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# Medical Travels of Polish Female Migrants in Europe\*

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**Abstract:** The article discusses the medical travel (medical tourism) of Polish women migrants based on a study conducted between 2008 and 2011 on Polish women who migrated to London, Barcelona, and Berlin. The author argues that the principal reasons for medical travel to Poland are the lower costs of private treatment, the relatively easy access to specialised health care, and personal comfort derived from linguistic and cultural competency. The women in the study who travelled to Poland for medical treatment combined the economic resources acquired while living abroad with their knowledge of the cultural and medical system in Poland to choose the best options for them. The treatments they sought included gynaecological, dental, and other specialised treatments, for which they turned to the private health sector in Poland. Some of the women also sought treatment in other countries. The women in the study highlighted the advantages of medical travel and mobility while also reflected on the dilemmas they faced in choosing the best care. The author argues that medical travel poses a challenge to the national borders of health-care systems and the national availability of medical procedures, and found that while such mobility generates inequalities it also leads to greater agency and creativeness on the part of patients when they challenge the given regulations, authority, and expert knowledge in one country.

**Keywords:** medical travels, migration, health-care systems, cross-border health care, Poland

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## Introduction

This article analyses the medical travel (medical tourism) of Polish females and their families who migrated to London, Barcelona, and Berlin after 1989. I argue that the main reasons for medical travel to Poland from their new countries of residence are the lower cost of private treatment, relatively easy access to special-

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ised health care, and personal comfort based on linguistic and cultural understanding. In various individual situations, migrants who have local medical insurance and access to a local health-care system still choose to travel to their home country. For people lacking medical insurance abroad (legal migrants but illegal workers), trips to Poland are the easiest way to get access to health care. In the literature these people are called 'medical refugees' or 'medical exiles' [Mildstein and Smith 2006]. Yet, there are also Poles who undertake cross-European trips to third countries (neither their home nor their residence) to receive health care. I argue that despite national systems of medical health care, medical travel is growing in tandem with the increasing mobility of migrants in Europe. The objective of this paper is to analyse reasons for medical travel undertaken by Polish migrant women and to show how medical travel challenges the national structure of the health-care system.

The political changes after 1989 radically transformed the situation of Poles in terms of their mobility. Post-2004 Polish migration to the countries of the European Union has re-emerged as a phenomenon of a different quality owing to a number of factors: the open labour market, the rise of new and low-budget modes of communication and travel, the impermanent nature of migratory decisions, the fluidity of migration, and the large numbers of Poles 'on the move', estimated to be two million [Grabowska-Lusińska and Okólski 2009; Glorius, Grabowska-Lusińska and Kuvik 2013]. Recent Polish migrants in most cases maintain ties with their country of origin and some decide to undergo medical treatments in Poland. There are also migrants who have moved more than once between different countries in Europe, people who regularly commute between countries, and migrants with different residence and work addresses—some of them might have easy access to medical treatments in two or several different countries. Even if the national health-care systems and insurance companies restrict health care to within state borders, migrants are sometimes entitled to free health care in different countries or choose to go to private practices abroad. Medical travel is thus a challenge to the national borders of health-care systems and the procedures established within them. I argue that the change in the nature of migration and the plurality of migration experiences has a substantial impact not only on daily life, education, employment status, gender roles, and identity, but also on migrants' choices of medical treatments.

For Poles the motives for medical travel are complex and have to do with economic, social, and legal circumstances, as well as the medical services and products available on the market during the transformation of the Polish medical system and of other European medical systems. I maintain that patients' mobility generates inequality but also agency and creativeness as a challenge to regulations and authority. Stereotypes about the poor, less developed, and backward 'East' are challenged by migrants who find the medical care in their background country attractive and more accessible than in their new countries of residence. Post-socialist medical care in Poland is criticised for its limited financial resources and shortages of health professionals (who also migrate to other countries) compared to Western

Europe [Sagan et al. 2011: xxv]. Yet, privately paid treatments there are cheaper than in Western European countries. Furthermore, some migrants are more satisfied with the quality of health care in Poland and find it more professional and advanced than that offered in their new countries of residence. The review of the European Observatory on Health Systems and Policies indicates, however, that the satisfaction with medical care is lower in Poland than it is in other European countries [Sagan et al. 2011: xxvi]. The OECD report states that 'the self-assessed quality of care appears to be one of the poorest in Europe, most likely due to poor access to new technologies and long waiting times for highly specialised treatment' [Boulhol 2012: 14]. This inconsistency might be explained by the poorer access of migrants to medical treatments, lack of knowledge about health care, and the lack of language and cultural understanding in their countries of residence. But since Polish migrants use the private sector of health care when they return to Poland, they do not experience the difficulties of state-paid health care.

I divided this article into four sections to provide insight into the medical travel of Polish migrant women in London, Barcelona, and Berlin. The first section is a brief discussion of my fieldwork and methodology. The second section presents definitions of medical tourism, travel, and cross-border care. In the third section, I discuss the diverse motives migrants have for undertaking medical travel back to Poland to see specialists and consultants there. Last, I discuss the medical travel of Polish migrant women across the EU to receive health care, showing how these trips represent a challenge to the national organisation and regulations of health-care systems.

### **Fieldwork and methodology**

I selected narratives about medical travels from the material collected during the ethnographic research I conducted among Polish migrants in London, Barcelona, and Berlin between 2008 and 2013.<sup>1</sup> I carried out a total of 98 interviews with female migrants and health professionals:<sup>2</sup> 38 in Barcelona, 42 in Berlin, and 18 in London. The female migrants chosen for the interviews had lived abroad for at least a year, yet the majority had been abroad for more than five years; their

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<sup>1</sup> These cities were chosen for personal reasons and connections. The interviews were conducted only among women because I observed that they usually had more experience of medical care (especially for their reproductive health), visited doctors and nurses more often, and not only cared for their own health but also for that of their children and husbands/partners.

<sup>2</sup> Although several interviews with health professionals were conducted, the analysis of medical travel is essentially based on patients' narratives. I decided that the research would rely on patients' narratives, their personal experiences and memories, in order to present 'the view from below'. Further research is needed to investigate the experiences of medical professionals in Poland who treat patients from abroad.

ages varied (22 to 65). They came from very diverse educational and social backgrounds and different family situations: single, with a Polish or a foreign partner; mothers or childless. The selection was made using the snow-ball method and purposeful sampling aimed at interviewing diverse groups in terms of age, education, length of migration stay, and family situation. The interviews examined the reasons for and trajectories of migration, respondents' access to and experiences with local, Polish, and other health-care systems, and changes to their health-related practices and beliefs. Over an extended period of time I spoke to 10 women out of 98 (3 in London, 3 in Barcelona and 4 in Berlin), met their families and friends, and observed their daily routines.

At the time I was a temporary migrant and patient in London, Barcelona, and Berlin and this allowed me to explore my own experiences [Aull Davies 1999: 179]. As a Polish national I was an insider in the Polish communities abroad [Carling, Bivand Erdal and Ezzati 2013: 1–19]. To some of my respondents I made it clear that I was a temporary migrant who was also experiencing difficulty adjusting to the new realities of living in London, Barcelona, or Berlin. The fact that I was a mother of a small child and that at times we were in need of medical assistance in Barcelona turned some of my respondents into 'guides' to local services and led to a blurring of my position as a 'researcher'. My previous migratory experiences were also an important factor in gaining the trust of my respondents.

