Chapter 1

Introduction

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Introduction

The fields of medicine and healthcare, historically organised at a local or national scale, are being radically transformed by new communication, transport and biotechnologies that facilitate the creation of a genuinely globalised sphere of biomedical production and consumption. This emerging market is characterised by the circulation of bodily materials, patients and expertise across what have traditionally been relatively secure ontological and geographical borders. Bodily parts that were once functionally non-transferable (for example tissues, organs and genetic information) are now capable of being sustained across space and time, available to be re-incorporated within other failing bodies or employed commercially as economically generative resources within burgeoning global life science industries. Individuals with the inclination and financial capacity now, similarly, have unprecedented opportunities to travel internationally to seek out the bodily resources and medical expertise necessary to make their goal of corporeal regeneration a success. The servicing of these desires is equally drawing medical personnel to, and from, their respective countries of origin towards global hubs of biomedical expertise, while the opportunity to ‘outsource’ therapeutic and compassionate labour that was once thoroughly ‘domesticated’ is everyday creating vibrant new economies in ‘offshored care’.

While the global circulation of bodily commodities, medical tourists and healthcare workers has been the subject of some research to date, this work is often disparately located within disciplinary fields and specialisms. Policy responses to different aspects of the globalisation of medicine similarly target specific interventions and issues (such as the UK strategy of sending NHS patients abroad for treatment to help reducing waiting lists (Hanna et al., 2009), while published reports and factsheets examine trends in isolation, as evidenced by recent global reports on organ trafficking (Nullis-Kapp, 2004); medical tourism (Chinai and Goswami, 2007) and the migration of health workers (WHO, 2010). As academic and policy debates tend to focus on particular issues and perspectives there is little opportunity for scholars, policy makers and professionals in medicine and healthcare to share insights into the different ways in which bodies cross national borders, or to explore the overarching ethical, legal or social implications of the acceleration of bodily circulations within this emergent political economy of globalised biomedical healthcare. This book draws together a number of important
contributions from acknowledged leaders in these three respective fields (bodily commodities, medical tourism and the migration of health care professionals) with a view to elucidating the common themes, concerns and issues of relevance to those whose work either addresses, or is affected by, the global circulation of bodies across borders. The book explores and maps out the key characteristics of this emerging, although as yet poorly researched global trade, paying particular attention to the social and spatial dynamics of this transactional economy. These typically echo those that attend the circulation of other forms of capital and resources in contemporary society: travelling from rural to urban areas, from poor to rich and from the Global South to the Global North (Scheper-Hughes, 2000).

It poses a series of key, crosscutting questions designed to illuminate the cultural, ethical and legal implications of the dynamics of this circulation of bodies across borders. These include: i) How, where and why do bodies cross borders? ii) How does the global circulation of bodies and body-parts impact on healthcare services? iii) How are and should the circulation of bodies across borders, in the service or pursuit of medicine and healthcare, be regulated?

Part I (Corporeal Circulations) builds on an existing body of academic scholarship (see, for example, Scheper-Hughes and Wacquant, 2002; Waldby and Mitchell, 2006) that has explored the emergence of new global economies in bodily commodities. Much of this work has focused on the question of how different kinds of bodily materials, from gametes to fresh kidneys, are circulated internationally and under what terms and conditions. Particular attention has been paid to examining how changes in the constitution of such materials – from embodied organs to extracted tissues, sequenced DNA or bioinformation – affects how they can then be utilised as resources (for example as components of new manufactured technologies such as stem cell lines) and how this, in turn, shapes how they enter the market: be it as gifts, commodities or alienable forms of property (Parry, 2004).

One of the most developed set of literatures in this field concerns bio and tissue banking. Here scholars have drawn attention to concerns about the ways in which such samples are collected and made available as economic as well as scientific resources (Parry, 2008; Greenhough, 2006). Chapter 2 by Chadwick and O’Connor extends these debates by examining the specific issues associated with the transportation of biobanked materials across national borders, highlighting how the movement of these materials differs from the other forms of circulation considered in this volume. They argue that the trajectories of the materials banked by tissue donors are distinct from those made by prospective patients and medical professionals as they are not self-directed. Donors to biobanks arguably lack both autonomy and agency, having, effectively, no say and no control over how their samples will be used, or by whom. Chadwick and O’Connor highlight some of the challenges that arise when seeking to protect the interests of donors across international and regulatory boundaries, including protecting the interests and confidentiality (where requested) of donors, and addressing the inequalities that may arise between those who provide biobanked material (particularly those in less developed economies) and those who benefit from
its exploitation. They also propose some useful ways forward, including proposals to enhance the role of contractual agreements between donating and receiving nations and enterprises; cross-border harmonisation of regulations (something also explored later in this volume in relation to medical tourism) and a complementary harmonisation of ethical values.

