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Horsfall, Daniel Gary orcid.org/0000-0003-1262-4489 (2019) Medical tourism from the UK to Poland : how the market masks migration. Journal of Ethnic and Migration Studies. ISSN 1369-183X

https://doi.org/10.1080/1369183X.2019.1597470

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Medical tourism from the UK to Poland: how the market masks migration

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ABSTRACT

Much medical travel happens, but it is misleading to label it as 'medical tourism'. Rather, patterns of travel reflect a range of drivers: from longstanding cultural, economic and political ties to the country providing treatment, to word-of-mouth networks. Poland provides a particularly interesting case, as it has been touted as the leading medical tourism destination for UK medical travellers in Europe; marketing by Polish providers is advanced and there is strong government support for the industry. In this paper examining data from the UK's International Passenger Survey for the past 15 years, we demonstrate that, while travel to Poland has indeed increased dramatically, much of this actually reflects a wider pattern of Polish migrants living in the UK and returning to Poland for medical care rather than increased 'medical tourism' consumer activity by Britons in Poland.

KEYWORDS

Medical tourism; migration; Poland

Introduction

Medical tourism is a multi-billion-pound industry that has seen substantial growth over the last fifteen years (Horsfall and Lunt 2015). During the last decade there has been a shift in how medical tourism is discussed, with medical tourism located within a wider process of medical travel or patient mobility. Whilst patient mobility – the process of travelling for health or medical care – is often still referred to as medical tourism, to label it thus is misleading. Studies that have highlighted how the complexity of medical migration (Kangas 2010; Ormond 2015; Whittaker and Chee 2016; Ormond and Sulianti 2017), diaspora return for care (Inhorn 2011; Lunt, Horsfall, and Hanefeld 2015a, 2015b) or even 'consumer-driven' medical tourism (~~Lunt et al. 2014~~**[Q1]**; Hanefeld et al. 2015; Lunt, Horsfall, and Hanefeld 2015b) all stand in contrast to a market position that often seeks to normalise the process as simply consumers in search of value. Indeed, rarely is this the case; patterns of travel reflect a range of drivers, from longstanding cultural, economic and political ties to the country providing treatment, to word-of-mouth networks (Hanefeld et al. 2015; Lunt, Horsfall, and Hanefeld 2015a; Ormond and Lunt, this issue; Rouland and Jarraya, this issue).

Poland is a particularly interesting case as it has been touted as the leading medical tourism destination for United Kingdom-based medical travellers in Europe (Horsfall and Lunt 2015; Horsfall and Pagan 2017). Marketing by Polish providers is advanced and there is strong government support for the industry. In this paper we explore International Passenger Survey data for the past 16 years and highlight that, while travel to Poland has indeed increased dramatically, much of this reflects a wider pattern of migration rather than increased consumer activity.

This example of transnational healthcare mobility is particularly interesting for a number of reasons: first, Polish migration to the United Kingdom (UK) is not a new phenomenon, though there has been extensive work detailing the heterogeneity within the various 'waves' of Polish migration. Second, Polish migration to the UK has occurred within a changing European (Union) landscape – one that is likely to shift dramatically over the next few years. Third, the UK's NHS is residency-based in terms of entitlement to access; what we see in this paper is substantial numbers of Polish nationals, resident in the UK, returning to Poland for healthcare. Triangulation with other studies – especially those commissioned by local health service providers – indicates that much of what is being travelled for should be freely available through the NHS but is being eschewed by those choosing to travel. This raises important questions for Policy makers in the UK, Poland and the European Union (EU).

From medical tourism to patient mobility

For Lunt, Horsfall, and Hanefeld (2015a, 2015b), medical tourism can be considered as the process by which patients travel to another country to pay 'out-of-pocket' for medical treatment. These journeys may be long distance and intercontinental, for example from Europe and North America to Asia, and cover a range of treatments including dental care, cosmetic surgery, bariatric surgery and fertility treatment.

There are however many objections to such a definition, and even to the very fusion of 'medical' or 'health' with 'tourism'. A number of scholars argue that the notion of often major procedures being somehow conceptualised as tourism, with connotations of enjoyment, is at best crass (Connell 2015). The much more neutral 'health (or medical) travellers' is preferred by some, however the most vehement rejections of the terms 'health or medical tourism' come from those who have researched the great hardships faced by those who have had to travel for life-saving treatment. Here we see labels such as 'healthcare migrants' (Horton and Cole 2011; Inhorn 2011), 'medical refugees' (Inhorn 2011; Cohen 2012**[Q2]**), 'medical exiles' (Inhorn and Patrizio 2009; Kangas 2010), or even 'biotech pilgrims' (Song 2010) being suggested.

Given the difficulties associated with defining medical tourism, it is hardly surprising that measuring it is also problematic. Unpicking the various forms of patient mobility, which are usually recorded simply as 'travel for medical purposes' is incredibly difficult. Added to issues of definition is the fact that most of the records related to medical tourism flows are held in the hands of private organisations, many of which have a vested interest in depicting a robust industry. This has led to many suggesting that most numbers in the public domain have been subjected to industry 'boosterism' (Connell 2013, 2015).

While there is little agreement on the size of the medical tourism market, a conservative estimate suggests that globally, at least five million people travel to another country and pay out-of-pocket for medical treatment each year (Horsfall and Lunt 2015).