The majority of the respondents were women between the ages of 25 and 40, and their medical experiences were in most cases related to reproductive health and paediatric care. The women also varied in their state of health, ranging from some who were very healthy to others who were terminally ill, but the majority were in good health. The medical trips were undertaken in order to receive medical treatment in reproductive, dental, and specialised care, in private and state-funded systems. Even Poles who have been abroad for more than 20 years were visiting medical professionals in Poland. Many of them also consulted Polish-language websites and forums related to health and health care and local press published for the Polish communities in Berlin and London (there is no Polish local press in Barcelona due to the small size of the Polish community). The majority of the women in the study maintained strong connections with Poland, continued to visit and welcome family and friends, and brought back products, including medication, from Poland. Their mobility between their countries of residence and Poland had both social and practical reasons, and medical treatment constituted an important motive to travel.

This article offers a qualitative examination of migrants' narratives about their experiences with health care in three countries of settlement, in Poland, and in other countries that they visited to obtain health care. First I shall analyse the narratives of Polish migrant women in order to find emerging themes and categories. Then I shall formulate interpretations of the trends observable in the studied sample and search for complexities of the phenomena of migrants' medical travel. The existing literature on health-care systems and medical tourism—discussed in the next section—provides both context and inspiration for my interpretations.

### **Medical tourism, medical travel, and cross-border care**

Medical tourism is defined as ‘the organized travel outside one’s natural health-care jurisdiction for the enhancement or restoration of individual’s health through medical intervention’ [Carrera 2006: 449]. Medical travel is a rapidly developing industry that impacts both the sending and receiving countries, but also the ‘view of health as a commodity rather than a right and a global public good’ [Whittaker, Manderson and Cartwright 2010: 337]. Lower costs, shorter waiting times for consultations and treatments, the affordability and ease of travel, and the offer of new, experimental or more advanced procedures not available in the home countries are some of the many reasons for medical tourism [Eissler and Casken 2012; Whittaker, Manderson and Cartwright 2010; Whittaker and Speier 2010; Weiss 2011]. Medical travellers are sometimes migrants returning to their ‘home’ countries for treatment; one airline survey found that 46% of people traveling out of the United States for health care were foreign-born US citizens [Warner 2009 as cited in Whittaker, Manderson and Cartwright 2010]. Medical tourism is most often undertaken for the purpose of dental treatment, eye and orthopaedic surgeries, plastic surgery, and assisted reproductive technologies. ‘Health tourism’ is a broader term and also includes travel for health benefits generally—for example, to spas [Carrera 2006]. Several studies of medical tourism in Eastern Europe have dealt with Czech spas [Speier 2011] and reproductive travel [Whittaker and Speier 2010]. A study on changes in health and the interaction of Poles with the British NHS, in which mention is made of the issue of (medical) travel to Poland, analyses the significance of age, psychological and cognitive resources, social support, discrimination, and economic status as shaping views about health and what is expected of health services [Goodwin, Polek and Goodwin 2013].

The term ‘medical tourism’ refers to a common combination of medical treatments and leisure activities [Ackerman 2010]. However, in some cases medical travel is the only way to obtain medical help in life-threatening situations. Beth Kangas has described cases of Yemeni patients who were unable to obtain advanced medical treatment at home and had to travel abroad, often after taking out a loan to fund the trip. Kangas [2010: 353] suggested that the term ‘medical travel’ is a better option since the term ‘tourism’ trivialises the state of health of the given person and the situation of limited medical services in the home country.

In a critical post-colonial interpretation, medical tourism is understood as a contact zone between core and periphery countries, between exclusive consumption and inequality in access to health care [Buzine and Yarnal 2012: 783]. There are ethical issues surrounding systems that provide services to medical tourists: on the one hand the state is obliged to ensure access to health care for every citizen, on the other it promotes cutting-edge technologies for foreign patients [Helble 2010: 70]. Other ethical concerns are that medical personnel work for tourists and not for local patients, the financial benefits to those who care for a foreign clientele, and the blurring of lines between the private and state sectors [ibid.: 784].

Migrants undertake medical travel not only because of the lower costs, lack of waiting time, and the availability of new, experimental, or more advanced procedures, but also because they often have worse access to health care in their new countries of residence. This can be due to language barriers, cultural misunderstandings, or a lack of familiarity with the system [Solé-Auró and Eileen Crimmins 2008: 5; Rechel et al. 2011]. Connell [2010: 45] points out how migrants 'remain "hidden tourists", largely undocumented and ignored in public, yet they have effectively pioneered medical tourism in some countries'.

Migrants seeking health care in their countries of origin have been the subject of several studies: on Turkish immigrants and their descendants in Denmark [Smith Nielsen et al. 2012], Korean immigrants in New Zealand [Lee, Kearns and Friesen 2010], Mexicans in the United States [Wallace et al. 2009], and migrants from various backgrounds in Ireland [Migge 2011]. In most cases migrants travelled to the countries of origin to get minor treatments or check-ups because it was faster and cheaper. In a very few cases the costs of their treatments were covered by private insurance or state systems. The migrants in this study usually arranged the visits and paid for them themselves. Singe Smith Nielsen [2012: 2] used the term 'cross-border health-care services' to characterise patient mobility involving migrants. The reasons migrants seek health care in their country of origin are familiarity, availability, cost, quality, and bioethical legislation. He found moreover the cultural background of Turkish migrants and formal and informal access to the health-care system in Denmark also to be important factors. Among the informal barriers to the Danish system are doctor-patient communication, different patient preferences, and different health-seeking behaviours.

Sabina Stan [2014] uses the term 'transnational health-care practices' in order—as she explains—to 'avoid both the supply-side and consumer connotations of "medical tourism" and the demand-side and medicalization assumptions of "cross border patient mobility"'. She points out that Romanian migrants in Ireland, the actors behind these practices, are transnational migrants who travel for diverse reasons and cannot be simply defined as patients. While the Danish health-care system provides universal coverage to all residents [Smith Nielsen et al. 2012], this is not the case in Ireland, where access to health services is marked by inequality [Stan 2014]. In 2010 about 42% of migrants had no health insurance (while around 20% of Irish nationals were in such a position). The choice was either to pay out of pocket for health care in Ireland or to use transnational health care [Stan 2014; Migge 2011]. Although the situation of Polish migrants in the UK, Germany, and Spain is different in terms of access to local health care, Polish and Romanian groups also have some things in common: in most families women are responsible for ensuring their own, their children's, and often their husband's or partner's access to health-care services [Stan 2014]. Women have a dominant role in providing for the health and well-being of families and in many societies are the family link to the health-care system [cf. Salganicoff, Ranji and Wyn 2005: 39]. These social and cultural roles played by women may even be reinforced in the situation of migration, where families face new challenges.

## **Specialised consultations (check-ups and therapeutic care) in Poland**

The analysis in this article is concerned with planned, elective medical treatments sought by Polish female migrants in Poland, while emergencies or treatments resulting from accidents or sudden illness are not taken into consideration. I study two different types of destinations for medical travel: visits to specialists in Poland and cross-European travel. These treatments are made within the framework of insurance coverage by the Polish national health-care system, or they are paid privately, or they are paid by insurers in the new country of residence. The reasons for these travels are very diverse, depending on local—in London, Barcelona, and Berlin—access to medical professionals and treatments as well as on the personal and family situation of migrants.

