an international health care perspective, Belgium is somewhat known, but it has not yet profiled itself particularly effectively. Health care, being a social good and right has never been seen as a potential industry. A difference can be observed in reference to the case study of Bavaria below. However, in terms of a ‘health region’, it is argued that the area surrounding Brussels would have the opportunity to be a health region, because of the extent of medical expertise, easily accessible airports, the presence of many embassies, quality hotels, and having the overall international character of a capital city. In conclusion, Belgium, and Brussels in particular, could develop into a sustainable health region if policy levels were structurally more open for managing patient mobility.

Maas-Rhine region, the Netherlands
In this region there are several stakeholders investing in solving health issues but the regional government is not driving this dynamic. The consequence of this is that they are in less of a position to steer the region towards becoming a health region. However, there are other powerful stakeholder groups who are influential. Using a top-down perspective, the EUREGIO (a cross-border cooperation organization) Maas-Rhine organization operates at several policy levels in order to influence public health matters. On the other hand, there are
bottom-up organizations such as EUPrevent which include several stakeholders, but from a public health prevention perspective. Additionally, hospitals such as the university hospitals of Maastricht (AZM) and Aachen (UK Aachen) are trying to establish centers of excellence but have difficulty in promoting themselves in other policy levels.

Ethical/local community perspective: One can observe a gap between the reality of cross-border patient mobility in the Maas-Rhine region and the inherent conservatism within the political establishment, which at the moment is more against than for the EU.

Branding/promotional perspective: This region has been seen for years as a region where cross-border patient mobility plays a significant role. This is known to several stakeholders in Europe, but it is less seen as such by the resident population. The political context also plays a role here. The Dutch government is not in favor of large volumes of mobile patients and other EU initiatives, due to the present political constellation. In conclusion, this is a region which is developing slower than previously, but with organizations such as EUREGIO and EUPrevent acting as steering bodies there remains an opportunity to develop further as a health region.

**Veneto region, Italy**

Stakeholder perspective: In the 1990s 20 regions were created. Ninety per cent of hospitals are controlled by these regions and regional policies are strongly linked to the local economy. The region is an important tourist destination which places demands on local services, including health services. For example, this year there were 20,000 usages of a cross-border insurance card for minor/major emergencies. There is, therefore, already close alignment between extant regional economic and health policy. Close connections with bordering regions are conceived as important for this regional government: in particular with Austria, Slovenia, Croatia. The present health care system means that there are no gains from increasing the volume of international patients because the majority of hospitals are publicly funded. However, the specter of the EU patient rights directive will mean adapting to new challenges. This means new chances to prepare medical staff for international patient care and to obtain quality accreditation. Concerning the role of stakeholders, if a hospital is interested in attracting international patients, then the regional government needs to sign bi-lateral agreements, to prove commitment, and to offer a framework for local administrators. In this way, the involvement of regional government is assured. It is observed that in regions with a strong dependency on tourism the case for the involvement of a wider set of stakeholders is more easily made.
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Ethical/local community perspective: The preoccupation of Veneto citizens are linked to length of waiting times for treatment in emergency rooms, given the large amounts of tourists arriving every year in the Veneto region. The government is responding by investing in primary care provision and health promotion.

Branding/promotional perspective: The promotion of the hospitals of Veneto is lacking at this stage. There is little awareness, on a pan-European basis, of the quality of health care in Veneto, consequently Veneto is known as a tourism destination rather than as a health region as such. A recent tendency is that hospitals, which opened 2-3 years ago, are beginning to promote themselves as medical treatment centers but these actions are taken independently. In conclusion, the Veneto regional government is committed to health care but the focus of its response to tourism is very much related to the demands of tourists for emergency care. However, the region’s image as a well-known tourist destination would be a good starting point from which to develop as a transnational health region.

**Bavaria: ‘a better state of Health’, Germany**

Stakeholder perspective: A lot of the efforts of the Bavarian state department of health and economic development are centered around the enhancement of the medical chain. Greater efficiency is needed to effect improvements for the local as well as for international patients. They also have signed bilateral contracts with other nations to enhance patient mobility. They are actively developing new integration initiatives. For example, they have provided funds to and accredited with a quality mark 17 (of 70 counties) health regions in Bavaria, based on their commitment to providing health care. These are regions which depend on a public health economy, as a large part of their economic value lies with the health care sector. The state government funds them to create networks and cooperation between several stakeholders. As such, the government has enabled the players to work together and to accommodate organizational and management functions, literally under one roof. There is strong cooperation with local political officials who are charged to make the cluster networking work.