Methods and data

A key source that has been used to generate this figure of five million is the International Passenger Survey (IPS), through which the Office for National Statistics collects data at all UK ports of departure and entry (ONS 2016). Here we present some of this data, drilling down to focus on flows to and from Poland. While the primary focus of the IPS is to monitor medium-to-long-term migration, the question that seeks to establish the primary purpose for travel allows 'medical treatment' as a response. Caution must be exercised when exploring the IPS data. First, the IPS only samples 0.2% of all travellers (in and out of the UK) and then uses a weighting variable to produce total numbers. This weighting procedure may skew total medical traveller numbers; second, medical travellers are only recorded as such if they state that their primary purpose of travel is medical. This second issue is particularly problematic as it undoubtedly underestimates the number of people who access medical care whilst visiting or leaving the UK for other reasons – an important issue for those who travel to a 'home' country or one with which there are substantial historical or familial ties. A third issue is that many of those who are registered UK nationals may be migrants (first, second or third generation) who are returning to a country with which they have strong connections, but this is not captured in the IPS data. For this study, the inability to track second and third generation migrants is clearly a shortcoming.

Medical travel to and from the UK

According to the IPS across the period 2000–2010 the number of UK residents travelling outside the UK for medical related reasons increased from 8500 to 63,000 (an increase of roughly 750%) while the number of people not resident in the UK travelling for treatment in the UK rose from near 35,000–53,000 in the same period (ONS 2016). The most recent IPS data depicts a slowdown in the growth of non-UK residents recorded as travelling to the UK for primarily medical reasons over the past couple of years (after a decade of steady increases), and in fact since 2012 the numbers have been in decline, falling from 63,000 to just over 52,000 in 2016. Similarly the number of outbound travellers increased steadily until a peak in 2006 before decreasing until a sharp turnaround in 2015.

Numbers taken from the IPS are incredibly important given the problems identified with nearly all other reported measure, however, notwithstanding the possible issue related to how the samples are weighted, even if we are incredibly confident that the IPS has accurately recorded just over 52,000 inbound and 144,000 outbound medical travellers in 2016, this does not offer as much clarity as one might hope. In particular the IPS undoubtedly underestimates these flows, with the error likely to be much larger for particular 'types' of medical tourist. This is particularly problematic and not easily resolved. The IPS, as with any similar attempt to survey medical tourism in such a way will significantly underestimate all those groups that do not consider that, or are unwilling to state that, their primary purpose of travel is to seek medical treatment. Not only is one's health often a rather private issue that a person might not freely disclose, the primary purpose of travel – even if medical treatment is a planned for the visit – might not actually be 'medical', with treatment a secondary motivation to travel, or simply something that you organise whilst you are there. Noree, Hanefeld, and Smith (2014) for example, found that the majority of UK residents who had medical treatment in Thailand underwent low-cost elective treatments that were unlikely to have been the primary purpose of travel – for them tourism was their purpose of visiting Thailand. Using patient records from a number of hospitals in 2010 Noree et al.

identified 4000 individual UK residents who had accessed non-emergency treatment in Thailand, while the IPS recorded only 700 UK medical tourists to Thailand.

In addition to genuine tourism-first medical tourists such as those highlighted by Noree, Hanefeld, and Smith (2014), three other forms of medical tourist are likely to be under or unreported in mechanisms such as the IPS. One group of medical tourists who are unlikely to be documented through any tool that requires self-disclosure is the aforementioned travellers who travel for treatment that is perhaps illegal in some countries. We do not explore this group here, but work by Cohen (2012, 2015) provides a useful overview. The other two groups of medical tourists that are likely to be under or even unreported in most medical tourism records are those belonging to diasporas or with strong cultural or familial ties to a location where they access care; and finally, expatriates (see Horsfall and Pagan 2017; Ormond and Nah, this issue).

The issue of diasporic medical travellers is particularly important; as Connell (2015) notes, much medical tourism is across nearby borders, from diaspora populations, and of limited medical gravity, conflicting with popular assumptions. It should be noted that the use of the term diaspora is perhaps itself controversial (see Cohen 2008, for a detailed discussion), with many academic usages tied to 'a network of people, scattered in a process of non-voluntary displacement, usually created by violence or under threat of violence or death' (Gilroy 1997, 328). Temple (1999; see also Garapich 2008) even suggests that the concept can be exclusionary in terms of those who do not identify with, or are not seen as conforming to diaspora identity. Temple goes on to highlight that diasporas are not homogenous and, as such, while the term has value, it should be used with care (Temple 1999). Here we adopt a looser definition of diaspora, taken simply to mean 'members of a community dispersed transnationally'.[1] We do not infer that such groups have a completely shared identity or history, nor do we underestimate the heterogeneity between and amongst various diasporas, however for the purpose of this discussion the term diaspora taken with a 'broader' meaning is valuable.

Research confirms that a substantial component of medical travel consists of migrants travelling to their home countries. Most such returnees probably travel for a multiplicity of reasons, including visiting relatives, and may not be travelling to 'distant' places (Lu and Zhang 2016; Spallek et al. 2016). Some of the largest flows of cross-border travellers are diasporic, to 'backyard' rather than 'tourist' destinations (Ormond 2008). One group of medical tourists who are most definitely under-represented owing to the fact that medical treatment is not their primary purpose of travel, is those with cultural or familial ties to a country (Inhorn 2011; Nielsen et al. 2012; Connell 2013; Hanefeld et al. 2014; Şekercan et al. 2014; Chee and Whittaker, this issue~~; Lunt, this issue~~ **[Q3]**; Rouland and Jarraya, this issue). It might even be that diaspora represent the largest proportion of those who travel for treatment, often not travelling far, rather crossing borders. Connell (2013), for example, cites the case of India, often described as one of the biggest medical tourism destinations, where 22% of medical tourists are actually Non-Resident Indians. This is in addition to large numbers of second-generation overseas Indians. In fact, only 10% were of US or European ancestry (Connell 2013, 4). Similarly, those in the US with ties to Mexico (Horton and Cole 2011; Vargas Bustamante, this issue) and South Korea (Lunt et al. 2014a), for example, might travel in large numbers 'back home' and whilst there undergo medical treatment. While they might not think of this as their primary reason for travel, it is integral to the journey.