### *Visiting specialists as a consequence of local misunderstandings*

The most common reasons for medical travel to Poland<sup>3</sup> were to visit one or more medical specialists, such as dentists, gynaecologists, dermatologists, allergists, paediatricians, cardiologists, and surgeons. The trips were usually made to the migrant's home town or a large town nearby and were often combined with visits to family for holidays such as Christmas, Easter, summer holidays, or family celebrations (weddings, first communion). Usually, the more often a person visited Poland the more often she was able to seek medical services there. The Polish women I interviewed in London visited Poland and doctors in Poland more often than the Polish women in Barcelona. The Polish migrants in Berlin also often visited Poland at least a few times a year, yet they hardly ever used specialised health care in Poland.

The reasons for differences in the scope of medical travels are complex. The first factor is the frequency of visits to Poland. The lower cost of flying and the availability and frequency of air services was more advantageous for Poles in London than in Barcelona, encouraging visits to Poland more often. The short distance and low cost of travel from Berlin to Poland (especially cities in the western part of the country, where the majority of my respondents came from) led to frequent or very frequent visits to family and friends, yet the interviewed migrants hardly ever visited doctors in Poland. Thus the second factor is satisfaction with access to and the quality of the local health-care system. Polish migrants in Berlin were satisfied with the medical care in Germany and were able to get a referral to a specialist and even consult with another doctor under their German health insurance. This was not the case in London. Krystyna<sup>4</sup> said: 'When I go to Poland, I visit the gynaecologist, I have a pap smear done, I only give the results

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<sup>3</sup> This section is based on interviews with 98 individuals; the quotes were selected as typical and exemplifying general trends.

<sup>4</sup> The names are chosen randomly to protect the women's anonymity. All the interviews

here [in London], because in terms of medical treatments in the [British] state system, I am not convinced ... I don't trust it being done here ... I prefer to do it privately in Poland, I know they do it accurately.' Krystyna was 30 years old and had lived in London for more than 6 years at the time of the interview. Marta (34 years old, 5 years in London) stated: 'Whenever I go to Poland I always go to see a doctor ... various ones ... When I was pregnant here I also went to see a doctor in Poland.' The issue of trust surfaced in several interviews. During pregnancy there are fewer tests and checks in the British NHS system than there are in Poland so some Polish pregnant women had no trust in general care practices in the UK and either went to Poland (some went regularly until the seventh month of pregnancy, when they could no longer fly) or visited Polish private practices in London.<sup>5</sup> I would argue that there are structural reasons for this distrust in state-provided care that have to do with the way health care is organised.

Some migrant women entitled to health care under the British National Health Service chose to arrange private visits to a doctor in Poland because they found it difficult to get a referral to a specialist in the UK. Zofia (30 years old, 4 years in London) said 'my impression is that the GP is like a shield to defend the specialist ... he has to treat everything: my gynaecological problems and my husband's psychiatric problems ... It frustrates me a lot ... when my husband mentioned his [psychiatric] problems to the GP, the GP asked him about our financial situation. It took my husband more than two weeks to get over it.' The couple finally changed their GP and her husband got into a therapy group. Dissatisfaction with the GP treatments offered in the UK results from the different structure of health care in Poland and the UK. Within the state system in Poland a patient can visit six different specialists without any referral; these specialist areas are gynaecology, oncology, dermatology, ophthalmology, psychiatry, and dentistry. Moreover, in Poland many treatments are carried out by doctors, while in the UK nurses, midwives and other staff have more responsibility. Typical examples given by my respondents are pap smears and pregnancy care procedures, which are done by gynaecologists in Poland but in the NHS are delegated to nurses and midwives. Children are taken care of by a GP in the UK while in Poland by paediatricians. Such differences, frequently voiced during the interviews in London, led to misunderstandings and to the women seeking additional care in Poland.

Another reason for medical travel to visit specialists in Poland is the long waiting time for a doctor's appointment in the UK. When women are referred to a specialist, there can be a long waiting time (periods of three to seven months were

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were conducted in Polish, the mother tongue of the researcher and of the interviewed women. The quotes were translated by the author.

<sup>5</sup> There are several Polish medical practices in London and the Polish women I met at a nursery place often discussed their services and the doctors working in them; their opinions were very diverse.

mentioned), so they chose to travel to Poland and have a private consultation at a specialist clinic. Helena (38 years old, 6 years in London) said: 'I had to wait five months for an allergist appointment ... I got pissed off and bought a ticket to Poland ... it [the visit] was quick and efficient.' Another woman got a referral to an oncologist after being diagnosed with a growth on the wall of her uterus, but she had to wait 6 months for a specialist; she was so worried that she flew to Poland within a week and had a private consultation that allayed her worries (it turned out to be benign). My interviewees were aware that private treatment in the UK is available, but it costs more, so financially it made sense to make appointments in Poland, especially since they could combine travel with visiting family or with business. Anna (28 years old, 4 years in London) had kidney problems, and while she was cared for by her GP in London, every time she went to Poland she privately visited a nephrologist: 'I go at least once a year, my dad makes me an appointment with a nephrologist and a gynaecologist.' Visiting specialists at home was also typical among Turkish migrants in Denmark and was interpreted as an example of a person getting a second opinion from a specialist or a hospital in their country of origin [Smith Nielsen et al. 2012]. Another study shows how Korean migrants in New Zealand used medical services back home after they had negative experiences with local services, often due to cultural and linguistic misunderstandings [Lee, Kearns and Friesen 2010: 114].

The lack of language competency is another reason for dissatisfaction with the local health care and a motive to travel to visit a doctor in Poland. As noted in the literature, '[I]imited language skills can restrict a migrant's ability to locate services, understand provision entitlements, or communicate successfully with medical staff' [Goodwin, Polek and Goodwin 2013: 166]. However, among the interviewed women in London, Barcelona, and Berlin very few admitted having such problems. Usually, if they were not sure about their communication skills, they asked a friend or a family member to go with them. This solution was mentioned by the respondents in London, Barcelona, and Berlin in relation to the initial period of their stay.

### *Traveling for in vitro fertilisation*

Hanna, married to a Catalonian man, decided to travel for an vitro fertilisation (IVF) procedure from Barcelona to her home town in Poland, which is an example of reproductive travel, also referred to as reproductive tourism or procreative tourism [Bergmann 2011]. After two years of trying to get pregnant Hanna and her husband consulted doctors since they were both approaching the age of 40. No particular health problems were found, yet, because of their age, they were encouraged to use assisted reproductive technologies. They had private insurance so they paid only partially for one insemination, but it was not successful. They did not qualify for free-of-charge IVF due to age limits and waiting times; the cost of private IVF in Barcelona was much higher than in a private clinic in

Poland. Hanna found a clinic on the internet in her home town and sent them the results of previous examinations. The appointments were made by phone from Spain and she started taking medicine soon after arriving in Poland. The couple stayed in her father's flat. 'My husband was doing the injections, the clinic was very modern, they took care of me and did their best. They really wanted good results.' After a successful transfer Hanna became pregnant with twins. She returned to Barcelona and arranged for pregnancy care there. Hanna told the doctors about the IVF, took medicine to help maintain the pregnancy, had extra consultations, and was satisfied with the care she received while pregnant.

