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Exploring medical tourism in Mexico: a territorial analysis of health services offered to foreigners, 2022

Explorando el turismo médico en México un análisis territorial de los servicios de salud ofertados para extranjeros, 2022

Abstract: The inequality in access to health services, that are thought as commodities rather than a human need, has boosted medical tourism. The growth of this activity in the 21st century has been exponential, especially in developing countries, and this rises the need of studying the dynamics between countries of origin and countries of destination, a task that lacks of studies from geographers of the Global South. One of the most emblematic cases of medical tourism is the one that takes place between the USA and Mexico, widely featured in the specialized literature. A territorial analysis of medical tourism in Mexico, based in quantitative-qualitative methodology, was implemented in order to understand which of the 32 states that conform Mexico participate in this economic activity, and how. The construction of a weighing matrix that was based on qualitative data led to a thematic map with analytic elements such as border nodes related to the demand for medical services for foreigners, as well as the expansion and diversification of these services in several locations throughout the country. Medical tourism in Mexico results from the existing problems in the US health system and the deep economic inequality between these two countries.

Keywords: globalization of health; medical tourism; tourism geography; health access

Resumen: La desigualdad en el acceso a servicios de salud, que son pensados como mercancías y no como una necesidad humana, ha impulsado el turismo médico. El crecimiento de esta actividad en el siglo XXI ha sido exponencial, especialmente en países en vías de desarrollo, lo que lleva a la necesidad de estudiar las dinámicas entre países de origen y destino, una tarea que carece de estudios geográficos del Sur Global. Uno de los casos más emblemáticos de turismo médico es el que acontece entre Estados Unidos y México, ampliamente referido en la literatura especializada. Fue implementado un análisis territorial del turismo médico en México, basado en metodología cuantitativa-cualitativa, con el objetivo de entender cuáles de los 32 estados que conforman México participan de esta actividad económica, y cómo. La construcción de una matriz de pesos, basada en datos cualitativos, llevó posteriormente a la elaboración de un mapa temático con elementos analíticos como nodos fronterizos relativos a la demanda de servicios médicos para extranjeros, así como la expansión y diversificación de estos servicios en localidades específicas a lo largo del país. El turismo médico en México resulta de los problemas existentes en el sistema de salud estadounidense y la profunda desigualdad económica entre ambos países.

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Introduction

In recent decades, tourism has become increasingly relevant in global economy. In spite of its negative impacts, developing countries see in tourism an ally that fosters economic growth, and its expansion is promoted in various segments (Hall, 2013). Mexico is no exception. The tourist market is concentrated along coastal destinations and metropolises; however, in recent years, in an effort to increase the sector's revenue, this activity has grown to include new issues as culture, convention venues, adventure, and health and medical services.

This article focuses on medical tourism, its development and its territorial dimension, analyzing it from a geographical perspective according to the principles of location, distribution, causality and connection (Santos, 2004; Moreira, 2007), so the main focus is not centred on the promotion of tourism or marketing strategies, but rather on the socio-spatial impacts of the activity, its links to other social problems and the movement of tourists within and across territories.

The aim of this work is to show the territorialities of medical tourism in Mexico, until 2022, through a quantitative-qualitative methodology, at statal scale –in order to expose the complexity and heterogeneity of this economic activity in Mexican territory. The information used in the final product was obtained from a weighing matrix, built from an own-database on health services to foreigners.

According to Moreira (2007), the analysis of data in Geography is not limited to a single scale of thought or section of the world, because differentiations, interactions and relationships take place at more than one level, so geographical principles are the interrelation of extension, connection, distance, position, location and distribution. According to those principles, the analysis and the ensuing explanation presented in this work cover historical, economic, political and social aspects at various scales, discussing the generalities and particularities of medical tourism in Mexico thereby revealed. Thus, Geography is inscribed among reflections of human sciences dealing with spatial dimension of totality, and it shall study the spatiality of social life, which is understood as a particular mediation of history in a specific society (Luna-Nemecio, 2022). Under that perspective, spatialization is singularizing and historicizing, as locating the analyzed object not only temporally but also in space.