Medical tourism(?) to Poland

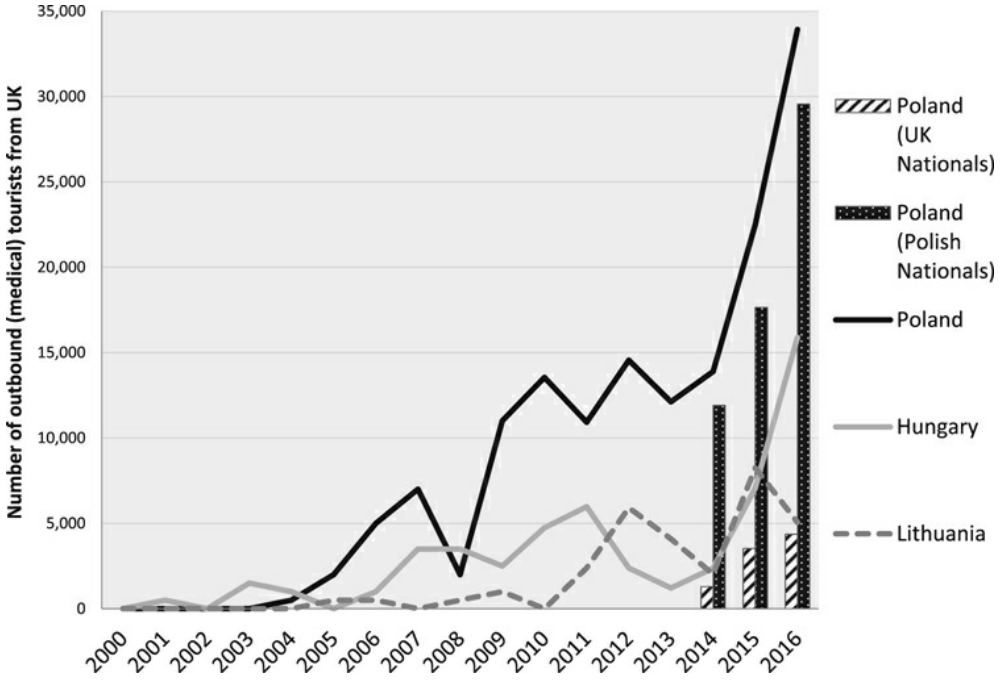
If we turn to Poland, data is particularly interesting – posing more questions than it answers. It is first worth noting that Poland and the wider Central and Eastern European[2] region are viewed within the industry as key sites of medical tourism activity (Lubowiecki-Vikuk 2012; International Medical Travel Journal 2013; Youngman 2016; Horsfall and Pagan 2017). Indeed the region is held as an example of the growing popularity of medical tourism and what can be achieved by investing in the industry at the national level (Lubowiecki-Vikuk 2012; IMTJ 2013).

Looking at the headline numbers there is much to support the industry's assertion that Poland and the wider region is at the heart of a vibrant medical tourism market. In 2005 Central and Eastern Europe was the destination for just under 8000 medical tourists, compared to over 9000 to Southern Europe[3] and just over 27,000 to North and Western Europe[4] (all data in this section is taken from the International Passenger Survey (IPS) – ONS 2016). While both Southern Europe and North and Western Europe have seen a decline in numbers travelling from the UK, the CEE region had reached 21,500 by 2010 and just short of 55,000 in 2015, making it the most visited region for UK residents seeking medical treatment. Work by Lunt et al. (2014b) had noted that for all the opportunities that medical tourism was purported to hold, people generally preferred to be treated close to home. Even amongst those who did elect – for whatever reason – to travel for treatment, there was a clear preference for closer locations. Lunt et al. (2014b) spoke of a medical tourism paradox wherein people were travelling, sometimes great distances, despite a desire for 'local' treatment.

The last two decades has seen the CEE region become much 'closer' to the UK largely through the increasing availability of low-cost airlines (Burrell 2011), as well as strengthening political ties through the EU – cemented by accession (Burrell 2009). These two factors, alongside an actively marketed medical tourism industry in the region have been used to explain increased extant, as well as predict even greater future, flows. While the region has undoubtedly witnessed increased activity even within official data

