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Transnational healthcare, cross-border perspectives

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1. Introduction

As we write this introduction in September 2014, two major 'medical tourism' stories have recently broken in the international news. First was the case of twins born to a Thai surrogate mother on behalf of an Australian couple. One twin was born with Down's Syndrome and apparently 'left behind' in Thailand with his surrogate mother. Second was the case of a five-year-old boy 'abducted' by his parents from a UK public (NHS) hospital and taken first to Spain, and then to the Czech Republic, to undergo specialist cancer treatment unavailable to him at home. Both cases have been extensively covered in national and international media (see, for example, Brierley 2014; Davies 2014; Dugan 2014; Hardy 2014; Jabour 2014; Meade 2104).

These two cases in different ways exemplify many of the issues raised in this special issue. In the second, Ashya King, a young boy from the South of the UK undergoing treatment for a brain tumour, was reported 'missing' from his hospital bed -- staff alerted police that Ashya had been taken from the hospital without the approval of his doctors. The following day UK police launched a campaign on television and social media claiming that, because a battery for his feeding tube was due to run out, Ashya's life was in danger. Interpol subsequently issued a missing persons alert and the following day a European arrest warrant was issued for parents Brett and Naghemeh King, based on suspicion of child neglect. Ashya later appeared with his father in a video posted to YouTube, in which Brett King outlined his family's reasons for

their actions (YouTube 2014). Ashya's parents were then arrested and held in jail in Spain for 72 hours, before being released and allowed to take Ashya to the Czech Republic for specialist treatment.

As the story developed, it transpired that the couple were seeking proton beam therapy, an advanced cancer treatment not yet available in the UK. While some children from the UK can have the therapy abroad, its public health service (the National Health Service (NHS)) paying treatment, flight and accommodation costs for the child and a carer in countries like the US, in Ashya's case, doctors felt that conventional treatments were more appropriate. After this decision, relations between doctors and Ashya's parents broke down, leaving the latter feeling that the only option was to 'steal' their son from his hospital and sell their second home to pay for proton beam therapy in the Czech Republic. Eventually, payment for the treatment was provided by the NHS via the EU directive on patient mobility, discussed below (Davies 2014).

This story raises many issues, and the role of the state in providing healthcare is central to them. The King family's case is partly a question of the allocation of NHS resources and finances – a recurrent theme in political, media and popular debate (see, for example Donnelly 2014). But cost is also played off against quality of care, and with patient mobility and access to information about treatments abroad freely available online, the question takes on a transnational dimension: what does it mean for public healthcare when a new treatment is unavailable in the UK but is offered in the Czech Republic?

In the private sector, meanwhile, business is booming. The expanding global middle classes are enjoined by a range of social actors to take control of their health and become

responsibilised citizens, managing their own health and accumulating medical knowledge (Connell 2011). In place of the passive patient who leaves healthcare decisions and responsibility to the medical authorities, citizens are being disciplined to become more active and engaged healthcare consumers for the sake not only of themselves but also of their families and of national health systems (Ormond and Sothern 2011). In Ashya's case, the breakdown in the doctor-family relationship in the UK demonstrates some of the tensions generated by patients and their families acknowledging that a greater array of care and treatment possibilities may be available privately outside of their own countries. In an interview published in the British newspaper *The Independent*, Brett King explained:

> We pleaded with them (in Southampton) for proton beam treatment. They looked at me straight in the face and said with his cancer – which is called medulloblastoma – it would have no benefit whatsoever. I went straight back to my room and looked it up and the American sites and French sites and Switzerland sites where they have proton beam said the opposite, it would be very beneficial for him. (in Dugan 2014)

Commenting on the issues raised by this case, paediatrician Joe Brierley wrote for UK newspaper *The Guardian*'s website:

> Patient empowerment, whether through the internet or other data sources, can be perceived as a mixed blessing. How do I maintain the professionalism demanded of me when families with ready access to a wealth of information challenge my recommendations? (Brierley 2014)

In most cases, treatment choices in the UK are based on what can be provided through the NHS and whatever 'supplements' patients and their families can afford. As wealthy Britons and therefore citizen-consumers with options, the Kings had a strategy. There was no proton beam treatment available in the UK. Treatment in the US may have been beyond their means. But treatment in the Czech Republic was manageable if they sold their second home. Medical tourism can make the unaffordable affordable, the unavailable available, but still only for those that can raise the funds. And whilst proton beam therapy may be reputable, albeit as yet not fully tested (for an interesting assessment of the treatment, see NHS Choices 2014), what of the other treatments available globally? Stem cell treatments to rejuvenate spinal cord injuries, for example? How can patient-consumers (as we might call them) decipher the legitimacy of their treatment choices? Information found on the internet or through word of mouth reflects a battleground of disputed claims and commercial interests. How should a patient with no medical training negotiate this interested information overload? As we shall see, this is a central concern for those who catch planes, trains and buses, who drive or who simply walk across borders each year in search of everything from the most complex to the most basic treatments unavailable at home.