The private hospital sector in Poland developed after the fall of the communist regime. In 2008 private hospitals made up 25% of all hospitals in Poland, yet the number of private hospital beds constituted only 7% of all hospital beds.<sup>6</sup> Private hospitals offer a variety of treatments, including plastic surgery, pregnancy care, childbirth, orthopaedic care, and eye surgery. Users are mostly Poles, who either have private medical insurance coverage, usually co-sponsored by their employer, or pay individually for particular treatments. Data on medical tourists coming to Poland are limited; most tourists come from the United Kingdom, Germany, Scandinavian countries, and the Netherlands, also depending on the hospital's location in Poland.<sup>7</sup> Several private hospitals do not even have web pages in English or in a language other than Polish. Yet, according to data from the Ministry of the Economy, annual income from health tourism is an estimated 800 million zlotys (200 million euro) [Wcisło 2012].

The reasons for seeking medical treatment in Poland tended to be very practical, according to the interviewed migrants; for instance, the above-mentioned couple was able to stay with the woman's father, which was convenient and free, the cost of IVF was much lower than in Spain, the doctors made a good impression on them, and the clinic looked modern. Hanna also knew how the medical system was organised given her past medical education in Poland, and the couple spoke Polish. Going to Poland was the first option for her since the treatment was very expensive in Barcelona and she had no connections to other countries. She said: 'I just wanted to give it a try ... over summer ... nothing would have happened in Barcelona so why not ... And it worked out so well.' The studied case of assisted reproductive technology involved no egg or sperm donation, so there were no legal issues influencing the decision about the location of the treatment [cf. Van Hoof and Pennings 2012].

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<sup>6</sup> From an online report report [Szetela n.d.] on the private health-care sector in Poland published in the web magazine 'Modern Clinic': <http://www.nowoczesna-klinika.pl> (retrieved 20 December 2013).

<sup>7</sup> From the website of Third Congress of Private Hospitals: <http://www.szpital.org/kongres2013/iii-kongres/> (retrieved 20 December 2014).

### *Dental care among Polish migrants*

Dental care is the most common reason for medical travel from London to Poland because there are long waiting lists for dental care within the NHS and it is only partly refunded—there are co-payments (with some exceptions, such as pregnant women or children) [Kravitz and Treasure 2009]. The cost of private dental treatment in Poland is considerably lower than in the UK. Among the 18 women interviewed in London, only two received dental care in London, both were generally satisfied with the British medical care and had lived in the UK for more than ten years. The rest decided to travel to Poland for it.

Receiving dental care in Poland was also typical for Polish women in Barcelona, who would visit a dentist during family visits and holidays. More thorough dental interventions were often scheduled for the summer break. For example, Monika went to Poland to get dentures. Two years later she had problems with bleeding gums, yet she still decided to wait for her next summer visit to Poland to have the problem dealt with. Monika was anxious when talking about her discomfort then, but she feared the high costs and doubted the quality of dental care in Barcelona. She preferred to wait. Several similar cases were mentioned during the interviews. When I asked about the local dentists I was told they were not well trained and were very expensive and that only limited emergency care was offered free of charge. Renata believed that in Spain dentists only studied dentistry for one year after their medical studies, while in Poland they studied for five years. She and her Spanish partner visited dentists in Poland. In fact, both systems of dental education and training are similar and the duration of study in both cases is five years [Kravitz and Treasure 2009]. Renata is a very well-educated person, fluent in Spanish and Catalan, and she has been living in Barcelona for more than 25 years, but she has a very negative view of local health care, including dentistry.

Dental care in Germany is to a large extent covered by state health insurance. The women interviewed in Berlin in almost every case visited a dentist there. The quarterly appointment fee was much smaller than the cost of treatment in Poland, but the cost is very high if a patient misses check-ups. There are also substantial differences between different health insurers ('sickness funds') in terms of the dental coverage offered. In the very few cases where the women would have had to pay for their dental treatment in Berlin they sometimes chose to travel to Poland for it.

### *Private versus public care*

Polish migrant women travelled to Poland owing to a certain lack of trust in state-provided health care abroad, as witnessed in London and Barcelona. This could be interpreted as a consequence of their experience with state and private medical health care in Poland. A report on the health system in Poland reads: 'Private

expenditure accounts for 30% of total healthcare expenditure in Poland, with the largest burden falling on private households ... Since co-payments for publicly provided healthcare services are not foreseen in the Polish law, it can be assumed that private household expenditure for outpatient care reflects direct payments for privately purchased services. In 2008, Polish households spent PLN 6.1 billion for this purpose, almost 54.6% of which was spent on dental services and 35.9% in outpatient clinics and care centres (mainly on specialist services)' [Sagan et al. 2011: 79–80]. The amount spent by Poles on private specialised care doubled between 1999 and 2008. The increasing privatisation of health care, private co-payments and rising expectations among patients for high-quality services—noted by Stan [2014]—are also typical for post-socialist Poland.

I would argue that for many Poles private care is seen as better and more reliable, and in many cases they prefer to pay and assume that the provided treatment will be of better quality. This stereotype about private care manifests itself as a distrust in public and state-managed health care. Distrust and negative opinions about state-funded medical care is fuelled by media coverage that has described many cases of corruption and poor-quality treatment.<sup>8</sup> A recent report of the Spanish Foundation BBVA on the most trusted professions in the EU, based on public opinion polls, shows that doctors in Poland are little trusted by Poles (on a 0–10 scale, the level of trust in doctors among Poles is 6.1, while for the populations in the UK and Germany the figure is 7.1, and in Spain it is 7.6).<sup>9</sup> Another study shows a decrease of trust in doctors in Poland: 73% in 2011, 64% in 2012, and 57% in 2013.<sup>10</sup> Distrust in public services, including health care, could be interpreted as a legacy of the communist regime in Poland. Polish sociologist Piotr Sztompka [2003: 177–178] has listed several reasons for the high distrust of Poles in the state: the legacy of the communist regime, post-revolutionary malaise, and new conditions of uncertainty in the neo-liberal system. The post-2004 extensive migration of Poles is commonly cited as one of the signs of distrust in the political and economic system. In the 1990s, as soon as the state-run health-care system lost its monopoly, a large proportion of patients immediately switched to private doctors and their clinics, despite their high costs [Sztompka 2003: 166]. This ten-

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<sup>8</sup> In 2002 a procedure known as 'skin hunters' was revealed by the media where paramedics in an emergency unit killed the patients and sold information to funeral services. In 2007 the director of Cardiac Surgery Hospital was arrested and charged with corruption and murder. These cases were extensively covered by the media for months and years. Many other cases of neglect, malpractice, ignorance, and corruption on the part of medical personnel have been described and shown in the media in recent years. The Eurobarometer report states that the likelihood of being harmed in a hospital is high in Poland compared to other European countries [Eurobarometer 2010: 15].

<sup>9</sup> From an article published in the largest Polish daily *Gazeta Wyborcza* on 25 April 2013, 'Księża, dziennikarze...': <http://www.wiadomosci.gazeta.pl> (retrieved 2 January 2014).