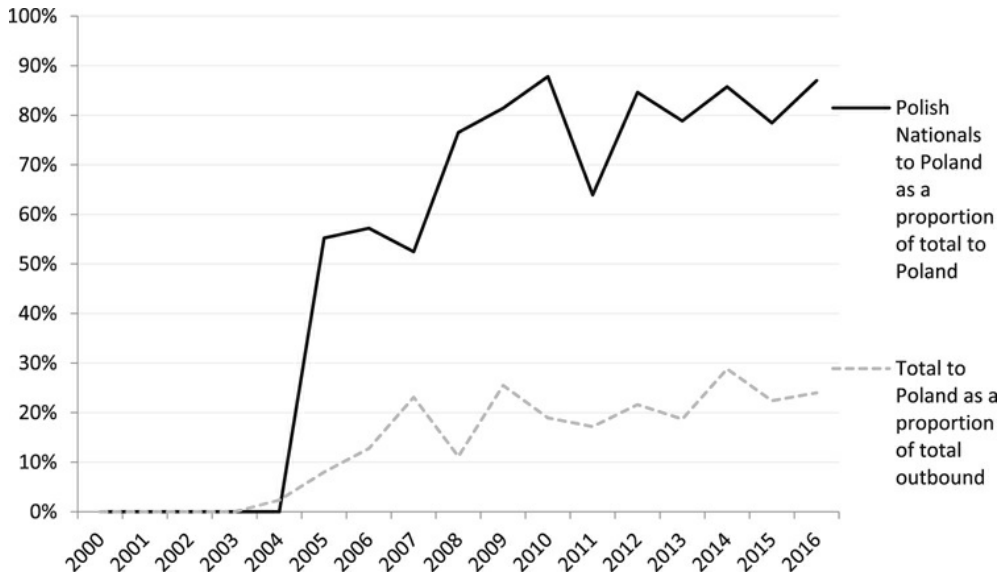
from the IPS, it is to Poland that the greatest flows have been recorded. Prior to accession in 2004 there are no recorded departures of UK residents travelling to Poland primarily for medical treatment. However as Figure 1 shows, from 2005 numbers rose dramatically, consistently surpassing 10,000 a year from 2009 onwards, and standing at just over of 33,900 in 2016.

Figure 1. Number of people travelling primarily for medical treatment to selected CEE countries 2000–2016 with a breakdown in terms of nationality of travellers to Poland in 2014–2016. Source: Author's calculations from the International Passenger Survey (waves 2000–2016).



For those in the industry this has been taken as confirmation that Poland is the place to go for medical tourism – in particular cosmetic, dental, and fertility treatment (International Medical Travel Journal 2013; Lunt et al. 2014b; Youngman 2016; Horsfall and Pagan 2017). The rapid increase in the number of people travelling to Poland for medical treatment has been reported as a reflection of the general rise in medical tourism's popularity; increasing dissatisfaction with public healthcare options in the UK; cost barriers to private treatment in the UK – exacerbated by the global financial crisis; and the ever maturing 'Brand Poland' for high-quality, low-cost care (Lubowiecki-Vikuk 2012; IMTJ 2013; Youngman 2016). For those with a stake in the industry – especially the Polish medical tourism industry – this has been not only incredibly encouraging, it is in itself marketable. The sense is that in the UK people do not travel for medical treatment because it is rather 'alien'; people have grown up with a local GP providing access and referral to treatment that is free at the point of use within a public health system (Lunt et al. 2014b; Hanefeld et al. 2015). Enticing patients from the UK therefore not only requires favourable financial conditions, but also necessitates historically-rooted behavioural – perhaps even cultural change. It is then a great boon for those in the industry to be able to point to 'hard' data from the ONS that shows not only that Poland has seen increasing numbers of people travelling for treatment, but that since 2009 Poland has been the destination for somewhere between a fifth and just under a third of all those who have left the UK for medical treatment (see the broken line in Figure 2).

Figure 2. Polish nationals as a proportion of total UK (medical) travellers to Poland over time and travellers to Poland as a proportion of total (medical) travellers from the UK over time. Source: Author's calculations from the International Passenger Survey (waves 2000–2016).

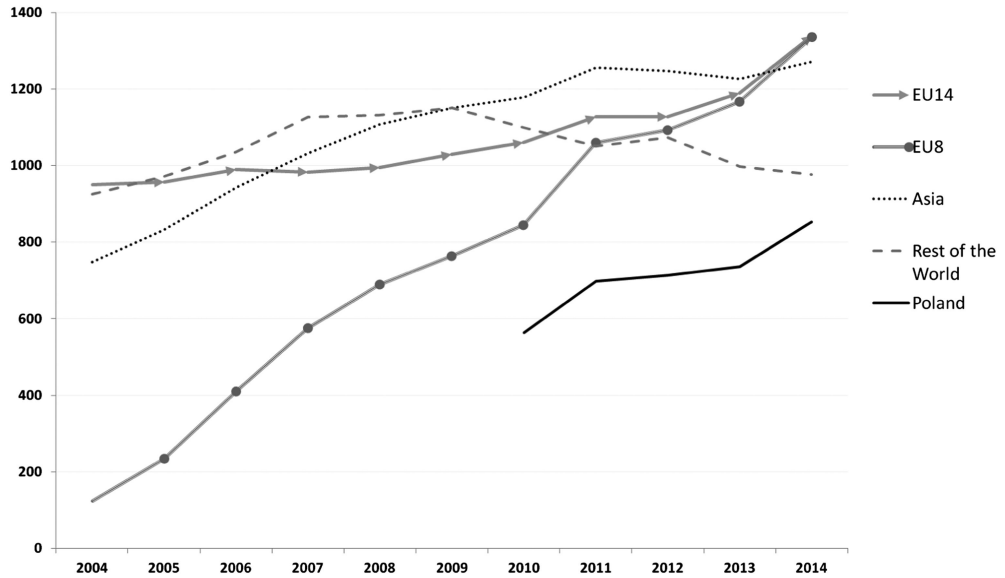


What Figures 1 and 2 also show is that while there is an undeniable trend of UK residents travelling for treatment to Poland (and the CEE region), most of these travellers are actually nationals of the country to which they are travelling. Figure 2 (solid line) shows that in each year the majority of those travelling to Poland have been Polish nationals, with the number rarely under three-quarters. It is worth noting that not all those non-Polish nationals are UK nationals either; the IPS has recorded other CEE nationals travelling from the UK to Poland. Even where those travelling to Poland are UK nationals, we do not know whether they have any familial or cultural ties to Poland.