The second story that dominated the international news media in August 2014 focussed on transnational surrogacy. At the end of July, the Thai media broke a story about Pattaramon Chanbua from Chonburi province, south-east of Bangkok, who entered, via an agent, into a surrogacy arrangement with an Australian couple. She was paid a fee of AUD16,000, and gave birth to twins – a boy and a girl – in December 2013. Thailand is a medical tourism hub, although commercial surrogacy is technically illegal in the country. The boy twin was born with Down's Syndrome and was reported as having been 'left behind' by his Australian

parents when they discovered his disability. Pattaramon, already a mother of two children, explained in an interview:

> The money that was offered was a lot for me. In my mind, with that money, one, we can educate my children, two, we can repay our debt. (in BBC News 2014)

The motives for entering into such transactions for surrogate mothers are at first glance very clear. However, Patteraramon was now left holding an extra baby, Gammy as she named him, and one in need of significant medical treatment that beyond her means. Inevitably the story became more complicated. Having been named in the media on August 10, the Australian couple, David and Wendy Farnell, appeared on the Australian Channel Nine Network to present their side of the story (see Jabour 2014; Meade 2014). Gammy's Down's Syndrome had been diagnosed early on in the pregnancy, they claimed, and they had asked Pattaramon to abort his foetus. However, Pattaramon has refused on ethical grounds, as a Buddhist, to undergo an abortion, and so carried him to full term. Pattaramon said that she was scared, since the Australian couple (whom she never met during the surrogacy process) wanted Gammy aborted, that they might now harm him, leading to her decision to keep the baby. In a further turn, by early August more than AUD160,000 had been raised by charities to support Gammy's care and his Thai family, whilst his sister, Pipah, remains under close scrutiny by child protection agencies in Australia. The Thai and Australian governments are both urgently reviewing the legal frameworks surrounding surrogacy, and transnational commercial surrogacy in particular.

The ethical issues in the case of Gammy Chanbua seem much more stark than those raised by Ashya King's. Both cases, of course, foreground the spectre of the disabled child and to what

extent this is viewed a tragedy, avoidable or otherwise. However, the issues raised in Ashya's case seem relatively mundane compared with those of Gammy's. Ashya's parents suffered financial losses in securing expensive treatment for their son, while for Gammy's surrogate mother, the AUD16,000 she was paid for having the twins as a 21 year old mother of two meant an investment in her children's education and escape from debt that could mean a significant change in the fortunes of her family. Of course, there are many who act as surrogates in the West – in the UK, for instance, surrogacy is perfectly legal so long as no payments other than 'expenses' are made, typically a maximum of around GBP15,000. But transnational payments from high income to low income countries for embodied services – surrogacy, egg donation, organ transplant and so on -- take on extra significance. These two stories may have captured the international media spotlight, but they are part of a much bigger picture.

2. Rethinking transnational healthcare

What these two cases primarily tell us, then, is that the provision and regulation of healthcare within national boundaries is currently profoundly shifting. Growing numbers of people are going abroad in pursuit of healthcare, and the social, political and economic significance of these flows at a range of levels cannot be ignored. This special issue brings together papers from a key international conference held in June 2013, Transnational Healthcare: a Cross-border Symposium – an event that was itself transnational, with hosting shared by institutions in two countries: first in Wageningen, The Netherlands, with delegates then travelling to Leeds, UK, for further presentations and discussion. The aim of this symposium was consider the impacts of 'medical tourism' in a range of different contexts, and it brought together

scholars involved in cutting-edge empirical and conceptual studies of the transnational pursuit and provision of medical care. It included findings from small-scale as well as large, multi-site research projects.

In this introduction, we outline the articles' main themes and highlight priorities and agendas for the vital shared project of empirically and conceptually investigating the multi-scalar relational geographies -- from the macro/national to the local/embodied – that are currently transforming policies, economies, professions and patient experiences of what some scholars suggest might more appropriately be called 'international medical travel' (Kangas 2007) or 'transnational healthcare practices' (Stan, this issue) instead of 'medical tourism'.