<sup>10</sup> 'Lekarz', an article published on the website 'Pulse of Medicine' on 9 July 2013, <http://www.pulsmedycyny.pl> (retrieved 10 January 2014).

dency has continued in recent years: people trust doctors more when they visit them as private patients and pay for the visit. Therefore, Polish migrants in London might prefer visiting privately specialised care rather than relying on NHS-provided care, since they assume that they will be better served. As they cannot afford private care in the UK, they choose to travel to Poland.

Finally, the question arises of why medical tourism to see a consultant or specialist in Poland is not observed among Polish migrants in Berlin. The explanation offered by my respondents was that they were satisfied with the medical care offered within the German system. As described above, it was easy to get access to specialised care and possible to receive several consultations about one's medical problem and waiting times were acceptable. This assessment is similar to findings from the Eurobarometer study, in which German citizens are consistently positive about their national health care [Eurobarometer 2012: 66].

The only cases of planned visits to see consultants in Poland were when a migrant had difficulty getting access to German health care because they had recently migrated or owing to administrative issues. Anna was in such a situation, she has been working on a contract in Berlin for more than a year when she became pregnant. Only then did she realise that she had not registered in the German health-insurance system and was actually not entitled to use the German medical system. Therefore, Anna regularly visited a gynaecologist in Wrocław, her previous place of residence, and she paid much less for these private visits than she would have in Berlin. She decided to give birth in Berlin in a *Geburtschaus* (a birthing house), which was the cheapest option. Only a few months later her insurance situation was clarified and she was reimbursed for the cost of giving birth and postnatal care. However, there are many Polish circular migrants in Berlin who have no access to German health care<sup>11</sup> and receive medical care in Poland.<sup>12</sup>

### Medical travel to countries other than Poland

Polish migrants not only travel to Poland to get medical treatments but also undertake trips to other European countries where they used to live or have access to health care. A WHO study of cross-border health care and mobile patients in the European Union lists several categories of patients traveling abroad: residing in border areas, sent abroad by their home systems, and going on their own initiative to seek treatment. The last category of medical travellers seek care using

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<sup>11</sup> Medical insurance has been obligatory in Germany since 1 January 2009, yet there are migrants who work without insurance, for example, in home care.

<sup>12</sup> Since I focused my research on resident migrants I learned about such cases second hand from Polish NGOs and medical personnel. More research on non-insured migrants is needed.

private health or travel insurance or pay out of pocket [Legido-Quigley et al. 2008: 44]. Poles may receive permission from the national health-insurance system for treatment abroad when waiting times are unreasonably long or necessary medical treatment is not available in Poland; however, in 2009 only about 200 authorisations were issued [Sagan et al. 2011: 52].

The few cases described below illustrate the situation of Polish medical tourists who knew how to use health care in other EU countries and how to demonstrate that they are entitled to it. The growing Polish migration in Europe might lead to the spread of such practices, especially when access to and the quality of national health care in Poland lags behind other European countries and transnational connections are increasing.

#### *Using short access to free dental care*

Lena's case provides an example of medical travel to Berlin to receive dental surgery. Lena moved from Poland to Barcelona to join her Polish husband in the summer of 2010. He was actually sent by a German company to work in Catalonia for one year. When he signed his contract he also filled in the forms for German health insurance. In Barcelona the couple registered in a local practice showing their residency registration. The husband also received a German insurance card, but Lena did not. They reapplied and she received her card in November. Just a month later Lena had a bad toothache and visited a private dental clinic in Barcelona. She was charged 60 euros for an X-ray and consultation, and was advised to have the tooth removed and get an implant. Since Lena was not satisfied with this advice she electronically sent the X-ray to her Polish dentist and to a cousin in Berlin, who had many times told her a story about her 'magic' dentist. Within a few days Lena knew that there were good chances of saving the tooth. Her cousin's dentist made an appointment at a specialist clinic in Berlin, and Lena flew there for a week to have the tooth's root removed (root resection). She paid only a 'symbolic' fee, as she called it, of 10 euros (appointment fee for every three months). The stiches were removed in the local Barcelona practice where she was registered. After that she never had problems with the tooth again.

The case of Lena shows that medical travel makes it possible to receive treatments that are covered by a person's insurance in another country. It is also made possible by technological advances—the possibility to e-mail X-rays, availability of low budget flights—and personal connections (a cousin in Berlin with knowledge of the local system). Lena received advanced medical treatment in Berlin where she neither lived nor worked, and only had a health-insurance card that was valid for a few months. During that year she was actually using medical services in Poland, Barcelona, and Berlin, though legally she should be entitled to services from one system.

*Choosing a place to terminate a pregnancy*

Agata was on holiday in Cyprus when she discovered she was pregnant. She had very recently moved from London to Berlin. She was almost 40, had two children, and had no plans to have another child. She decided to have a termination. Since she was unfamiliar with German medical care, she phoned her last GP in London and arranged a visit. She flew to London and was directed to a local clinic where she had a termination. Clearly, Agata knew that abortion was legal in Germany and she had German medical coverage under her husband's contract. Yet she was much more familiar with the NHS, spoke English, and preferred to fly to London. Bearing in mind that termination of a pregnancy is illegal in Poland (with very few exceptions), travelling to Poland was not an option for her. In a study of Canadian abortion tourists [Sethna and Doull 2012: 459], extra-legal factors prompting travel to obtain an abortion included the geographical distance that had to be travelled to obtain an abortion, the costs of the procedure, the waiting times involved, the difficulty of referral or approval policies, gestational limits, inappropriate or limited facilities, uncooperative or untrained medical personnel, anti-choice harassment, and confidentiality issues. In the case of Agata, the issues of confidentiality, legality, and language competency were the most important in her decision to choose London.

*Transnational in vitro fertilisation*

The transnational migration story of Marta started when her fiancé got a job in London and she began visiting him regularly in 2006. They both registered with a local GP showing their tenancy agreement. After two years of trying to get pregnant the couple privately visited a doctor in Poland, did medical tests, had two unsuccessful attempts at (artificial) insemination and started to consider in vitro fertilisation. Assisted reproductive technologies (ART) were at that time not covered by the national health insurance in Poland (this changed in 2013) [Radkowska-Walkiewicz 2013]. Marta found out on the internet that they actually might have a chance to get it done under the British NHS. They took all the results from Poland to her GP in London and got referred to a specialised ART clinic. While waiting for an invitation letter and a consultation date, they decided to have two more insemination procedures in Poland. Marta was not pregnant and they finally got an appointment at a London clinic. In the area they lived they were entitled to one free cycle of in vitro fertilisation (the system is colloquially referred to as a 'postcode lottery', since there are large differences across the UK in access to ART). They paid a small fee for medicine and Marta started stimulation while still living and working in Poland. She flew for the last weeks of the procedure and waited after the transfer for the results. She was pregnant. She said that if it were not for the private visits in Poland she would not have been prepared emotionally to deal with the London clinic and the 'whole system': the different language en-

vironment and approach of the system [*cf.* van Balen and Inhorn 2002: 14]. Marta also stressed that the London clinic had better results than the private ART clinics in Poland, where they would have had to spend a lot of money and had smaller chances of success. She felt herself very lucky. She still remembers that she and her husband extensively discussed whether to continue the treatment only in London or to try again in Poland. They were tired of flying on specific days of her cycle or treatment. Marta had problems at her job in Poland due to her many absences. A few years later she could still recall the difficulty of these decisions.