While industry sources have not reflected on this, the fact that the take-off in numbers of people travelling to Poland and the wider region is largely driven by Polish and CEE nationals returning to the region coincides with accession to the EU is perhaps not surprising. It is important to locate the fact that the fact that the number of Polish nationals travelling to Poland for medical treatment in 2016 (29,560) was 11.3 times larger than ten years previously (2617), within the wider context of population growth. In the ten years following accession the number of Polish nationals resident in the UK has undergone a twelvefold increase from 69,000 in 2004 to 853,000 in 2014 (Hawkins and Moses 2016), a figure that now sees Polish the most common non-UK nationality of UK residents.

As Figure 3 illustrates, the same decade that has seen the CEE region overtake all others as the destination for UK residents who travel abroad for treatment has also seen the number of CEE nationals living in the UK increase to such an extent that it all but equals those from the UK's closest European neighbours. Here we see also just how significant the number of Polish nationals is; Polish nationals do not just represent 16% of all non-UK nationals resident in the UK, they represent 1.4% of the entire UK population (Hawkins and Moses 2016).

Figure 3. **[Q16]**Resident population of the UK by non-British nationality. Adapted by the author from ONS, 2015. EU 14 comprises: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Luxembourg, Netherlands, Portugal, Republic of Ireland, Spain and Sweden; EU 8 comprises: Czech Republic, Estonia, Poland, Hungary, Latvia, Lithuania, Slovakia and Slovenia.



Rather than the industry perspective that celebrates the successful Polish business model of exporting healthcare to 'customers in search of value', we must reach the conclusion that the only 'hard' data we have access to suggests that travelling to Poland for medical treatment is largely the preserve of Polish nationals, and reflects a wider context of migration. We are still left with a number of questions however. First, given the weaknesses in the methodology that underpins the IPS we have to ask how many more people travel to Poland for treatment and what proportion of these people are Polish nationals or have strong cultural or familial ties to Poland? As mentioned, a key weakness in the IPS data is that it enquires as to a person's primary purpose of travel only. The issue of tourism-first medical travellers was briefly highlighted (see Noree, Hanefeld, and Smith 2014) and ex-patriates noted (see Horsfall and Pagan 2017), and here we have established that most of those travelling to Poland are part of the Polish diaspora. It is reasonable to suggest then that as with other diasporas whose 'health-returning' journeys have been documented, health is only one of many reasons for return (for a rich debate on how frequently people return 'home' and their reasons for doing so, see Safran 1991; Lie 1995; Cohen 2008; Burrell 2010; Ormond 2013; Lu and Zhang 2016; Spallek et al. 2016).

The IPS data also tells us nothing about what medical services people are accessing and how they are paying for them. All of this would not only be valuable information for healthcare providers in Poland, it would also be incredibly useful for those with an interest in migration and health. In particular, we must establish what services are being accessed and how they are being financed. It is possible that Polish nationals are acting like 'customers in search of value', travelling to Poland to access treatment that is unavailable on the NHS and too expensive privately within the UK. However, what little evidence there is suggests that Polish nationals are travelling for a broad spectrum of health services, many of them routine or diagnostic, and often services to which they would be entitled to access for free within the NHS (Osipovič 2013; Healthwatch Reading 2014; Ingold 2014; Madden et al. 2014; PHAST 2015, 16). This mirrors the findings of studies that have explored other cultural groups or diasporas that have returned home or travelled en masse to other countries for medical care (Lunt et al. 2014b).

Four questions then present themselves and while we focus primarily on the final question, all are incredibly important. These questions have not been directly broached by existing research, nor can we fully answer them here, but it is important we begin to understand more about each and further study is needed. First, are these Polish nationals who travel for treatment accessing all of their care in Poland, or do they also utilise health services in the UK (either privately or through the NHS)? Second, where the services being accessed are primary or even some secondary care, we must ask whether those who travel could, in principle, be reimbursed under the 2011 EU Directive. If so, given that we know people are not being reimbursed (European Commission 2016), we should ask why; is it because they simply do not know that the possibility exists? Third, what are the implications for the NHS of people accessing care abroad? If complex treatment takes place does the NHS have to play a role in the continuation of care? And finally, *why* are Polish nationals returning to Poland for care? One of the key talking points since 2004 has been the twin processes of acculturation and integration of Polish nationals alongside the forging of a clear Polish presence and identity within the UK (see Burrell 2003, 2009; Garapich 2008; Rabikowska and Burrell 2009; Newlin-Łukowicz 2015), why then do Polish nationals feel compelled to return for healthcare?

Why do Polish nationals return from the UK for health?

Here we consider why migrants, and particularly Polish migrants, return to their country of birth for medical treatment and what the implications of these reasons might be. The evidence-base is not the deepest with the issue of health missing altogether from a rather comprehensive, recent, literature review conducted by White (2016). However, a small number of studies by local authorities or Clinical Commissioning Groups (CCGs) (or former Trusts) [5], alongside a limited number of academic enquiries exist and are helpful. It is clear however that a much more detailed understanding of how recent migrants access healthcare and how this varies between migrant communities and changes over time is required. Indeed the fact that a rather piecemeal approach has developed, largely driven by CCGs trying to plan for the changing demographics in their locality alludes to the lack of any coherent or 'joined-up' approach to the health needs of migrants.