Ethical/local community perspective: The importance of the public health economy is being exemplified because a significant part of the population works in this sector. At the same time, the state government needed to search for cost efficiency for the medical sector in Bavaria. One of the policies adopted was to encourage hospitals to work closer together by clustering services in order to improve quality. It also involved the development of medical specialties at specific hospitals.
Branding/promotional perspective: With the strong strategy ‘Bavaria, a better state of health’ and an underlying logic of the public health economy, it seems that making connections between different stakeholders and being present in the right spaces has been beneficial for the region of Bavaria to position itself as a sustainable health region. In conclusion, the importance of the public health economy and its treatment as an industry and the involvement of state government in developing the region as a health region connects Bavaria to the concept of sustainable health destination management.

Taking a comparative overview of the four case study regions, several differences and stages of development are apparent. Belgium and the Maas-Rhine region share the condition that governmental support is less forthcoming in the current political context, although these regions do have characteristics which are conducive to sustainable health destination development. The Veneto region is more dependent on the regional government, although it is driven more by its notoriety as a tourist region, but with health system implications. Finally, the Bavarian case shows how integration and cooperation of stakeholders, steered by specific initiatives and solid commitment from the government can produce a health region approach. The type of governance demonstrated in Bavaria is very near the model of sustainable health destination management (SHDM) and transnational health region development that we are proposing. Although the regions are different from each other, they share a joint characteristic, of having a certain openness towards mobility and a willingness to be more than a local region. Practices such as the EUREGIO in the Maas-Rhine region, Health Care Belgium, the installation of health regions in Bavaria, and the large health care infrastructures in the Veneto region, show an ability to anticipate the changes occurring across borders.

4. Discussion: Health regions and Cross-border health care in Europe

As a further contribution to the implications of applying destination management to patient mobility frameworks, we have analyzed how this is related to the current EU debate on cross-border health care. In this section we examine how our ideas about health region development sit against EU health policy considerations (see also chapter X).

Firstly, following Glinos’ (2010) observations on cross-border health care in Europe: what is the willingness of EU populations to consume health services
abroad? Secondly, there is a factor of significant socio-economic differences in Europe, which has an influence on patient mobility and the related national policies. Finally, the current economic climate could also not be the most beneficial for the development of economical patient flows (with a tendency towards localized versus globalized patients). Developing transnational health regions could enhance patient mobility and the willingness of EU populations to travel for their health, but it could also constrain the willingness to travel because of the socio-economic differences among EU nations and regions (for example Hungarian citizens not being able to travel for health reasons to Germany). The development of a health region is also an economic activity which could be beneficial if it leads to cost-efficiency, but overall not all EU national governments are in the position to invest in such an initiative.

When arguing in terms of the EU Directive on Patient Rights, which is the latest approach of the EU commission to govern patient mobility in Europe, a set of scenarios can be stipulated around the potential of the model of health region development (Mainil et al., 2012). Scenario 1: The current regulations under the EU Directive will not create the dynamics for more cross-border mobility. This means that health region development will only be accidental and based on individual governmental decisions. The framework of the directive is not seen as an opportunity to build capacity by governments for their citizens. Scenario 2: Current regulations (EU Directive on patient rights) are implemented: this means that national governments have to argue and act in terms of management of European and/or international patient flows which opens the possibility to think in terms of health region development, with the government as a mediator, as is occurring now in the Bavarian case. Scenario 3: Implementation creates a dynamic on several stakeholders – such as insurance providers/hospitals/supportive services/governmental structures/citizens - to become transnational, resulting in transnational health regions. In this case it is not enough that regional and national governments are steering health region development, but that also supra-national bodies such as the European Commission need to steer the development of health regions. This involves taking decisions on which medical chain initiatives (a steered process of several providers in the delivery of medical services) should be embedded in which health regions. For the three scenarios different levels of capacity building can be employed in developing the supra-(national) public health systems. This could include transnational health region development that incorporates an increased capacity within public health provision that serves both local and transnational patients.
5. Conclusion

This paper has sought to establish both a conceptual as well as practice-based link between the ideas implicit in the terms ‘destination management’ and ‘transnational health care’. This takes the form of a model of sustainable health destination management (SHDM) that potentially results in transnational health region development. Several regional cases have been explored within the framework of the factors of destination management (stakeholder – ethical – branding theory). Finally, we have considered our proposals within the current challenges facing cross-border patient mobility in the EU. Future research needs to include how the EU directive on patient rights is implemented and how its effects could be assessed. Furthermore, an assessment of whether regions in Europe are or tend to be transnational health regions, and how this relates to public health provision, would be an interesting line of research.