Comparing the cases of Lena, Agata, Marta, and Anna (a Berliner travelling to Wrocław while pregnant), it is clear that access to the German medical system is more tightly controlled than the British and Catalan ones. Every patient has to show a valid local health-insurance card to obtain care. Thus, Anna was not able to receive care during pregnancy, but Lena, though she lived in Barcelona, was able to have dental surgery there. The British NHS is based on tax-funding and everyone with a proof of address (a bill with the person's name and address) is admitted to a doctor or a hospital. To be entitled to a treatment one has to be a resident of the UK, but Marta, living transnationally between Poland and the UK, was actually entitled to treatment in both places. The three migrant women were using health care in more than one country—a situation partly made possible by the phenomenon of multiple migration [Main 2014]. National insurers insist that patients can only belong to one medical system and try to limit patients' mobility.<sup>13</sup> However, the differences in access to and the quality of treatment are increasingly known to patients (or potential patients) owing to extensive mobility, social networks, the internet, which results in increased agency and creativity in getting health care. I would argue that the present situation of the increasingly multiple and transnational migration of Poles influences their perception of medical care and prompts them to seek, in their view, better treatment.

## **Conclusion**

Poles' motives for medical travel are complex and have to do with the economic, social, and legal circumstances of migrants as well as the medical treatments offered in the new country of residence and in the transitional Polish health-care system. Clearly, the economic circumstances of the women I interviewed were

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<sup>13</sup> Implementation of EU Directive 2011/24 on Patients' Rights, including the mobility of patients, has been postponed for a few years and most Member States are only starting to plan its implementation [Greer 2013: 1142]. The Directive is not a means for a patient to obtain reimbursement for the costs of a treatment that they obtain in another EU member state if the same or equivalent treatment could have been made available to that patient under their home health service. See Gov.uk for an explanation of patients' rights in the UK according to the Directive: <https://www.gov.uk/government/publications/eu-directive-on-patients-rights-in-cross-border-healthcare> (retrieved 20 December 2013).

relatively good and they could afford to pay for private appointments and treatments in Poland or in local Polish clinics. Access to local health care was based on a person's registered place of residence (in London and Barcelona), or, in Germany, on being legally employed and registered with one of the health-insurance companies. A lack of access led in some cases to medical travel. The perspective from three localities, London, Barcelona, and Berlin, makes it possible to see the impact of the perceived quality and accessibility of health care on the decision to travel to Poland and to arrange medical treatment there.

Illness during migration could be compared with the periods of cultural transition when 'explicit ideologies directly govern action, but structural opportunities for action determine which among competing ideologies survive in the long run' [Swidler 1986: 273]. Swidler understands culture as a collection of symbols, stories, rituals, and worldviews; furthermore, culture provides components that are used to create strategies of action. My respondents used strategies influenced by their culture (their knowledge and experience of Polish and their new society) to decide about their medical treatments. Since their selection of cultural components is restricted, their access and use of medical travel is also limited. For example, the lack of trust, misunderstanding, and dissatisfaction with the NHS system led to the common practice of arranging medical appointments in Poland during holidays and on other occasions. I would argue that their dissatisfaction is fuelled by a distrust of the state services they remembered based on their experiences in Poland. The different way of organising health care, with the delegating of some tests to nurses and larger responsibilities given to GPs, was perceived negatively by Polish migrants. Even if Polish health care is assessed by local patients as worse than the NHS care, the Polish women decided to travel (away from their new place of residence) to seek private and public treatment in Poland.

The lower cost of private treatment in Poland, especially in the case of dental care, of which only a small part was covered by the state systems in the UK and Catalonia, led the women to plan treatment and check-ups in Poland. Consultations with specialists were much cheaper in Poland and were made by the migrants either in cases of emergency (when the waiting time for a visit was unacceptable) or occasionally 'just to be sure'. The lower cost of IVF in Poland compared to Barcelona's clinics was a reason for the Polish-Catalan couple to travel to Poland over the summer. There is thus a wide selection of types of medical travel (to see specialists, for reproductive health care, or for dental surgery).

Finally a few cases of intra-European medical travel and transnational medical treatments were analysed here. This shows the agency and creativity of migrants in seeking what are in their opinion the best medical treatments. This kind of travel is possible thanks to personal competency, social connections, language skills, the internet, and travel advances, and familiarity with the experience of mobility. This new phenomenon may develop further as a result of the recently increased mobility of Europeans, as well as growing differences between the quality and scope of medical care covered under the state and private health insurance.

The medical travel of the women in the study occurred at the intersection of privilege and marginalisation: on the one hand, these women were privileged enough to travel for treatment; on the other hand, some of them may have travelled because of a lack of resources, knowledge, or access to treatment in their country of residence.<sup>14</sup> A lack of cultural competency, limited trust in local health care, and/or feeling uncomfortable in another language triggered the need for medical travel in the case of Polish migrant women living and working legally in Spain, Germany, and the UK. As in the case of other contexts, cross-border health care may be aligned with the patients' preferences and thus be beneficial to him/her [Smith Nielsen 2012: 1].

Last but not least, this study addressed the positive and negative consequences of medical travel. On a personal level there was an element of personal agency and creativity in the act of arranging preferred medical treatments and taking advantage of the best options (in the view of the interviewed women). However, there was also insecurity and doubts about where and whether to arrange treatment in the other locations. Postponing medical appointments and treatment until it was possible to travel to Poland could have negative consequences. On a structural level, referring to private care in Poland instead of national care in the UK or Spain might lessen the burden on these systems. Yet, it also might 'disconnect' these patients from regular check-ups within these health systems and may hinder prevention. A patient becomes the agent of his/her cure. Medical tourism to Poland also stimulates the growth of the hard-to-control private health market. Even in private care patients get referrals for tests and treatment within the state system, which has the effect of blurring the two spheres, leads to incidents of corruption, and increases the burden on the post-socialist state health-care system.

This article explored the relatively common experiences of Polish women who had moved, mostly as economic migrants, to West European countries and frequently settled or stayed there for a longer period, yet continued, especially in the case of the women in London and Barcelona, receiving medical care in Poland. Their improved economic situation allowed them to devote resources to the use of private health care in Poland under the post-socialist transformation. While the communist system was organised around state-controlled redistribution [Burawoy and Verdery 1999: 3], including access to health care, the private sector, and the 'grey zone' were already tolerated during the last decade of the communist regime in Poland [Staniszki 2005: 192]. The collapse of the communist system did not eliminate the black market, the second economy, and the significance of extended kinship ties, but rather caused them to flourish even more [Burawoy and Verdery 1999: 6]. More than two decades after the change of the political regime, the standard of medical care, the qualifications of doctors and health professionals, and the quality of medical equipment have substantially improved, yet access

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<sup>14</sup> I would like to thank the anonymous reviewer for this point.

to health care has been worsening. This is the result of the rising costs of medical treatments and the relatively small individual contributions to state-managed health insurance in Poland (well below the EU average). Many Poles spend large sums of money on privately-paid health care and legislative projects to organise a systemic form of private health insurance have been unsuccessful.<sup>15</sup>

The Polish national health-care system co-exists alongside private health insurance and individual payments (only partly registered), and many Poles decide to pay to receive prompt and attentive health care. This strategy becomes even more common when people have more financial resources to spend on medical treatments. Some Poles have a lasting distrust in state-organised care, which could be seen as a post-socialist legacy, and misunderstand the organisation and philosophy of local health care (in the country they migrate to). At the same time, medical tourism and trans-border care are seen as sources of potential clients for the expanding private sector of medical care in Poland.<sup>16</sup> From analysing the current experiences of Polish migrants in the UK and Spain, it is plausible to assert that Polish migrants may constitute future customers of the private sector in Poland.