In the genesis of medical tourism, globalization and neoliberalism combine to model the activity's dynamics at national, regional and local levels, a phenomenon that has a worldwide spread as Sheppard (2015) quotes: "in common parlance, capitalism references the currently taken-for-granted way that economic activities are, and should be, organized worldwide…Thinking geographically about globalizing capitalism raises a series of profound questions about this common-sense, creating space to consider possible alternatives" (pp. 9-10). A geographical view of this matter is necessary to understand this economic activity, and the proposed case of study, Mexico, shall contribute to a better comprehension of the territorial expressions of medical tourism.

This topic has been studied especially from business and marketing perspectives, and far less from other social science perspectives (Connell, 2015). In the particular case of Mexico, studies have been conducted within management approaches (Guzmán, 2015), but less from geographical studies (Rodríguez-Blanco, 2020). This is a gap to fulfill, due to the importance of Mexico as a main receptor of this type of tourism, as pointed by Rodrigues et al (2017).

Theoretical background

Globalization of health and medical tourism

Globalization has transformed the economy, trade, regional politics and international treaties, and its influence on technological progress, migration, mobility, and socio-cultural tendencies is palpable, particularly in the context of increasing unemployment and social inequality (Lunt & Mannion, 2014). It is a process that reshapes spatial categories due to the free flows of information, imaginaries and goods that produce a certain fluidity of territorial boundaries in various scales –international, regional (country or state) and local (county or municipality), as observed by Santos (2004).

Health is an essential need, indivisible, social and individually desired but faces inequality, and it has several links with globalization, passing through economic, technological, cultural and political issues. When nation-states were created, health was a public good, but since mid-20th century countries started to produce private goods from the public sphere; in different degrees, the governments drove health to the medical-industry-pharmaceutical complex, in a clear attempt to reduce costs after the breakdown of the welfare state (Franco, 2003).

Private health services grew in the second half of the 20th century, mainly because of the weakness that neoliberalism introduced in the social and welfare state, since they are based on the principle of exclusion: only people with capability to pay can be assisted (Lunt & Mannion, 2014). After several economic crises that reduced their clients, some private providers (mainly from low-and middle-income countries) started to search new customers outside their national frontiers, matching with the expansion needs of the tourism industry, that continuously generates new consumption niches as it enters into a system of competitiveness and segmentation that leads to the development of money-making projects (Hall, 2013).

Although there are numerous discussions about the term medical tourism, there is a certain consensus in the academic literature in defining it as the movement of individuals who travel to other countries than the country of residence with the intention of receiving some type of medical treatment (Adams et al, 2017). As Lunt & Mannion (2014) set, this subcategory includes procedures as cosmetic surgery; dentistry; cardiology/cardiac surgery; orthopedic surgery; bariatric surgery; fertility/reproductive system; organ, cell and tissue transplantation; eye surgery and diagnostics and check-ups. Usually, these services are not paid by medical insurances, and patients are driven by low cost as well as the avoidance of waiting lists in their own countries. Furthermore, there is a continuous intense debate on the ethical implications and impact on the host country, along with an increasing interest in research of medical tourism (Johnston et al, 2010).

From the perspective of this work, there at least three factors that directly intervene in the existence of medical tourism: a growing search for medical treatment due to unmet necessities in the own health system and an increasing international mobility (Hall, 2013), but also the global reach of information (Santos, 2004).

Towards some authors analyze medical tourism as a logic consequence of the privatization and corporatization of medical services (Chee, 2010), others discuss that it is a new configuration of medical services offer, directly derived from the globalization and the lack of regulation and responsibility. For the aim of this work, we understand medical tourism as the practice of traveling to another country with the main purpose of obtaining healthcare,

excluding wellbeing practices such as homeopathy, alternative treatments and spa, that may be better understood with the term health tourism as they involve different processes of decision-making and consumption (Connell, 2015).

Several factors account for the decision to travel abroad to seek medical attention, such as delays in receiving medical treatment locally, the improvement of quality in the medical services of developing countries, differences in the ethical criteria governing medical procedures, the option to use pension resources to access medical services, the intensification or international (human) mobility, the return of migrants to their country of origin in order to gain access to a medical specialty, and a willingness to try experimental practices, for example, stem-cell implants or transplants of tissue from non-human species (Hall, 2013).