As discussed earlier, the term diaspora is problematic and the Polish migrant 'community' is perhaps one of the most demonstrative cases in point, with Newlin-Łukowicz referring to the Polish Diaspora as an 'imagined community' (2015, 334). While it may be tempting and occasionally useful to consider Polish migration in terms of two 'waves' – one centred around WWII and the another related to accession to the EU in 2004 – of Polish migration to the UK, there is in fact a much more complex pattern (Garapich 2008; Burrell 2009). While 1939 and 2004 are important, the changing nature of the political climate in Communist Poland, as well as the fall of communism, are also highlighted as driving patterns of migration to the UK (and other countries) throughout the twentieth century. As expected, there are some commonalities, but they all speak to slightly different processes. It is impossible not to believe that different identities are tied to each wave and that these are shaped by the Poland they left and the manner in which they left and the UK they travelled to. Issues of force in terms of 'displacement', which is central to some conceptions of diaspora (see Safran 1991; Cohen 2008), have certainly not been experienced homogenously by all Polish migrants now resident in the UK (Johns 2013; Orlik and Shevlin 2015**[Q4]**). While not assuming homogeneity, and being cautious of embracing the term diaspora, when discussing pre-accession Polish migrants, Burrell (2003) feels that the term is useful.

Even in terms of socio-demographics we are clearly discussing a varied group. Polish migrants are dispersed throughout the UK, occupying varied roles within the labour market, including seasonal workers, students, labourers, public sector workers and professionals. Again, the intersection between the nature of person's migration, the location they have moved to, the job they do and the nature of their support networks, as well as other characteristics such as class and gender, will all shape their identity. Indeed, Spitzer cautions against considering migration alone in attempting to explain health variations, advocating instead an intersectional approach to such issues (Spitzer 2016). What is clear is that we are certainly not discussing an homogeneous diaspora and in fact the idea of Polish migrants as a transnational people is more pertinent (Burrell 2003; Garapich 2008; Kusek 2015; White 2016).

Despite this variation, or perhaps without fully considering it, a number of themes emerge from studies that explore motivations for both general and medical return to Poland. Dividing these into push and pull factors aids the flow of this section. However, there is a dialectical relationship between that which pushes Polish nationals from the UK and pulls them to Poland. What evidence exists is inconclusive with regards to whether Polish nationals (or other migrants) have greater or lower usage of NHS services, especially when demographics (such as the fact that Polish nationals in the UK – especially post 2004 migrants – are more likely to be younger and male than the either the wider UK population or the population of Poland) are controlled for or at least considered (PHAST 2016, 9). However, barriers to accessing the NHS; dissatisfaction with the NHS; and the costs associated with private alternatives to the NHS in the UK can all be considered as push-factors in terms of Polish nationals leaving the UK for treatment.

Push factors

Barriers to accessing the NHS

While the evidence relating to usage is mixed (Sarría-Santamera et al. 2016), data pertaining to registration with GPs is much clearer; Polish nationals resident in the UK have low registration rates (Osipovič 2013; Healthwatch Reading 2014; PHAST 2015, 16). This is in part attributed to the unfamiliarity of the UK system, in particular the need to be referred by a GP for secondary care. Across a number of studies, the rather substantial differences between the Polish and UK systems is cited (Osipovič 2013; Healthwatch Reading 2014; Ingold 2014; Madden et al. 2014; PHAST 2015, 16) as a barrier to accessing health services. There is also a sense that the NHS is a complex system and recent migrants in particular are not necessarily well-informed as to their rights with regards to access.

Compounding the complexity and lack of clarity relating to rights is the issue of language. While there is inconsistent evidence when it comes to English language proficiency amongst Polish nationals resident in the UK (Osipovič 2013; Newlin-Łukowicz 2015), the issue is consistently raised in all studies of Polish migrants' use of NHS services. Whilst individual clinics, hospitals, and CCGs are rapidly 'catching up', even recently it was not uncommon for pertinent information to be unavailable in Polish, and translation services are at best patchy (Healthwatch Reading 2014; Madden et al. 2014; PHAST 2015, 16–17). Language barriers are clearly an issue for the healthcare seekers, with respondents to the numerous studies cited in this article reporting anxiety with regards to communicating in a healthcare setting.

It may be that the issues such as language and the complexity of the health system, along with culture intersect with other established barriers to accessing health such as gender (Şekercan et al. 2014; Matthews 2015; Watts 2015). In particular access to family planning services may be difficult or 'off-putting'.

Dissatisfaction with the NHS

While barriers to NHS care appear to be a push-factor for Polish nationals, there also appears to be rather widespread dissatisfaction with NHS services amongst those Polish migrants who access them (Duckworth et al. 2012; Osipovič 2013; Ingold 2014). Again, some of this stems from the differences between the Polish and UK health systems and the expectations that exist as a consequence of experiences of such a different system (Osipovič 2013; Ingold 2014; Madden et al. 2014; PHAST 2015, 16; Lindenmeyer et al. 2016), in particular the waiting times associated with accessing care. This is exacerbated by the referral system within the NHS, with many of the services that require GP referral in the UK being directly accessible in Poland (Duckworth et al. 2012; Osipovič 2013; Ingold 2014; Madden et al. 2014; Lindenmeyer et al. 2016).

That accessing services is perceived to take so long sits alongside issues relating to the perceived quality of care (Osipovič 2013). In particular, the fact that the primary contact with the NHS and initial diagnosis may involve a nurse or other healthcare professional who is not a Doctor seems to not conform to the expectations and desires of many Polish nationals (Duckworth et al. 2012; Ingold 2014; Lindenmeyer et al. 2016). It has been suggested that this in-part informs a collective opinion that the UK system is of a lower quality than its Polish counterpart (Duckworth et al. 2012, 16; Osipovič 2013). This is compounded by what some refer to as the 'paracetamol service' issue (Osipovič 2013; Healthwatch Reading 2014; Madden et al. 2014; PHAST 2015, 16; Lindenmeyer et al. 2016), though it has been suggested that this is more of an urban myth than a regular experience (Healthwatch Reading 2014). What is meant by the 'paracetamol service' is the sense amongst Polish migrants (though it is not confined to this

group – see also Lunt et al. 2014) that a prescription of paracetamol is the standard 'cure' to most ailments within the NHS (Osipovič 2013, 11). This stands in contrast to the ease with which antibiotics can be accessed in Poland (Ingold 2014; Madden et al. 2014; PHAST 2015, 16; Lindenmeyer et al. 2016).