I would argue that another key factor influencing the phenomenon of medical travel of Poles was the country's accession to the EU in 2004. Obviously, EU integration and the gradual opening of the EU labour market led to large-scale migration. EU involvement in shaping health policy in Poland was another result of this. EU law and policies affect many aspects of health policy, such as mobility (of pharmaceuticals, patients, and medical professionals), research funding, public debate, and public health policies [Greer 2013]. The state's role with respect to health is thus influenced by EU regulations, and this influence requires further research. The mobility of migrants and transnational families living in several EU countries, as analysed through the several examples in this paper, permitted free use of health services in more than one country and resulted in people challenging the national health-care systems. The study of medical travel undertaken by Polish migrants shows the complex relationship between individuals, institutions, the economy, law, and perceptions of health and medicine in the (post-)transitional period marked by considerable mobility.

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<sup>15</sup> From 'Legislacja' (Legislation), an entry on a website for private medical entrepreneurs: <http://www.medycynaprywatna.pl> (retrieved 23 January 2014).

<sup>16</sup> See note 15.

## References

- Ackerman, S. 2010. 'Plastic Paradise: Transforming Bodies and Selves in Costa Rica's Cosmetic Surgery Tourism Industry.' *Medical Anthropology: Cross-cultural Studies in Health and Illness* 29 (4): 403–423, <http://dx.doi.org/10.1080/01459740.2010.501316>.
- Aull Davies, C. 1999. *Reflexive Ethnography: A Guide to Researching Selves and Others*. London: Routledge.
- Boulhol, H., A. Sowa, S. Golinowska and P. Sicari. 2012. 'Improving the Health-care System in Poland.' *OECD Economics Department Working Papers* 957. Paris: OECD Publishing, <http://dx.doi.org/10.1787/5k9b7bn5qzvd-en>.
- Burawoy, M. and K. Verdery. 1999. 'Introduction.' Pp. 1–18 in *Uncertain Transition: Ethnographies of Change in the Postsocialist World*, edited by M. Burawoy and K. Verdery. Lanham: Rowman & Littlefield Publishers.
- Buzinde, C. N. and C. Yarnal. 2012. 'Therapeutic Landscapes and Postcolonial Theory: A Theoretical Approach to Medical Tourism.' *Social Science & Medicine* 74 (5): 783–787, <http://dx.doi.org/10.1016/j.socscimed.2011.11.016>.
- Carling, J., M. Bivand Erdal and R. Ezzati. 2013. 'Beyond the Insider–Outsider Divide in Migration Research.' *Migration Studies* 2 (1): 36–54, <http://dx.doi.org/10.1093/migration/mnt022>.
- Carrera, P. and J. Bridges. 2006. 'Globalization and Healthcare: Understanding Health and Medical Travel.' *Expert Review Pharmacoeconomics and Outcomes Research* 6 (4): 447–454, <http://dx.doi.org/10.1586/14737167.6.4.447>.
- Connell, J. 2011. *Medical Tourism*. Wallingford: CABI, <http://dx.doi.org/10.1079/9781845936600.0000>.
- Eissler, L. A. and J. Casken. 2013. 'Seeking Health Care Through International Medical Tourism.' *Journal of Nursing Scholarship* 45 (2): 177–184, <http://dx.doi.org/10.1111/jnu.12014>.
- Eurobarometer. 2010. *Special Eurobarometer 327: Patient Safety and Quality of Health Care*. Retrieved 8 December 2014 ([http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_327\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf)).
- Glorius, B., I. Grabowska-Lusinska and A. Kuvik. 2013. 'Introduction.' Pp. 7–17 in *Mobility in Transition: Migration Patterns after EU Enlargement*, edited by B. Glorius, I. Grabowska-Lusinska and A. Kuvik. Amsterdam: Amsterdam University Press.
- Goodwin, R., E. Polek and K. Goodwin. 2013. 'Perceived Changes in Health and Interactions with "the Paracetamol Force": A Multimethod Study.' *Journal of Mixed Methods Research* 7 (2): 152–172, <http://dx.doi.org/10.1177/1558689812463782>.
- Grabowska-Lusińska, I. and M. Okólski. 2009. *Emigracja ostatnia? (The Last Migration?)*. Warsaw: Wydawnictwo Naukowe Scholar.
- Greer, S. L., T. K. Hervej, J. P. Mackenbach and M. McKee. 2013. 'Health Law and Policy in the European Union.' *Lancet* 381 (9872): 1135–1144, [http://dx.doi.org/10.1016/S0140-6736\(12\)62083-2](http://dx.doi.org/10.1016/S0140-6736(12)62083-2).
- Helble, M. 2011. 'The Movement of Patients across Borders: Challenges and Opportunities for Public Health.' *Bulletin World Health Organization* 89 (1): 68–72, <http://dx.doi.org/10.2471/BLT.10.076612>.
- Kangas, B. 2007. 'Hope from Abroad in the International Medical Travel of Yemeni Patients.' *Anthropology & Medicine* 14 (3): 293–305, <http://dx.doi.org/10.1080/13648470701612646>.
- Kravitz, A. S. and E. T. Treasure. 2009. *Manual of Dental Practice*. Version 4.1 (2009). Cardiff: The Council of European Dentists.
- Lee, J. Y., R. A. Kearns and W. Friesen. 2010. 'Seeking Affective Healthcare: Korean