This tourism segment depends on the persistence of economic, administrative and legal disparities between countries, which lead to competition among providers of medical services and products (Oberle & Arreola, 2004). The three factors of production (land, work and capital) have a direct influence on the cost of medical services, and medium and low income countries are in a position to offer more competitive prices due to: i) land concessions by the state for hospital construction, ii) a comparatively low salary of health professionals, and iii) the attraction of transnational companies to absorb installation costs and open up assembly plants (maquiladoras) for the supply of non-specialized goods (Whittaker, 2015).

The global emergence of health-related industries (health professionals, transnational companies in the pharmaceutical and insurance sectors) is a function of this market niche, in which health is regarded as both a public good and an international commodity. The consequences of this activity depend on the institutional framework of the country in question, but are little known and lie mostly in speculation and a vision from the Global North (Johnston et al, 2010). Medical tourism does not work for every country, for it thrives on the economic and political advantages brought by state intervention in the surge of private services that proliferated during the heyday of neoliberalism (Sengupta, 2011).

Medical tourism is a transitional phenomenon in an era of relaxation of border protocols in health services and an increased mobility, factors that reorganize the relations between work, capital, the State, and the patients (Chee, 2010). The growth of this activity, notably since the beginning of the 21st century, fuels debate regarding various contemporary issues such as inequality in access to medical services and their gradual privatization, the technological dependence of medium and low-income countries, and the globalization of medical services (Connell, 2015).

According to other case studies, the question arises as to whether medical tourism is fostering the creation of dual health systems in the receiving countries. The answer depends on each country's policies, their ability to regulate, the degree of subsidizing, and the presence of financial redistribution mechanisms (Whittaker, 2015). Defined as it is by privatization, deregulation and competition, medical tourism is controversial when it comes to social justice. Satisfying the needs of people with higher purchasing capacity, leads to uncertainty as to the extent of coverage of the medical needs of the population in the receiving country, as health workers, medical infrastructure and financial resources are concentrated elsewhere (Connell, 2015).

The growth of private health markets in developing countries has taken place at the expense of public systems, and the direct beneficiaries are health providers. However, private initiatives can hardly succeed without the participation of the government and a favorable legal system. The often-decrepit public health systems are neglected in order to focus on

revenue, generating private-public alliances; in the absence of regulation, this may lead to a decline in the quality of medical services in the countries of origin too (Whittaker, 2015).

Medical tourism is both a symbol and a product of the failures inherent in the privatization of medical services, as well as the increasing deterioration of national health services. These circumstances have paved the way for a global medical market, which its main priority is the attention of high-income social sectors in order to grow profit rates (Adams et al, 2017). In the official discourse, medical tourism is described as an activity that contributes to the economic development of the receiving communities while guaranteeing access to health services. However, it has been denounced as a "perverse flow" of people and resources, that may threaten the capability of national health systems and exclude the lower sectors of population from the technological improvement and other benefits it generates (Connell, 2015).

Evidently, the global health crisis derived from the COVID-19 pandemic (Luna-Nemecio, 2020) affected the international tourist movement. Despite the crisis, Mexico was the third most visited country internationally in 2020, due to the government decision not to restrict the entry of tourists or require a negative test for SARS-COV-2, quarantine or proof of vaccination to enter the country (Kido-Cruz & Kido-Cruz, 2021). This situation particularly privileged the arrivals by land of tourists from the USA and Canada, traditional issuers of tourists to Mexican territory, including medical tourists.

Medical tourism in Mexico: historical review and current panorama

Given its geographical proximity to the USA, the source of the largest flow of medical tourists globally, Mexico is one of the countries in which medical tourism is most developed (Hall, 2013). The Mexico-USA border has a history of transnational exchange and collaboration, including free trade zones. This, together with the policy of easy access of US citizens to Mexican territory, serves to the advantage of medical tourism. Records of the medical, dental, and pharmacological services offered exclusively to US visitors in the Mexico-USA border area since the 1970s (Oberle & Arreola, 2004; Rodríguez-Blanco, 2020), show that medical tourism in Mexico is far from new, and its expansion has gathered impetus in recent years under globalizing liberalism.

Interactions can be examined at different scales (country to country, cities to tourist sites), and flows may take an inter-scale character, with international visitors moving into a country. Given the close relationship between the two countries and the large volume of US patients treated in Mexico (ProMéxico, 2016), the case under analysis calls for a comparison of the institutional framework of health services in both countries, and also to compare the socio-economic context (Table 1). A geographical analysis of tourism must go beyond the study area and acknowledge the existing relationships with other markets and destinations (Alvarado-Sizzo & Costa, 2019).