Yea’s following Chapter 3 highlights the key role that cultural, moral, social and economic factors play in shaping the contexts within which human body parts are circulated through the burgeoning global organ trade. Her analysis of the experiences of economically marginalised male Filipino kidney donors/sellers does not seek to deny the exploitative nature of this trade, but simultaneously works to refute the now commonplace tendency in the international media, and in some academic papers, to portray such donors as simply ‘victims’. Where Chadwick and O’Connor draw our attention to the lack of control that biobank donors have in dictating how their bodily commodities are used Yea highlights how these Filipino men reclaim some degree of agency, if not over the use of their organs, then at least over the way in which they, as donors, are characterised in the public domain. As she carefully details, they exert their agency by challenging their identification as ‘victims’ of organ trafficking with discourses that assert their role as both male breadwinners and ‘heroes’ who have suffered and sacrificed their vitality for the good of their families and dependants. Yea’s focus on Filipino men who remain at home also provides an interesting counterpoint to other studies that focus on the experiences of Filipino nurses who have migrated abroad to meet the demands of the ever expanding global North healthcare sector (Choy, 2003).

Like Chadwick and O’Connor, Parry in Chapter 4 explores the global variation that exists in approaches to regulation of biobanks but she does so in order to demonstrate how this heterogeneity provides the conditions for the establishment of a highly variegated international marketplace for human sperm. In order to explore why the United States seems to be dominating this emerging market she begins by analysing how the global circulation of reproductive materials first became possible, paying particular attention to the historiography of the development of its usage as a bankable commodity. Like both Yea and Chadwick and O’Connor, she demonstrates how significant aspects of globalisation have been in facilitating the technological and commercial development of this trade. Alongside this, however, like Yea, she also explores how aspects of this trade are represented and socially constructed. Drawing analogies with practices of selective breeding, husbandry and pedigree in agriculture she demonstrates how sperm donors are ‘characterised’, a performative act that plays a key role in ‘singularising’ them in relation to their competitors in such a way that they are favourably evaluated and judged as preferable. Parry voices concerns about the nature of these representations, suggesting that part of the implicit work of donor profiling is to create new technologies and devices that construct and embed wider societal norms of what counts as ‘good’ and ‘bad’ stock and to separate them one from the other. Whilst this can be viewed simply as a technique for maximising healthy conception, it can also, she argues, have more troubling implications
invoking the spectre of eugenics and its belief in the need to engineer for better ‘population quality’.

Part II (Transnational Bio-medical Tourism) examines the transnational movement of patients across borders as part of the recent dramatic rise in medical tourism. There has been some debate as to what distinguishes medical tourism from other forms of health travel, such as a visit to a health spa or retreat, with some authors (see, for example, Turner and Schneider, this volume) suggesting that the term ‘tourism’ perhaps trivialises the often serious and complex medical procedures undergone by patients and should, more rightfully, be revoked in favour of more accurate terms such as cross-border care or medical travel. The billing of places as glamorous global health destinations or ‘health theme parks’ (see Connell, this volume) sits uncomfortably beside Turner’s (this volume) reminder of the very serious and complicated nature of many of the procedures there undertaken and the risks involved for these purported ‘tourists’.

It is difficult to find accurate numbers to map the growth in patients travelling abroad for medical treatment, but the rapid increase in the number and size of facilities in the top medical tourism destination countries, including Thailand, Malaysia, India, Singapore, The Philippines and Mexico (Connell, 2006; Turner, 2007), reflects how medical travel has changed from being dominated by local cross-border movements, or journeys made by expatriates returning ‘home’ for medical treatment to a genuinely global industry. Amongst others influences, the growth in medical tourism has been driven by three key factors: the rise in the internet which has facilitated the direct marketing and promotion of medical tourism destinations to patients (Lunt and Carrera, 2011; Connell, this volume); the growth in medical tourism intermediaries (Turner, this volume), who, not unlike the kidney brokers described by Yea, have actively expedited the movement of bodies across borders; and the support and investment provided by governments in destination countries who see medical tourism as a growth industry and an important source of foreign direct investment (Ormond and Mainil, 2014).