- Immigrants' Use of Homeland Medical Services." *Health & Place* 16 (1): 108–115, <http://dx.doi.org/10.1016/j.healthplace.2009.09.003>.
- Legido-Quigley, H., M. McKee, E. Nolte and I. A. Glinos. 2008. *Assuring the Quality of Health Care in the European Union. A Case for Action*. Brussels: The European Observatory on Health Systems and Policies.
- Main, I. 2014. 'High Mobility of Polish Women: The Ethnographic Inquiry of Barcelona.' *International Migration* 52 (1): 130–145, <http://dx.doi.org/10.1111/imig.12119>.
- Migge, B. and M. Gilmartin. 2011. 'Migrants and Healthcare: Investigating Patient Mobility among Migrants in Ireland.' *Health & Place* 17 (5): 1144–1149, <http://dx.doi.org/10.1016/j.healthplace.2011.05.002>.
- Milstein, A. and M. Smith. 2006. 'America's New Refugees—Seeking Affordable Surgery Offshore.' *New England Journal of Medicine* 355 (16): 1637–1640, <http://dx.doi.org/10.1056/NEJMp068190>.
- Pracodawcy Medycyny Prywatnej [Private Medical Employers]. 2013. 'Legislacja w ochronie zdrowia.' (Legislation to Protect Health) Retrieved 23 January 2014 (<http://www.medycynaprywatna.pl/legislacja-w-ochronie-zdrowia-stan-obecny>).
- Puls Medycyny. 2013. 'Lekarz—zawód bez zaufania?' (Doctors—A Profession without Trust?) Retrieved 10 January 2014 (<http://pulsmedycyny.pl/3220713,91825,lekarz-zawod-bez-zaufania>).
- Radkowska-Walkiewicz, M. 2013. *Doświadczenie in vitro: niepłodność i nowe technologie reprodukcyjne w perspektywie antropologicznej*. (The In Vitro Experience: Infertility and New Assisted Reproduction Technologies in a Perspective of Anthropology) Warsaw: Wydawnictwo Uniwersytetu Warszawskiego.
- Rechel, B., P. Mladovsky, W. Devillé, B. Rijks, R. Petrova-Benedict and M. McKee. (eds.) 2011. *Migration and Health in the European Union*. Maidenhead: Open University Press.
- Sagan, A., D. Panteli, W. Borkowski, M. Dmowski, F. Domański, M. Czyżewski, P. Goryński, D. Karpacka, E. Kiersztyn, I. Kowalska, M. Księżak, K. Kuszewski, A. Leśniewska, I. Lipska, R. Maciąg, J. Madowicz, A. Mądra, M. Marek, A. Mokrzycka, D. Poznański, A. Sobczak, C. Sowada, M. Świderek, A. Terka, P. Trzeciak, K. Wiktorzak, C. Włodarczyk, B. Wojtyniak, I. Wrześniewska-Wal, D. Zelwianańska and R. Busse et al. 2011. 'Poland: Health System Review.' *Health Systems in Transition* 13 (8): 1–193.
- Salganicoff, A., U. Ranji and R. Wyn. 2005. *Women and Health Care: A National Profile. Key Findings from Kaiser Women's Health Survey*. Menlo Park, CA: Kaiser Family Foundation. Retrieved 8 December 2014 (<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf>).
- Sethna, C. and M. Doull. 2012. 'Accidental Tourists: Canadian Women, Abortion Tourism and Travel.' *Women's Studies* 41 (4): 457–475, <http://dx.doi.org/10.1080/00497878.2012.663260>.
- Smith Nielson, S., S. Yazici, S. Gronwald Petersen, A. L. Blaakilde and A. Krasnik. 2012. 'Use of Cross-border Healthcare Services among Ethnic Danes, Turkish Immigrants and Turkish Descendants in Denmark: A Combined Survey and Registry Study.' *BMC Health Services Research* 12: 390, <http://dx.doi.org/10.1186/1472-6963-12-390>.
- Sobo, E. J. 2009. 'Medical Travel: What It Means, Why It Matters.' *Medical Anthropology: Cross-cultural Studies in Health and Illness* 28 (4): 326–335, <http://dx.doi.org/10.1080/01459740903303894>.
- Solé-Auró, A. and E. M. Crimmins. 2008. 'Health of Immigrants in European Countries.' *Working Papers* 2008/09. Research Institute of Applied Economics. *Working Paper* 2008/09. Retrieved 8 December 2014 ([http://www.ub.edu/irea/working\\_papers/2008/200809.pdf](http://www.ub.edu/irea/working_papers/2008/200809.pdf)).

- Speier, A. R. 2011. 'Health Tourism in a Czech Health Spa.' *Anthropology & Medicine* 18 (1): 55–66, <http://dx.doi.org/10.1080/13648470.2010.525879>.
- Stan, S. 2014. 'Transnational Healthcare Practices of Romanian Migrants in Ireland: Inequalities of Access and the Privatisation of Healthcare Services in Europe.' *Social Science & Medicine*. Retrieved 10 December 2014 (<http://www.ncbi.nlm.nih.gov/pubmed/24797693>) <http://dx.doi.org/10.1016/j.socscimed.2014.04.013>.
- Staniszakis, J. 2005. *Postkomunizm. Próba opisu*. (Postcommunism: An Attempt at an Explanation) Gdańsk: słowo/obraz terytoria.
- Swidler, A. 1986. 'Culture in Action: Symbols and Strategies.' *American Sociological Review* 51 (2): 273–286, <http://dx.doi.org/10.2307/2095521>.
- Szetela, P. n.d. 'Coraz więcej niepublicznych szpitali.' (An Increasing Number of Non-public Hospitals) Retrieved 20 December 2013 ([http://www.nowoczesna-klinika.pl/pl/artykuly/17/Analizy\\_Raporty/1/253/Coraz\\_wiecej\\_niepublicznych\\_szpitali](http://www.nowoczesna-klinika.pl/pl/artykuly/17/Analizy_Raporty/1/253/Coraz_wiecej_niepublicznych_szpitali), ac).
- Sztompka, P. 2003. *Trust. A Sociological Theory*. Cambridge: Cambridge University Press.
- Van Balen, F. and M. C. Inhorn. 2002. 'Introduction. Interpreting Infertility: A View from the Social Sciences.' Pp. 3–32 in *Infertility around the Globe. New Thinking on Childlessness, Gender, and Reproductive Technologies*, edited by M. C. Inhorn and F. van Balen. Berkeley, CA: University of California Press.
- Van Hoof, W. and G. Pennings. 2012. 'Extraterritorial Laws for Cross-border Reproductive Care: The Issue of Legal Diversity.' *European Journal of Health Law* 19 (2): 187–200, <http://dx.doi.org/10.1163/157180912X628226>.
- Wallace, S. P., C. Mendez-Luck and X. Castaneda. 2009. 'Heading South: Why Mexican Immigrants in California Seek Health Services in Mexico.' *Medical Care* 47 (6): 662–669, <http://dx.doi.org/10.1097/MLR.0b013e318190cc95>.
- Wcisło, A. 2012. 'Turystyka medyczna.' (Medical Tourism) Retrieved 20 December 2013 ([http://izp.cm-uj.krakow.pl/izp\\_files/20121004\\_wcislo\\_turystykamedycznawpolsc\\_154708.pdf](http://izp.cm-uj.krakow.pl/izp_files/20121004_wcislo_turystykamedycznawpolsc_154708.pdf)).
- Whittaker, A., L. Manderson and E. Cartwright. 2010. 'Patients without Borders: Understanding Medical Travel.' *Medical Anthropology: Cross-cultural Studies in Health and Illness* 29 (4): 336–343, <http://dx.doi.org/10.1080/01459740.2010.501318>.
- Whittaker, A. and A. Speier. 2010. "'Cycling Overseas": Care, Commodification and Stratification in Cross-border Reproductive Travel.' *Medical Anthropology: Cross-cultural Studies in Health and Illness* 29 (4): 363–383, <http://dx.doi.org/10.1080/01459740.2010.501313>.
- Wiadomosci. 2014. 'Książa, dziennikarze, lekarze ... Komu ufają Polacy.' (Priests, Journalists, Doctors. Who Do Poles Trust?) Retrieved 2 January 2014 ([http://m.wiadomosci.gazeta.pl/wiadomosci/1,117915,13807182,Ksieza\\_dziennikarze\\_policjanci\\_Komu\\_ufaja\\_Polacy\\_.html?order=najnowsze](http://m.wiadomosci.gazeta.pl/wiadomosci/1,117915,13807182,Ksieza_dziennikarze_policjanci_Komu_ufaja_Polacy_.html?order=najnowsze)).