Table 1. Institutional framework of health services in USA and Mexico.

Selected criteria	United States of America	Mexico
Background	Competition among private agents; regulation through private associations (1847: *American Association for Labour Legislation* and *American Medical Association)*	Social assistance schemes associated with the Church (1813: Provincial Public Health Boards)
Current operation	Competition among private agents (with financial support from federal programmes or out of pocket)	Universal coverage for the uninsured (federal government); institutional coverage for the insured; private services
Main federal government health institutions	Department of Health Services, and institutions derived from the Affordable Care Act	Health Secretariat, and Mexican Institute of Social Security (IMSS) (since 1943); Institute for Security and Social Services for State Workers (ISSSTE) (since 1959); Institute for Health and Welfare (Insabi, formed in 2020).
Main federal health-providing programmes (as of 2020)	*Medicare* and *Medicaid* (approved in 1965); *Affordable Health Care for America Act* (2010)	Insabi (active from January 2020, but lacking operational base).
Financing of federal health programmes	Mixed: federal resources, state resources, patients' own resources	Mixed: federal and state resources. The proposal is to gradually phase out patients' contributions by the end of 2020.
Population considered in federal programmes	Population over 65 and under 21 years old with high vulnerability; workers through their employer	Insured population through formal employment; uninsured population through Insabi.
Eligibility for federal programmes	Based on complex criteria of work curriculum and poverty lines established by each state	Having a formal job (affiliation to IMSS or ISSSTE); universal coverage intended for the uninsured
Legal framework	*Social Security Act* (1935); *Affordable Health Care for America Act* (2010, under negotiation)	Mexican Constitution (1917); General Health Law (reformed 2006)
Participation of the private sector in the provision of health services	It was, from the beginning (mid-19th century), a private system, consolidated in the 1920s	From the 1980s, with the structural adjustment programmes imposed after bankruptcy in 1982

Source: elaboration based on Joseph (2016) and Rodríguez-Blanco (2020).

The historical and political trajectories of each country in terms of health provision policies have influenced the emergence of medical tourism in Mexico. Medical tourism brings in multiple actors, most of them private. In contrast to the USA, where health services have been a private initiative since the beginning, private medical services in Mexico had an exponential growth throughout the 20th century as a result of the structural adjustment programs imposed by the IMF, implemented as a condition for a loan to alleviate the 1982 economic crisis. Private health practitioners in Mexico, particularly in the northern border

area, began to attract foreign patients, who had higher purchasing power than Mexican patients (Kido-Cruz & Kido-Cruz, 2021).

It can be said that historical and geographical reasons account for the establishment of medical tourism in Mexico. However, the traditional circulation of information and people across the border remains the main explanation. Despite its flagrant inequality in terms of migration policies, as US citizens may enter Mexican territory without a visa, whereas a visa is mandatory for any Mexican citizen entering US territory, this is one of the busiest borders in the world.

The nature of the USA-Mexico flow of tourists has changed through time. Back in the 1920s, during the prohibition era in the USA, visitors to Mexico were attracted mainly by the bars across the border. In the 1970s and 1980s, however, mostly as a result of macro-economic factors, but also on account of regional developments (the expansion of services by private Mexican concerns), Americans began to search medical, dental and pharmacological services in Mexico, notably in places such as Ciudad Juárez, Tijuana, Mexicali and Los Algodones (Oberle & Arreola, 2004). Ever since, more cities and destinations in the Mexican interior have added themselves to the list, with varying success (ProMéxico, 2016). Our interest here is to understand the development of medical tourism throughout Mexico.

The historic co-dependence of Mexico and the USA, the territorial evolution of Mexico, and the expansion of neoliberalism under the aegis of globalization, have been key processes in the growth of medical tourism in the country. Geographical thought must consider history as seriously as space (Moreira, 2007). Examined in terms of the geographical principles of location (vicinity), connection (trans-border symbiosis) and causality (historical co-dependence), this bi-national relationship explains for most of the medical tourism dynamics in Mexico.