The cost of private treatment

It is important to reflect on the fact that the discussion of healthcare has not really differentiated between the forms of treatment that are provided and accessed when of course particular issues are more likely to present with some treatment than others. One study (Healthwatch Reading 2014) demonstrates this neatly, identifying paediatrics, gynaecology and dentistry as key concerns amongst Polish nationals resident in the UK. In this study and elsewhere (see also Madden et al. 2014) the dominant position is that dentistry in the UK is too expensive and that as such it makes sense to access elsewhere. This reflects a wider feeling that private healthcare in the UK is substantially more expensive than in Poland, but that this expense brings no perceived clinical benefits (Madden et al. 2014).

One response to these push-factors has been the establishment of 'Polish' private medical clinics in the UK. A rapidly burgeoning niche has emerged, primarily, though not exclusively, in London, whereby private clinics aim to provide a 'polish' service to meet the needs of the growing community (Infante and Borland 2013; Osipovič 2013; Healthwatch Reading 2014; Lindenmeyer et al. 2016). These clinics are usually entirely staffed by Polish nationals, with much of the literature in Polish rather than English. While these centres do not solely cater to Polish migrants, they do represent the lion's share of business (Infante and Borland 2013; *The Economist* 2013; Horsfall and Pagan 2017). While such settings may be more familiar for Polish migrants, as with other private clinics, they can be expensive. It has been suggested that the costs associated are such that only the more affluent Polish migrants regularly use these services and that for many the return to Poland is either cheaper, or more desirable (Infante and Borland 2013; Osipovič 2013) for the reasons discussed below.

Pull factors

Despite the lack of 'one Polish identity' the pull of home is clearly felt (Ostrowski 1991**[Q5]**; Burrell 2003; Osipovič 2013). This may reflect a yearning for a familiar healthcare system, a desire to visit family, or the very nature of Polish migration.

'Home'

There is evidence from studies amongst other communities or diasporas that many of the push-factors outlined above are not unique to Polish migrants (Ingold 2014; Madden et al. 2014; Lunt, this issue).

In many respects the familiarity of home as a pull-factor is merely a mirror of the unfamiliarity of the NHS as a push-factor. However, that Polish migrants are able to access this sense of familiarity in their home country at a low cost and combine this with other purposes of visit such as seeing friends and family, attending festivals, or remitting physical resources, undoubtedly facilitates this. Additionally, it is clear that most Polish migrants have close family still resident in Poland and that for all the discussion of there being no homogenous Polish diaspora (Garapich 2008; Burrell 2009), there are clearly elements of the Polish homeland that are interwoven with the identity of Polish migrants in the UK (and elsewhere) and that Poland and the concept of home retains a significant pull in itself (Burrell 2003, 2009; Healthwatch Reading 2014; Newlin-Łukowicz 2015; White 2016; Filimonau and Mika 2017).

It is interesting that many of the studies conducted or commissioned by Local Authorities or CCGs in the UK have actually identified not only that Polish nationals make variable use of both NHS and Polish healthcare services, but that they also suggest that homesickness is a particular issue for many Polish migrants and that this has clear impacts on their mental health and well-being (Osipovič 2013; PHAST 2015; Filimonau and Mika 2017; see also Lu and Zhang 2016). Indeed in one report it is suggested that frequent returns to Poland, or at least the fact that this is possible, represents a safety-valve of sorts in combating homesickness and related mental health issues (PHAST 2015, 22).

The peculiarity of Polish migration (and the Polish diaspora?)

This ability and willingness to return home may exist to varying degrees amongst all diasporas, however it is particularly pronounced amongst Polish migrants (Burrell 2003; Okólski and Salt 2014; White 2016). There is substantial evidence that many migrants, whether they are categorised as, or feel part of a diaspora that meets at least to some extent the criteria of scholars such as Cohen (2008), ~~Terry (1999)~~**[Q6]**, Lie (1995) and Safran (1991), do not permanently emigrate from or immigrate to a particular location (Eade, Drinkwater, and Garapich 2007; Osipovič 2013; White 2016). The Polish diaspora is once again a demonstrative case here; when asked many Polish migrants – especially post 2004 – either categorically do not intend to migrate permanently, or have no firm plans relating to their migration (Eade, Drinkwater, and Garapich 2007; Okólski and Salt 2014). It has been suggested that more than many others the Polish migrants post 2004 could be better thought of a transnational community rather than a series of migrant populations (Burrell 2003; Okólski and Salt 2014; Kusek 2015; White 2016). This perhaps reflects what Cohen (2008) highlights as the impact of globalisation on diasporas (2008, 141), which has reshaped how academic debate

considers the very definitions of what constitutes a diaspora.