The chapters in this volume explore some of the challenges posed by medical tourism, including the impacts of this growth industry on host and destination countries and the differences in expectations and standards of care that emerge when patients cross national borders. The transnational healthcare industry has sharpened disparities in access between, for example, the private foreign patients who increasingly utilise the new state-of-the-art hospitals provided for them, and the majority of the domestic population who are consigned to the remaining very poorly resourced local public health services (see for example Chinai and Goswami’s 2007 report on India). Critics point to the diversion of both public funds and skilled personnel towards the medical tourism industry. This context informs Connell’s critical overview of the medical tourism industry in Chapter 5 in which he highlights how its development reflects broader trends in post-industrial societies, including the privatisation and globalisation of healthcare and the emergence of the patient ‘consumer’ with a robust sense of entitlement to physical and biological perfection.
For Connell, patients remain, for the most part, the beneficiaries of the emerging medical tourism industry. However, both Turner in Chapter 6, and Van Hoof and Pennings in Chapter 7, weigh the advantages of travelling abroad for medical care, including the opportunity to access services which are either inaccessible (due to, for example, long waiting lists or high costs) or illegal in the home country (for example fertility treatment for same sex couples), against what they perceive to be some of the significant disadvantages. In Chapter 6 Turner suggests that the profit-driven nature of the medical tourism sector puts patients at risk of being encouraged to opt for procedures that may be unnecessary, which may not meet leading international standards of health care provision (leading to a greater risk of complications and infection) and about which they may be poorly informed. Furthermore, once the procedure is completed, there are concerns about the provision (and cost) of post-operative care in the home country and legal redress should things go wrong. As a case in point in Chapter 7 Van Hoof and Pennings focus specifically on the issue of cross-border reproductive care, setting an appreciation of reproductive autonomy (as a human right) against concerns about safety, success rates and the possibility of legal redress, as well as highlighting some case-specific issues including the complications of obtaining citizenship for children born abroad using surrogate mothers and donor gametes (see also Schneider, this volume).

Part III (Migrating Medical Expertise) focuses on issues associated with the global circulation of medical professionals, knowledge and expertise. A global crisis in the health care labour force has been signalled in media coverage, policy bulletins and scholarly work with the World Health Organisation for some while, with the latter estimating a shortage of 4.3 million health care workers as early as 2006. While this category of ‘health care worker’ is broad, most attention has been paid to the migration of nurses, and to some extent doctors. A ‘brain drain’ from low-income countries is of particular concern. While nurses from the Philippines (110,000) and doctors from India (56,000) constitute the largest share of the migrant health workforce in Organisation for Economic Cooperation and Development countries, the WHO (2010, n.p.) notes that ‘countries with smaller populations than India and the Philippines may suffer from a larger impact in terms of expatriation rates. Over 50% of highly-trained health workers leave for better job opportunities abroad in some low-income countries’. A push-pull model in a global market where embodied medical expertise (doctors, nurses and other health care workers) is at a premium is commonly employed to explain and describe such movements. Rich countries providing higher salaries, training opportunities and better working conditions pull in workers, while poor working conditions and low remuneration in low-income and conflict-ridden countries push workers to other countries and world regions.

This migration is set within a global health worker labour market where health professionals comprise a flexible labour force moving to fill gaps while advancing personal interests and the economic goals of households. But individual and household decisions need to be located in global migration flows and their context.
Economic goals of nations, feminisation of the work force, demographic shifts, and work directives, such as EU working hours, all have an influence. While early migrations tended to follow the routes of colonial ties, this is largely superseded by economic movement and new geopolitical alignments (for overviews, see Dovlo, 2007; Kingma, 2007; and OECD, 2010). The UK, for example, has filled its long-standing gap in the domestic production of health professionals with health care workers from different regions of the world, with the most recent wave of recruitment targeting nurses from Eastern Europe (The Guardian, 2013). The Philippines incorporates the export of its nurses, as human capital, into its national economic strategy with remittances as a crucial source of income. As the largest global exporter of nurses it has long had more registered nurses working overseas than it does domestically (Ball, 2004). In sum, health worker migrants as skilled labour constitute an important commodity with exchange value in a global market.

Most literature and reports focus on the obvious concerns in relation to access to health care and health care provision in low ratio doctor to patient countries, and on ways to regulate flows of skilled health workers. Although this is difficult to monitor due to lack of systematic statistics, especially in the global South, progress has been made with attempts to retain staff through, for example, salary top ups, improved career structures and other measures, and a WHO code of conduct that actively discourages the poaching of nurses from crisis areas. While most work is at the macro level, some on nurses’ experience has shown how individual stories of migration mesh with government policy revealing also the gendered and racialised dimensions of health care worker migration (Hardill and Macdonald, 2000; Ball, 2004).