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CHAPTER 10

Synthesis
Synthesis: towards an integrated transnational healthcare setting

In the previous chapters, the contributions of several factors to transnational patient mobility have been described and analysed. In this concluding chapter I summarise these factors, demonstrate their significance and integrate them in a meta-analysis with a view to developing a coherent model.

Factor 1:
Worldmaking: a significant relation between provider and patient

Before addressing the positive aspects of worldmaking (Mainil et al., 2011), I first consider the original concept defined by Hollinshead (2007), who earlier already framed worldmaking as follows:

“We must improve our cognition of what the imaginal universes of tourism are doing to us — or rather, what we ourselves are doing to those important tribal matters of existence through tourism.” (Hollinshead, 2002)

The concept of worldmaking is known in the tourism field as the false imagery that is sometimes portrayed on the internet and in tour operator brochures. These media portray a tourism destination or hotel as an ideal place to be, with images of palm trees, beautiful buildings and rooms, stunning beaches, and happy staff and tourists. In some cases prospective tourists are misled because these images do not reflect reality. In most cases, however, the consequences have no impact on the health status of tourists.

When the concept of worldmaking is transferred to THC, the consequences can be much more far-reaching. The supply-driven medical tourism industry uses the internet for extreme marketing purposes. According to Lunt et al.:

“The internet is however not simply an increasingly interactive encyclopaedia offering information to surfers. Over the last decade the range of health treatments that have become available for purchase has dramatically increased and just as the internet cannot be contained within national boundaries, nor can the products that are available to consumers.” (Lunt et al., forthcoming)
Provider websites show images of smiling doctors and patients, and numerous examples of white beaches and palm trees. Furthermore, the messages on these websites use words and phrases such as “excellence”, “world-class doctors”, “the best of”, and “an exquisite experience” (Corney, 2011; Turner, 2011; Lunt, 2011). However, patient experiences in receiving medical treatment are often far from the concepts of happiness and wellbeing.

These websites influence the way individuals perceive and decide on travel for health. Bell et al. refer to place myths created around medical tourism destinations:

“Access might also involve something like ‘cultural proximity’ – language, for example (guidebooks often reassure readers that staff speak excellent English) – and familiar destinations. Many Spanish cosmetic surgery clinics, for instance, are based on the Costa del Sol in resorts already familiar with European tourists. ‘Cultural proximity’ can also extend to a vaguer notion of the kinds of destinations that are imaginable as offering appropriate levels of service – particular places trade on certain images (or maybe myths) in order to ‘sell’ themselves as a cosmetic surgery destination. (Bell et al., 2011)”

Through worldmaking it is possible to create place myths, a tool that benefits an industry in search of business prospects and economic value. Earlier in this thesis, the concept of worldmaking was extended to a positive variant that emphasises positive attributes in THC development:

“Medical tourism has the power to apply worldmaking in the sense of Hollinshead (2007) as a false imaginative process, but has also the chance of being a changing agent in how countries need to deal with global healthcare provision and globalisation tout court. This is worldmaking in the positive sense of the word.” (Mainil, et al., 2011)

This positive attribute is linked to the concept of globalisation and the network society (Castells, 2000):

Medical tourism is an interesting case. It arises in the interstices of the interacting networks of a global world. It crosses borders in line with global power-structures in a global network, but it also meets local resistances or regional obstacles which are related to other networks. Because of the rela-
tion between the local and global networks, in the case of medical tourism, the positive worldmaking capacity could come into play, whereas the false imaginative process could become prominent or turned down. (Mainil, et al., 2011)

In conclusion, further professionalisation and legitimacy processes are required to decrease imaginative processes in medical tourism and THC contexts, and should incorporate modes of integration for public governance bodies.