In recognition of the array of initiatives around the world that challenge and move beyond attempts at self-sufficiency in healthcare at the national level, this special issue draws attention to the breadth of regional capacity-building, forms of governance, relations and identities forged through both high-profile, long-distance pursuits of 'medical tourists' and more 'everyday' cross-border and intra-regional health-motivated flows (Ormond 2013b). The diversity of case studies presented in the special issue is intended to reflect the many forms of movement that together constitute transnational healthcare practices (though there remains much work to fully map these practices). In the remainder of this introduction, we draw out some of the themes and issues raised in the papers that prompt us to rethink 'medical tourism'

2.1. Many and multiple drivers

One key element in the diversity of transnational healthcare practices concerns the motivations of those who travel. Research to date has explored key drivers that both 'push' and 'pull' the various actors into crossing borders. While much of the public discussion of medical travel has sensationalised 'welfare tourism' or tended to focus on headline grabbing stories – either 'human interest', as in the cases discussed above, or 'horror stories' in frequent accounts of surgery abroad gone wrong (Connell 2011) – academic research has uncovered a much more variegated set of drivers, some of which are specific to the types of treatment accessed, some of which map onto the national healthcare and political systems of both sending and receiving countries, and some of which give us insight into the changing meanings of healthcare brought about by increasing privatisation, commercialisation and the forces of globalisation. In this issue, Holliday et al. (this issue) show how these different drivers can sometimes coalesce in a single site, as when Libyan casualties of war met British cosmetic surgery tourists in Tunisia. Here we see a very specific coming together of different healthcare movements, prompted and enabled by very different drivers: on the one hand those pushed violently from their own countries by internal conflict and overflowing hospitals into neighbouring facilities in a country with which Libya enjoys an existing cross-border healthcare agreement, on the other a small group of cosmetic surgery patients from the UK sold a 'luxury' package at a modest price in a tourist-friendly 'Mediterranean' country with whose broader regional political geography they are totally unfamiliar. At other times and in other contexts, the drivers and the routes for different travellers map divergent trajectories. The special issue thus contributes to the mapping of transnational healthcare mobilities at different scales and in different places and times. This should not be taken as meaning either an increasingly globally homogeneous healthcare system, or the declining importance of the nation-state. Rather, it is clear from the studies presented here that place and borders continue

to matter, and that the national scale remains of vital importance to framing how transnational healthcare practices take place.

2.2. Beyond the atomised mobile patient

While much literature to date has examined medical travel by focusing on what patients themselves do, believe and want, many of the articles in this collection call attention to the fact that individual patients are not the only ones on the move. Rather, drawing from assemblage theory and network analysis, several contributors have examined a range of other flows and 'scapes' (Appadurai, 1990) produced through, productive of and entwined with the multi-faceted phenomenon of transnational healthcare: the mobility of bodily matter (van Hoof et al., this issue; Lozanski, this issue); of popular, public and private regulatory imaginaries, such as understandings of what constitutes 'world class' care (Hanefeld et al, this issue.; Holliday et al., this issue; Whittaker & Chee, this issue); of health advocacy and social movements (Ormond, this issue); of medical personnel (Holliday et al., this issue; Walton-Roberts, this issue); of medical technologies, and so on.

In their study of a private Thai hospital promoting itself as 'international' for medical tourists, Whittaker and Chee (this issue) describe the coming together of patients from a variety of countries in a 'cosmopolitan heterotopia'. The authors show that far from being a utopian exemplar of multiculturalism, cultural misunderstandings and prejudices abound -- both between patients and hospital staff and between different national groups of patients. The label 'international' in this case was disputed or taken by some patients to favour certain nationalities – Saudi Arabian or Western, for example -- over others, and such tensions created temporal and spatial divisions of the hospital.

Holliday et al. (this issue) use network, assemblage and flow theories to explore cosmetic surgery tourism (CST), showing how CST needs to be seen as an interplay of places, people, things, ideas and practices. They also chart an emerging series of 'beautyscapes' that, like CST itself, they show to be multi-scalar, transnational and 'glocal'. The paper challenges 'wealthy West goes East' narratives demonstrating the relative economic marginality of some western medical travellers, and also foregrounds the role of the internet in facilitating CST. The authors claim that this kind of medical travel would be impossible without electronic resources providing information on hospitals, clinics, surgeons, agents and communities of fellow patient-consumers. Online patient communities provide flows of intra-patient information and sharing of experiences, that whilst not formally recognised by the medical establishment prove the most reliable and accessible source for would-be travellers.