Two chapters in Part III bring further depth to this field of study providing detailed analyses of the complex interweaving of economic and non-economic factors that facilitate and maintain migratory flows of skilled health worker migrants. The first of these is George’s exploration of the experiences of Indian nurses in the US in Chapter 8; the second, Bach’s analysis of the UK experience in Chapter 9. Bach notes that even in a context of enhanced global mobility and free movement of labour (in the case of the European movement), governments can still exert influence through immigration rules, licensing requirements and ethical recruitment codes. He traces three phases of state policy to illustrate the impacts of such regulations and their effects on migrant nurses’ experiences. George similarly provides a nuanced ethnographic account of Indian nurses’ experiences in the United States. This highlights the specific challenges faced by this group, notably the difficulties they experience being accepted as equals to their US peers. As she demonstrates, their pre-migration employment and training, differences in professional cultures, expectations around emotional labour and problems of trust together combine to create for them a highly racialised work environment and experience in the US context.

Part IV of the volume (Regulating Bodies Across Borders) is devoted to analysing the complex question of how, if at all, it might be possible to regulate the traffic of ‘bodies across borders’ in a globalised world. Both Cohen and Schnieder in Chapters 10 and 11 begin this task by focusing attention on the legal and ethical
implications of extending medical care beyond the conventional parameters of the nation state and the profound complexities of attempting to create regulations that can secure the quality and efficacy of this care. Cohen’s finely grained analysis of the filigree of domestic and international regulatory measures and international directives that interface to monitor and regulate the provision of health care across borders is particularly useful as it reveals the intricacy of the response that will be required to ensure that provision of care by offshore providers is both longitudinally cost effective but also, and relatedly, of sufficient quality.

His typology of the highly variegated plans that health insurance companies are offering their subscribers provides an important insight into the ways the global market for health care provision is likely to be articulated in the future and through which uptake of medical tourism is currently being incentivized. Significantly it also suggests points of entry for interventions, what Cohen calls ‘channeling regimes’, that can be employed to discipline the market by only directing prospective patients to those facilities with more robust accreditation; which would consent to international jurisdiction, or provide insurance in cases of medical malpractice.

Schneider reminds the reader of the diversity of the practices that have come to be encompassed by the term ‘medical tourism’, noting that these have included: travel for routinized medical care (such as hip replacements or dental work); the recruitment and migration of medical staff and health care workers; the acquisition and circulation of tissues, organs, stem cells and gametes used in advanced biomedicine; and even the outsourcing of clinical trials and the accessing of experimental treatments (such as preimplantation genetic diagnosis, surrogacy or stem cell therapies) that remain unlawful in the patients home country. The inherently extraterritorial nature of these practices stands in direct opposition to the thoroughly embedded nature of judicial law making which remains wedded (for the most part) to the concepts of sovereign rights and national jurisdictions. As she illustrates, whilst various instruments, such as criminal and civil law enforcement measures are available to those who wish to regulate the terms and conditions by which patients, providers, clinicians and researchers can access or develop care regimes, their effectiveness is ultimately constrained by the geographical limits of their legislative reach.

Both chapters clearly highlight a key challenge for regulators: that of how to generate commensurable information and universal metrics to determine quality of care that are based on objective indicators such as mortality, avoidable error and acquired infection rates rather than on more unreliable culturally inflected measures such as self-certification of standards. Whilst both Cohen and Schneider believe recent EU directives provide promising examples of how supranational regulation can be deployed to enhance the quality of cross border healthcare, patient trust and mobility, each suggests that the legality of some of these mechanisms remains in question. The most promising opportunities for the enhancement of regulation of medical tourism may lie, as Schneider argues in ‘soft law’ and in other horizontal forms of governance such as self-regulation within the industry (conditionalities
imposed by health care insurance providers and standard setting for international benchmarks of professional conduct and best practice) that could ultimately provide normative frameworks for medical governance that have the capacity to transcend territorial borders.