Factor 2:
Cross-culturalism: a relationship between provider and patient

THC entails movement of patients and professionals around the globe. The cultural backgrounds of these groups do not always fit. Although local medical doctors are trained in Western centres of excellence, there is still a cultural gap between patient and doctor, and on secondary basis between nurse and patient. How does a patient react to or experience the receiving context on travel for health reasons to a non-Western country? Does the patient’s cultural perception of health and healthcare differ from that of inhabitants and professionals residing in the receiving context?

From a provider perspective, it seems logical to make the patient as comfortable as possible, both physically and culturally. Thus, cross-cultural understanding by professionals surrounding the patient is a first step in the right direction. Before addressing more practical considerations, a theoretical foundation is in order. The conceptual thinking of Habermas on communicative action and strategic action is relevant:

“In globalising transnational health care, the intermediary organisations in-between the system and life-world seem to form the place where the tension between communicative and strategic actions is mostly felt. (...) Translated to Habermas’ concepts, this would refer to an intensified struggle between the system and life-world, in which the human values from within their life-worlds are coming under the pressure of the demanding wishes of highly efficient and effective markets.” (Mainil et al., forthcoming)

An organic and dialogic approach to communication is preferred by patients on the basis of equality and trust and an understanding built up through a history of communication based on values recognised by society. This seems to be a suitable way for professionals to deal with patients, using a mutual understand-
ing, being culturally aware about each other and applying a sense of cultural sensitivity.

However, professionals work for organizations that need to be managed with targets and a view to profits. Thus, strategies and non-democratic decision-making are replacing organic and dialogic communication. Habermas refers to strategic action for efficiency and economic wealth, but health and healthcare may not be suitable areas for such strategic action. We observed an international office (IO) of a German university hospital that has a focus on international patients. It was clear that both forms of communication were present, but that the balance between them was the most important issue. It was clear that they need to take into account the strategy of the hospital, management and medical professionals. At the same time, they need to take into account the perspective of international patients. The office functions as an intermediary between sometimes opposing players: the patient and the hospital:

“We consider ourselves as a service point or link between the patient and the clinic … we function as a link between patient and the departments, we often speak to both of them, we always try to do the best we can in the interest of the patient, but also try to do our best in the interest of the clinic. That is not always easy." (IO Management, UKE Hamburg Eppendorf)

Therefore, in adopting a cross-cultural approach, professionals should find the right balance between communicative action and strategic action. Most of the time the patient has no other choice than to travel for health reasons and will be culturally affected by this choice.

The tourism concepts of encountering a cultural shock and residing in an environmental bubble are both valid for the transnational health experience. On one hand, the patient resides in the haven of the hospital (bubble), not knowing what is happening outside the hospital; on the other hand, the hospital staff are messengers from that different cultural context.

If we connect culturalism to worldmaking and marketing, it is evident that this cultural experience is not always included in the worldmaking of medical tourism websites, for example. Such websites sometimes refer to a meeting between cultures, but patients with an illness are more likely to encounter more extreme experiences related to other cultures, or professionals who do not show much cultural sensitivity when treating patients. Imagine a patient travelling to
Bangalore, India who arrives at the airport with transport standing ready. The patient probably never considered horrendous traffic as a first cultural experience as an international patient, and the issue is probably never addressed in the promotional material of the Indian providers.

**Factor 3:**
The media: from provider to the patient
The media play a creational role in the debate on medical tourism. The way the media report on this phenomenon can influence public opinion. First, individuals will start to reflect on medical tourism and then prospective patients will use the information to orientate themselves towards the possibility of travelling for health reasons. It is therefore useful to analyse content in both international and local newspapers in the receiving context. One major observation is that since approximately 2002, news media have reported in a more business-oriented way. Articles are on opportunities and positive experiences, and professionals are given the opportunity to promote themselves. In the period before 2002, there was much more of an ethical debate. Medical professionals warned of the dangers of medical tourism, the danger of going abroad for treatment, and the ethical issues involved:

“Popular descriptions of medical tourism portrayed it as a hedonistic illustration of global supply and demand with many risks for underdeveloped countries. These risks were identified as being related to language problems, poor facilities and painful outcomes ‘when things go wrong’. For example, going to Africa for liposuction was built up as a low-cost option with the opportunity to see great wildlife (the market discourse) but a heavy accent was placed on the problems surrounding patient protection (ethical discourse). Sometimes medical tourism was said to be strongly rejected (Halpern, 1995) because of the emergent health staff in developing countries, where medical workers who have worked in developing countries were penalised for having ‘long holidays’ and irrelevant experiences for their future career (the medical discourse).” (Mainil, Platenkamp and Meulemans, 2011)