Ormond (this issue) shows how perceptions of international medical travel as an atomised, depoliticised form of consumption are limited and how instead this form of travel can be reconceptualised as belonging to a range of contemporary forms of critical political engagement with health and social struggles within patients' home countries and beyond. Through her study of Indonesians seeking care in Malaysia, she argues that medical travel can serve as a tool through which patients may access a host of transnational social actors who, together, voice concern and engage with questions of health rights, access and recognition.

Studies published in this issue emphasise time and again the many roles of diverse networks, both formal and informal, in facilitating transnational healthcare practices. Formal arrangements such as bilateral agreements produce particular networks with key players operating as gatekeepers controlling the flows that travel along the network. Medical travel

agents/facilitators also have a powerful networking role, in some cases defining the pathways that others travel along. But informal networks, often grounded in word of mouth and local social contexts, are shown to be equally important. Bochaton (this issue), for example, shows how complicated, multi-scalar networks are drawn together to facilitate cross-border travel from Laos to Thailand. She also shows how members of these networks accrue and deploy diverse forms of capital – indeed, how participating in transnational healthcare can itself be capitalised upon, a point also made in Stan's article on Romanian migrant healthcare workers.

2.3. Attention to medical travellers' source countries in the Global North and Global South

Global North countries benefiting from Global South health worker 'brain drain' are increasingly called upon to assume greater responsibility and to restrict exploitative practices (Mackintosh et al. 2006). By contrast, when it comes to medical travel, though a growing body of work exists on the impacts and responsibilities of destination countries relative to the medical travellers they receive, scant research has examined the responsibilities of, and impacts on, the source countries involved (but see, e.g., Snyder et al. 2011). The articles in this issue by Lozanski, Ormond, and Crush and Chikanda work towards filling this gap.

While commercial surrogacy practices are banned within Canada, Lozanski (this issue) suggests that the Canadian government's stance on citizenship provision for children born from commercial surrogacy extra-territorially indicates incongruous complicity with a practice it has condemned on human rights grounds within its borders. Reminiscent of Cohen's (2012) stance against the moral geographical pluralism advocated for by Pennings (2004), she argues that it is necessary to do away with this tacit complicity in order to protect

women outside of Canada from the oft-exploited and poorly-regulated embodied labour of commercial surrogacy.

Crush and Chikanda (this issue) and Ormond (this issue) de-centre the dominant focus on medical travel from the Global North to the Global South by calling attention to the directionality that constitutes the bulk of medical travel flows around the world: intra-regional medical travel between Global South countries. With South Africa serving as a medical travel hub for the growing middle classes and the medically-disenfranchised poor alike from throughout the continent, Crush and Chikanda (this issue) note that governments in African source countries vary dramatically in their ability to provide quality healthcare to their citizens at home. Both governments and individuals throughout the broader region may turn to the already overburdened South African health system as an alternative provider for everything from the most basic to the most complex health needs. Ormond (this issue), meanwhile, examines the current and foreseen impacts on Indonesian politics, society and economics of an estimated one million Indonesians leaving their home country each year for medical care abroad. Studies such as these are redrawing the global map of transnational healthcare, challenging some of the dominant myths surrounding medical tourism and its effects.

2.4. The supranational region as a meaningful scale in healthcare

While thinking 'regionally' beyond national borders is well-established in economic development discourses and practices, studies of healthcare have long been restricted by the confines of 'methodological nationalism' (Wimmer and Glick-Schiller 2002) due to the history of national-level regulation and protection. Yet several recent initiatives and

phenomena – such as the recent European Union directive on patient mobility and growing cross-border patient flows facilitated by liberalised travel regimes between Association of Southeast Asian Nations (ASEAN) member-states – have specifically demonstrated the relevance of the transnational region relative to emerging post-national understandings of supply, demand and responsibility in healthcare.

The European Union (EU), widely-known as a platform concerned with facilitating EU nationals' mobility within the region, is now at least 40 years into a process of continual expansion of citizens' rights with regards to patient mobility (Mainil et al. 2013). It initially focused on coordinating social and health policy for economic migrants and pensioners residing in EU countries outside their own. Temporary patient mobility, however, was only subject to individual jurisprudence until recently. A plethora of legal cases (e.g., Decker and Kohll in 1998) led the EU to develop a legal framework to enable/facilitate travel for health reasons within the EU, resulting in the EU Directive on Patients' Rights in Cross-border Healthcare (2011/24/EU), approved after long debates and many amendments. The Directive enforces legal and financial relationships between source and host countries within the EU.