All this, however, assumes that the object of regulation – this thing known as ‘medical tourism’ – remains stable and open to consistent classification. In the final chapter in this volume Lysaght and Sipp turn this presumption on its head with their incisive critique of current conceptualisations of what is described colloquially as ‘stem cell tourism’. Whilst as they note, this practice has been casually conflated with others forms of cross border health care seeking behaviour – it in fact varies from them in ways that are significant both ontologically and in terms of regulatory practice. As they note, most studies of medical tourism assume that patients are seeking standardised care and thus direct their analysis to the quality of care offered by medical providers. The touristic aspects of their health seeking behaviour are emphasised and travel is assumed to be unidirectional: e.g. the patients are travelling to the provider. In the case of stem cell therapies, however, patients are seeking to access care that is not only experimental but also, in many jurisdictions, illegal. The inconsistency of approaches to the regulation of stem cell therapy has created a highly differentiated legal landscape. In this instance it proves to be providers (who range from clinicians to research scientists) who are ‘shopping around’ to exploit regulatory loopholes and niche locations in which to establish clinics whose presence would not elsewhere be tolerated.

Attempting to subject this kind of therapy to the same forms of regulatory control that Cohen and Schneider outline is deeply problematic due in part to the fact that the ontological status of these practices is so uncertain: does stem cell therapy constitute medical care, a scientific experiment or an unregulated clinical trial? Whilst its status remains so unstable the register in which regulation could or should operate remains similarly indistinct. What is evident though is that the continued concentration on the narrative of ‘tourism’, serves only as Lysaght and Sipp demonstrate, to focus attention on the most vulnerable actors in this scenario – desperately ill patients – rather than the clinics and providers whose legal culpabilities in providing such unlicensed, risky and illegal therapies far outweighs any that can be laid at the door of the medical ‘tourist’, so described.

In conclusion, we would like to suggest a number of cross-cutting themes that are highlighted by bringing together different examples of the movement of bodies across borders from diverse disciplinary perspectives. Firstly, the chapters in this volume highlight the challenges of tracing the movement of bodies across borders. Yea’s need to draw on personal contacts to access Filipino men for her research on organ donors (see also Moniruzzaman, 2007), the lack of reliable figures on the number of patients travelling abroad for medical treatment (Connell; Turner, this volume) and the numbers of trained medical personal migrating from lesser to more developed nations, and the absence of commensurable information and universal metrics for evaluating medical tourism facilities all attest to the great difficulties of obtaining an accurate picture of the flows that characterize this new
economy. Secondly, the chapters have drawn attention to the role that technology has played in facilitating the circulation of these new resources, commodities and consumers. Advancements in storage, transport and communication technologies that range from the cryogenic preservation methods that allow for the storage and global circulation of human (and bovine) gametes, to the internet, with its role in promoting medical tourism and experimental techniques (such as stem cell therapy, Lysaght and Sipp, this volume) which, in turn, motivate patients to cross international borders have all been key drivers of this new trade. Thirdly, these works have revealed the key role played in all the case studies by ‘middle men’ or brokers who have identified new lucrative forms of employment in arranging the movement of bodies across borders, matching Filipino kidney sellers with buyers and transplant surgeons, providing medical tourist packages incorporating flights, accommodation and even excursions with surgery, and sourcing medical staff from the global South to meet care demands in the global North (Santiago, 2010).

Fourthly, this volume highlights commensurabilities and differences in the ethical, legal and social issues raised by these movements. Striking, for example, is the balance between the demand for anonymity (to protect the privacy of biobank, sperm and kidney donors or the confidentiality of medical tourists) with the need to ‘market’ the pedigree of bodily commodities, be they bio information, sperm, kidneys, or the expertise of medical professionals and medical tourist services. Finally, we might consider how the capacity to move bodies across borders can shape our sense of self and the extent to which we, as humans, feel able to exert control over our bodies and their derivatives. Chadwick and O’Connor (this volume) stress biobank donors’ lack of agency and control over what happens to their materials. Yea describes kidney sellers’ attempts to retain some control over their representation in the media, if not their donated kidneys as a reclaiming of agency, although others would argue that these kidney donors are victims of forms of structural violence which make their decision to sell a kidney perhaps less autonomous than it seems (Sunder Rajan, 2007). Connell’s chapter (this volume) highlights how, in contrast to the donor, the patient is reconfigured as a consumer who is entitled to the best health (and offspring) they can afford. Here the perfect healthy body increasingly becomes something that those who can afford the bodily commodities (e.g. stem cells or organ transplants or donors’ eggs) and medical services (such as those provided by medical tourism destinations like Bumrungrad International Hospital, Thailand) feel entitled to, reflecting how inequalities in economic wealth remain a key determinate of who is, and is not, ultimately in a position to benefit from the movement of bodies across borders.

References

Bodies Across Borders