This positive view on the phenomenon was evident as a global issue in both international and local newspapers, as shown for this Asian perspective:

*Obviously, the market discourse is overwhelmingly dominant. Examples are abundant in the Bangkok Post as elsewhere after the rupture. Philips’*
investments in the medical systems business in Thailand have been highlighted several times.” (Mainil, Platenkamp and Meulemans, 2011)

In this sense the media are a promotion route for the medical tourism industry, they are part of worldmaking capacity present in medical tourism. It would be an interesting exercise to find out how prospective patients read and interpret these articles and to analyse how patients use and interpret medical tourism websites.

Finally, it would be naive not to consider the full spectrum of (internet) media. Several organisations in the medical tourism industry, such as the Medical Tourism Association (MTA) in the USA and Intuition Communication Ltd. in the UK, have their own internet media tools that portray positively worded perspectives that can be imaginative in nature. Their task is to promote their stakeholders in the same way as a medical association promotes its distinguished members.

**Factor 4:**
**The issue of quality in THC**

Quality and quality management are and will be important for THC in the future. Several authors have indicated that quality is not yet optimal. Accreditation systems such as JCI have been implemented around the globe. This could be seen as a first step in quality management for THC. This holds for medical institutions, but other intermediaries, such medical tourism facilitators, should also be subject to quality assurance:

“Just as legislation is used to ensure accreditation of hospitals and clinics, licensing of health-care professionals and accreditation of travel agencies, legislation needs to be crafted to regulate the practices of businesses that integrate features of both travel agencies and health-care facilities. Medical tourism companies arrange travel to other nations, but they are also involved in coordinating provision of health services. Given their role in organizing health services for patients, medical tourism companies should be subject to external evaluation and accreditation.” (Turner, 2011)

International patient departments in hospitals deliver patient services other than medical treatment (Mainil et al., forthcoming). Such departments are increasing, so an evaluation instrument would be useful. I developed a survey instrument to measure the delivery of certain services by international patient
departments and if quality measures are taken. Pilot study material suggests major differences among hospitals in terms of the target group and the political context. Service delivery depends on whether a country is ready to see its medical system as a medical industry. Countries that have chosen this path are developing a strategy for international patient mobility.

In relation to culturalism, quality needs also to be taken into account. How culturally sensitive and aware are staff? Can they be trained? In the case of Germany, this means that German doctors and nurses need to be made aware of other (medical) cultures. In relation to media and website management, quality is also important. Medical websites based on quality would provide a better and more honest view for prospective patients. If the media were to report from a realistic perspective instead of taking a promotional approach, this would benefit international patients. Thus, there are opportunities for research into quality assessment for THC, which requires further professionalisation. The different stakeholders could be further assessed in terms of their processes and patient services.

**Factor 5:**
**The public health dimension**

The medical tourism industry is supply-driven. Because of this business perspective, EU policy-makers have a negative view of the industry. The question thus arises as to whether it is possible to opt for a direction in which business perspectives are combined with a governmental approach, so that the public health goals of health systems and THC can be attained. If regional governments are given more steering power, they could engage in dialogue with other stakeholders and decide which medical excellence centres could be placed within their region. Thus, regions with a centre of excellence could use this as a selling point. This information could also be made available to surrounding regions to avoid competition for specific expertise for centres of excellence. To make this an effective exercise, the regional government in cooperation with other intermediaries could strategically manage its image as a health region and position itself as a health region for both local and international patients. The EU could be an ideal ground for this concept because of the specific nature of the EU, with its inherited social security and national health systems. However, profound considerations such as the willingness of European populations to travel abroad for health reasons, the socioeconomic differences which exist in Europe and the current economic climate will be decisive for further development. Owing to the EU directive on patient rights and its objectives, the future
of European patient mobility should be more coordinated and managed from a supranational and national level.

In the EU, some regions are already moving towards regional steering. In the Maas-Rhein region, organizations such as EUREGIO and EUPrevent play particular roles in such steering. The first signs are also present in Belgium, where Health Care Belgium is focusing on bilateral contracts with other governments.
and international organizations for the delivery of medical and other professional expertise and to care for medical cases in Belgium within these contracts. Bavaria, with its strong slogan “Bavaria, a better state of health”, has a very integrated strategy that covers medical services, wellness and wellbeing, and actively promotes this provision of services. Finally, in the Veneto region, a historic tourist area, the government is committed to providing healthcare to tourists, international patients and the local population. At a more global level, in countries such as India, Singapore and particularly Malaysia (Ormond, forthcoming) the government plays a particular role in the development of transnational patient mobility.