In addition to numerous social and economic harmonisation measures, several EU instruments (e.g., the European Regional Development Fund (ERDF)) suggest that cross-border collaboration in healthcare is high on the EU agenda. However, with health systems heavily defined by national level regulation, scholars question the extent of actual and potential cross-border healthcare collaboration within the EU. The articles by Volgger et al. (this issue) and Glinos and Baeten (this issue) offer up two diverging perspectives on this issue. Volgger et al. examine the western Dutch province of Zeeland bordering Belgium and the north-western Italian region of Tyrol bordering Austria, both areas popular with tourists but suffering from

declining resident populations which could result in diminishing healthcare facilities. Volgger et al. combine health management, system theory and tourism destination management principles in their study of two embryonic top-down attempts by sub-national regional authorities at forging cross-border regional health hubs ('health regions') within the European Union. They moot that, in offering specialised health services in these areas to international/European patients, it may also be possible to generate a cross-border regional ecosystem capable of sustaining and improving on (health) services for local cross-border residents. This concern with ensuring that the use of public medical infrastructure by foreigners does not prejudice locals' healthcare access – and may even enhance it -- is shared by Lunt et al. (this issue), who cautiously and selectively embrace the entrepreneurialism currently unfolding within the British National Health Service's (NHS) Trusts, where medical tourism is used to cross-subsidise public healthcare without burdening or undermining the NHS's public service mandate.

In their examination of seven examples of existing cross-border healthcare collaboration throughout the EU, Glinos and Baeten's (this issue) findings contrast with Volgger et al.'s case studies, suggesting that the methodological nationalism underpinning the organisation of healthcare may prove too entrenched to overcome. Even if such collaboration is desirable, they argue, 'it is not necessarily feasible. Health authorities rarely seek to structurally share resources across borders; in the longer term domestic solutions are usually preferred, unless there is another policy agenda behind' them. They argue, however, that cross-border healthcare collaboration and contracting can be used strategically and creatively by local and national actors to 'discipline' domestic providers and break national monopolies at various scales.

A clear example of creative circumvention of national regulation at the micro level is described in van Hoof et al.'s article in this special issue on French lesbian women pursuing reproductive treatment across the border in Belgium, making use of variegated national moral stances. As the French government does not grant lesbian couples or single women the right to access donor sperm in France, these women are reliant upon cross-border cooperation between French and Belgian doctors that requires complicit French doctors to help 'game the system' in order to support the wishes of their patients.

2.5. Migration and diaspora

Over the last decade, much work in the domain of migration and health(care) has pointed to the creative-by-necessity transnational healthcare practices that migrants undertake to ensure access to quality care for themselves and their families (see, .e.g, Thomas and Gideon 2013; de Freitas and Mendes 2013). Only limited work on 'medical tourism' has explicitly engaged with this body of work so far, however (but see, e.g., Lee et al. 2010; Ormond 2013a). Rather, most research has to date conceptualised their object of study as little more than a discrete episode measured in days, weeks and perhaps months in which patients unproblematically leave their home countries, go abroad to receive care in countries in which they have a legal right to enter and stay for a set period of time, and then return to their home countries and resume their daily lives. However, several of the studies featured in this issue suggest that medical travel -- when facilitated by political arrangements and transport options -- can also be far more pendular, characterised by participation in multiple national health systems simultaneously and potentially frequent cross-border commuting.

The articles in this collection by Stan and Hanefeld et al. draw our attention to the significance of the politico-legal status of the travelling subjects themselves in both the source and receiving countries. Some EU member-states' governments and health systems have grown increasingly wary of potentially unmanageable inbound foreign patient flows, resulting in attempts to clamp down on 'welfare tourists' and NHS 'abusers' in the UK (Vargas-Silva and McNeil 2014), and in the Spanish government initially balking at the introduction of the EU patient directive (Villanueva 2010). Stan's study of Romanian migrants in Ireland points to the uneven mobility and employment rights of Romanians within the EU. Groups within Ireland, like the UK, fear and seek to curtail potential 'abuse' of public services like healthcare and education by poorer intra-regional migrants from Eastern Europe. The popular static and exaggerated portrayal of intra-regional migrants as burdens on host country health systems is shown to be unfounded. Stan notes that the migrants in her study 'have been quick to use their feet to defy any simplified image of a stable, and encroaching, migrant population'.