With regards to Poland, migration journeys appear to be personal, complex, non-permanent and with regular returns to Poland a key feature (Madden et al. 2014; White 2016). Eade, Drinkwater, and Garapich (2007) have attempted to loosely classify Polish migrants to the UK into four categories: 'storks', 'hamsters', 'searchers' and 'stayers'. The 'storks' are seasonal workers who travel between the UK and Poland and represent around a fifth of this grouping, while the hamsters, representing a similar proportion migrate to the UK for a long period, returning only after they have become economically 'safe' (Eade, Drinkwater, and Garapich 2007; Newlin-Łukowicz 2015). The 'searchers' though are a very different proposition, thought to represent two-fifths of the Polish migrant population, they maintain strong links in both countries in an attempt to maximise the benefits of migration and keep options open. It is here that the sense of transnationalism may be strongest and while we may only speculate, it is possible that this 'type' of Polish migrant may have increased in terms of numbers over the decade since Eade, Drinkwater, and Garapich's (2007) study.

Given the push factors mentioned, accessing services such as health while visiting Poland, or even visiting Poland specifically to access such services does not seem onerous or even strange. Especially when this is set alongside the fact that Polish nationals who visit Poland for medical treatments are not completely locking themselves out of the NHS; as all of the reports commissioned by local healthcare providers cited in this article state, even amongst those who do return to Poland for treatment, NHS services are still used (see also Osipovič 2013; Healthwatch Reading 2014; Ingold 2014; PHAST 2015).

Concluding thoughts

Medical tourism is clearly big business in Poland. Even the most cursory perusal of the internet returns hundreds of organisations, from small clinics to large companies, based in Poland and the UK, which play some role in the medical tourism industry. These industry stakeholders are ebullient with regards to the level of trade they are doing and their prospects for the future. The purpose of this paper is not to contradict or 'pour cold water' over such sentiments, rather to highlight the fact that a key source of evidence is actually speaking to a very different process. This process is not consumer-driven medical tourism, rather a much less clear and likely an incredibly complex dimension to migration patterns. That the 'explosion' in visitors to Poland travelling primarily for medical reasons coincides with a rapidly increasing Polish population within the UK is not surprising and reflects other patterns of migration and 'return healthcare' (Nielsen et al. 2012; Ormond 2013; Şekercan et al. 2014). When data confirms that these medical travellers to Poland are indeed Polish nationals we are provided with the obvious answer as well a series of questions.

Understanding the health-seeking behaviour of Polish nationals is crucial because, not only do they currently represent 1.4% of the UK population (Hawkins and Moses 2016) – which is likely to rise – they are dispersed throughout the UK and found in most parts of the country (Newlin-Łukowicz 2015). We do not know what proportion of the Polish nationals resident in the UK plan to remain permanently (or at least for a substantial period of time), let alone what proportion will stay for lengthy periods without it being the explicit plan. The 'divorce' of the UK from the European Union may have a profound impact on such plans – or not. We have seen that where migration is always complex, it is particularly so in the case of Polish nationals in the UK. Okólski and Salt speak of the post-2004 Polish migrants being the 'right people, in the right place, at the right time' (2014); young (with a bias towards male) people in a struggling labour market based in a country that was forging economic and political ties with the EU at a time when the supply of jobs within the UK labour market was outstripping supply in Poland. Similarly, Eade, Drinkwater, and Garapich (2007) provide a typology of Polish migration built around 'storks', 'hamsters', 'stayers' and 'searchers' that speaks to a highly mobile migrant population. As such being mobile patients is perhaps just another facet of migration, one that is particularly pronounced in the Polish diaspora. But how do local authorities and CCG plan for such 'transnational' groups? Equally, what happens when people who have travelled for health decide they are going to stay in the UK permanently? If returning to Poland addresses not only the immediate health need but also broader health, restorative, and cultural purposes, how do those who can't return, for whatever reason, deal with this?

How the UK's NHS cares for its migrant population(s) is of particular interest at this time; the very foundations of the NHS are built upon the principle of equal access, free at the point of use, for all UK residents. How residency and citizenship are defined and classified – especially in terms of access to health – have been the focus of both political debate and policy. Increasingly there is pressure on healthcare professionals to check the nationality of those seeking care for example. At a time when debates around austerity, access to public services, and an NHS under strain coincide with wider debates around migration and in particular, the UK's relationship with the EU, how the NHS will continue to meet the needs of migrants – and how these needs may shift with changing labour-market freedoms and relationships – going forward is unclear. The issue of 'Brexit' undoubtedly complicates this with questions relating to the status of EU nationals as well as reciprocal arrangements around access to services such as health likely to prove complicated and contentious.

There have been small studies that have sought to shed light on how Polish migrants to the UK are using health services and this is both valuable and in need of expansion. What is equally important and timely is research that explores the complex

relationship between migration and its peculiarities in the case of recent Polish migrants to the UK, and health and how these develop as the UK's withdrawal from the EU unfolds.

Notes

1. While it is perhaps even broader than what Cohen would include within their 'expanded concept of diaspora' (2008, 23), Conner (1986) provides the definition 'that segment of a people living outside their homeland'.
2. The OECD includes the 'A8' countries – Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia, alongside Albania, Bulgaria, Croatia, and Romania in its classification of Central and European Countries (OECD 2000), to which the Ukraine has been added.
3. Taken here to include Spain (including Balearic and Canary Islands), Portugal, Italy (and Sardinia), Greece, Malta, Cyprus, and Andorra.
4. Taken here to include Ireland, Belgium, France, Luxembourg, Netherlands, Germany, Austria, Switzerland, Denmark, Sweden, Finland, Norway, and Iceland.
5. These CCGs or former 'Trusts' are the regional bodies that oversee healthcare governance and delivery as part of the wider National Health System.

Disclosure statement

No potential conflict of interest was reported by the author[Q7].

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Attachment Files

1 Figure.3 .tiff *: Replacement image re Q.16*