Worldmaking as a marketing effect in the medical tourism industry is related to the media because it is very likely that the media are constructing an image around medical tourism that is not fully based on facts. Marketing efforts in medical tourism can obviously benefit from the role that the media plays. If we talk about culturalism by introducing the concepts of Habermas, then worldmaking, the media and marketing of medical tourism are obviously part of a strategic action model in which profit, strategy and targets are very important. Through effective quality management of both medical and support services, it should be possible to leave behind the worldmaking approach to medical tourism. If quality is of a good level, it is possible to market services on the basis of patient-centred values and measures, which should lead to a more communicative action model. To enhance the professionalisation of transnational health care, a connection needs to be made between public governance and the rapid growth of private medical tourism initiatives. Therefore, introduction of an augmented steering role for regional governments – SHDM – will mean that they can select initiatives that are aligned with their own strategy to position themselves as health regions. Once this selection is made, efforts will be required to manage the image, character and healthcare provision of the health region.

In managing a health region, quality (medical and supportive) needs to be maintained, and cultural sensitivity and awareness need to be promoted in the professional community and the local population. A relationship should be established between these governmental structures and the media in reporting true information by providing objective data. From out of a governmental public health perspective marketing should be performed from out of an ethical stance related to access to healthcare. Finally the trend towards transnational organizations in a globalised healthcare market could be enhanced by SHDM on behalf of the government by including these organizations in decision-making on the selection of regional centres of excellence.
Towards transnational healthcare settings

Finally, I would like to argue in terms of transnational healthcare settings. Most scholars apply the concepts of patient mobility (demand) and cross-border healthcare (supply) from a single standpoint: observing the international patient or assessing the providers and stakeholders in the provision of cross-border healthcare. I would like to integrate these two views in a setting in which both decisions and patient patterns are intertwined with professional frameworks.

**Figure 3: Transnational healthcare settings**
We depart from two archetypal international patient settings, TBAS and CBAS, on the basis of criteria. This results in eight different sub-settings based on searching for public/private patient access and public/private provision of services (receiving context actors –RCAs), with a context-controlled governmental steering mechanism based on a steering and governance framework: SHDM (Mainil et al., forthcoming).

In assessing this model, it can be concluded that SHDM can act as a framework between private stakeholders and public governance bodies for sustainable development in medical tourism and cross-border healthcare. It is likely that governments in the EU are already reflecting and acting on developments in this area to restrict or develop initiatives in the context of public health.

It remains an open question if there will a tendency towards more or less integration in the EU regarding transnational patient mobility. Several scenarios (Chapter 5, p. 204) are possible, but a balance between market development and (supra)national public health surveillance is required, which represents a large responsibility for policy makers. This document provides a basis for future exploration of the complex phenomenon of health and mobility.
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International patients are increasingly travelling for health reasons in a globalized health economy. In response, governmental bodies such as the EU are developing frameworks to regulate patient mobility. In other parts of the world less regulation and more privatization is taking place, creating the phenomenon of medical tourism in contrast to the cross-border health care seen in the EU. This dissertation proposes an alternative global terminology of transnational health care, as a professionalized, structured network of health services visible to the international patient. Furthermore a focus is on five factors which influence the international patient:

1. The role of worldmaking and the internet: Health providers are using the internet to attract international patients. The content that is put online, could be seen as ethically unjust.

2. The role of culturalism: Following Jürgen Habermas one can observe that in medical tourism both strategic and communicative actions are present. Culturalism can enhance the balance between those actions.

3. The role of the media: The media show a market discourse of medical tourism, presenting products as “opportunities”. An ethical discourse is still present, but is framed within this market perspective.

4. The role of quality in the sector: International patient departments guide the international patient in her or his quest for non-medical enquiry. In this framework measuring the quality of these services requires further exploration.

5. The relation with public health: International patients in the EU could be seen as both citizens with rights and health consumers. These perspectives have complex relationships with existing and future regulations.

Based on these five factors, a policy route is suggested to enable (regional) governments in steering the health provision potential of their region to position themselves as transnational health regions in view of visibility and quality for patients and other regions.

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