This is further demonstrated in Hanefeld et al.'s (this issue) study of UK residents travelling abroad for healthcare. Hanefeld et al. chose to not simply focus on people of British origin but also on migrants and members of diasporic groups settled in the UK. They noted that those in their sample of Somali and Indian origin were more familiar with, and thus better able to compare, the UK's public and private health system with those in their countries of origin as well as third countries in which they had studied or lived previously. The role of comparative knowledge in opting for medical care outside of one's country of residence speaks to our increasing hyper-mobility. These two articles call attention to the rationales for healthcare choices by the non-negligible numbers of people who have not only experienced a range of health systems but may also be living away from the systems with which they are most

comfortable, be they economic migrants, refugees, international students, expatriates, retirement migrants, etc. Both articles underscore the urgency of acknowledging the diversity and nuances of migration temporalities, employment statuses and integration trajectories and how these impact on migrants' engagements in (transnational) healthcare practices.

The articles by Bochaton (this issue) and Walton-Roberts (this issue) furthermore point to the significance of diasporic groups not only as patients but also as transnational healthcare facilitators, mediators and investors. Walton-Roberts highlights the role of Non-Resident Indian (NRI) investment and 'brain-circulation' of Indian doctors and administrators in the internationalisation of hospitals and medical education in India. Bochaton meanwhile shows how diasporic networks influence Laotians' pursuits of healthcare in Thailand, by offering advice based on their experiences with health systems in more developed countries and treatment funding via remittances. These examples demonstrate the range of formal and informal transnational care networks on which medical travellers may draw.

2.6. Care work and embodied labour

Several articles in this special issue call attention to the underexamined role and dimensions of formal and informal care work involved in international medical travel. Much research to date has drawn on the General Agreement on Trade in Services (GATS) as a way to demonstrate how international medical travel or 'medical tourism' fits within broader mobility and trade in services frameworks. However, there has been limited engagement with literature on health worker migration, with only a few studies showing the nexus between patients and health workers travelling abroad or other emerging transnational healthcare practices such as telemedicine (see, e.g., Whittaker 2008; Connell 2011).

The papers in this collection by Walton-Roberts, Lozanski, and Whittaker and Chee all bring to light novel ways of engaging with the variety of care workers that medical travellers encounter. Walton-Roberts (this issue) embeds the shifts in quality and costs of Indian nursing education within the context of globalised market demands that draw many Indian nurses abroad and/or to care for foreign medical travellers within India's growing number of private hospitals, diasporic investment in private healthcare and education, and brain-circulation at the managerial level that internationalises policies and development agendas. In their study of one private Thai hospital renowned for medical tourism, Whittaker and Chee (this issue) describe the culturally-shaped power relations among Thai nurses and orderlies as well as the incongruous expectations and behaviours that result in friction and dissonance between non-Asian foreign patients and these same Thai hospital caregivers. Lozanski (this issue), on the other hand, draws attention to the ways in which commercial surrogates' embodied labour is exploited by transnational surrogacy companies. This exploitation is in turn met with tacit approval by some intended parents' national governments that acknowledge the citizenship rights of children produced through commercial surrogacy. These articles point to the need to develop future research that engages with the growing literature on global care chains (GCC) as well as on forms of labour in the tourism industry (Gibson 2009) and in healthcare (Mol 2002).

3. Conclusions

The articles collected here provide us with empirical, methodological and conceptual tools for the ongoing task of mapping transnational healthcare practices. Moving beyond the clumsy

catch-all phrase ‘medical tourism’ – with all its attendant baggage – we have assembled accounts of very particular practices that lead certain people to decide to cross national borders to access healthcare. It should be apparent from reading the papers that there is no simple accounting for this situation, nor for understanding travellers’ motives and experiences and the impacts on the different (levels of) health systems involved. The papers show the importance of attention to detail and context, and for listening to accounts ‘on the ground’ that can then provide the basis for theorising. We set out in the call for papers for the symposium a challenge to define an emerging field, and to exemplify its key concerns. The papers selected for inclusion in this special issue have met that challenge -- in fact, they have well exceeded it. Taken together, they highlight the vital importance of closely following what is sure to be an evolving and expanding field. They show that multi-scalar, multi-disciplinary approaches are necessary, combined with deep immersion in the particularities of practices, whether these are enacted by healthcare workers, tourism workers, patients, families, care-givers, or by and through networks (both formal and informal) that draw together many different actors. We began this introduction with two very different, very particular accounts that show the complexities often lost in generalised discussion of ‘medical tourism’. We look forward to reading further accounts that continue the work we have contributed to in this issue of *Social Science & Medicine*.

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