In the context of COVID-19 pandemics, the full opening of borders in Mexico favored people residing in the USA when they were infected with COVID to travel to Mexico in order to receive medical emergency care with hospital treatment up to 50% cheaper than in their country of origin. On the other hand, despite the fact that the restrictions to enter the USA were much severer –including the total closure of the land borders with Mexico and Canada–, a large number of Mexican citizens traveled to the USA to obtain the vaccine against COVID-19 which had a slower and more restricted distribution in Mexico. Thus, citizens with fewer resources in the US traveled to Mexico to treat COVID, while a sector of the Mexican population traveled to the US to obtain the vaccine in better conditions than in their own country (Kido-Cruz & Kido-Cruz, 2021).

Materials and methods

A quantitative-qualitative methodological strategy incorporating several research techniques was designed for the present investigation. A bibliographic search (qualitative technique) was conducted, and the information obtained was filtered and processed in order to build a database. This led to the design of a weighing matrix (quantitative technique) for the analysis of the territorial behaviour of medical tourism in Mexico. Given the scale and intention of this endeavour, with a panoramic view of medical tourism in Mexico as its goal, the bibliographic search focused on a well-defined spatial-temporal framework. The search-refining criteria were:

a) Sources: articles in academic journals, book chapters, and other materials from institutions involved in medical tourism (World Health Organization, government bodies, Mexican private associations in the area).
b) Period: from 2004 (when scientific studies on medical tourism in Mexico began) to 2022.
c) Geographical reference: explicit reference to a Mexican location of medical tourism (any state or city).

With the information obtained from the bibliographic search, a database was built to record, for each state, the private health institutions attending foreign patients in Mexico. This allowed the construction of a weighing matrix for the analysis of the activity. A weighing matrix is a rectangular arrangement of numbers into rows and columns for the classification and analysis of a given situation, and a numeric value (weight) is assigned to one of these numbers according to its importance to the whole (Hernández et al, 2011). The database and the matrix allowed the design of a thematic map showing the spatial expression of medical tourism in Mexico.

The weighing matrix indicators for each state were:

1) **Number of private associations related to medical tourism**, being an indicator of interest and participation;
2) **Number of multispecialty corporate hospitals** (private hospital groups and/or clusters offering medical services with more than one speciality to foreign patients);
3) **Number of single-speciality clinics** catering to foreigners;
4) **Number of offered destinations in the state** (townships that receive medical).

To these variables, the following values (weights) were assigned: indicator 1, 30%; indicator 2, 30%; indicator 3, 30%, and indicator 4, 10%. These values are linked to the relative importance of the indicators for the presence of medical tourism in the state under analysis, the first three being fundamental to it and the fourth being a consequence of an already consolidated activity—which also has a direct role in attracting patients. The maximum value to reach would be 100.

Results and discussion

The weighing matrix obtained (Table 2) synthesizes the situation of medical tourism in Mexico (present in 15 of the 32 states). Some Mexican states were excluded from this study since they lacked an institutionalized offer (corporate hospitals or clinics).

Table 2. Weighing matrix of medical tourism in Mexico (2004-2022)

State	Private medical tourism associations	Multispecialty corporate hospitals	Single-speciality clinics	Density of destinations offered	Total points (out of 100)
Baja California	30	24	30	10	94
Jalisco	25	30	10	8	73
Ciudad de México	25	24	8	6	63
Quintana Roo	30	5	10	8	54
Nuevo León	15	15	15	6	51
Chihuahua	15	15	4	6	40
Guanajuato	15	10	8	2	35
Baja California Sur	5	10	5	2	22
Querétaro	15	0	4	2	21
Sonora	10	0	4	6	20
Nayarit	5	10	0	2	19
San Luis Potosí	15	0	0	2	17
Tamaulipas	15	0	0	2	17
Durango	5	5	0	2	12
Sinaloa	0	2	3	3	8

Source: elaborated by the authors, 2022.

The five states in which medical tourism is highly developed are Baja California, Jalisco, Ciudad de México, Quintana Roo and Nuevo León, in contrast with those states with an incipient development of the activity, and various degrees of development in between. In other states such as Chihuahua, Guanajuato and Baja California Sur, medical tourism is fairly important, and others have a less-balanced growth of medical tourism (Sonora, Querétaro, San Luis Potosí, Tamaulipas, Nayarit, Durango and Sinaloa).

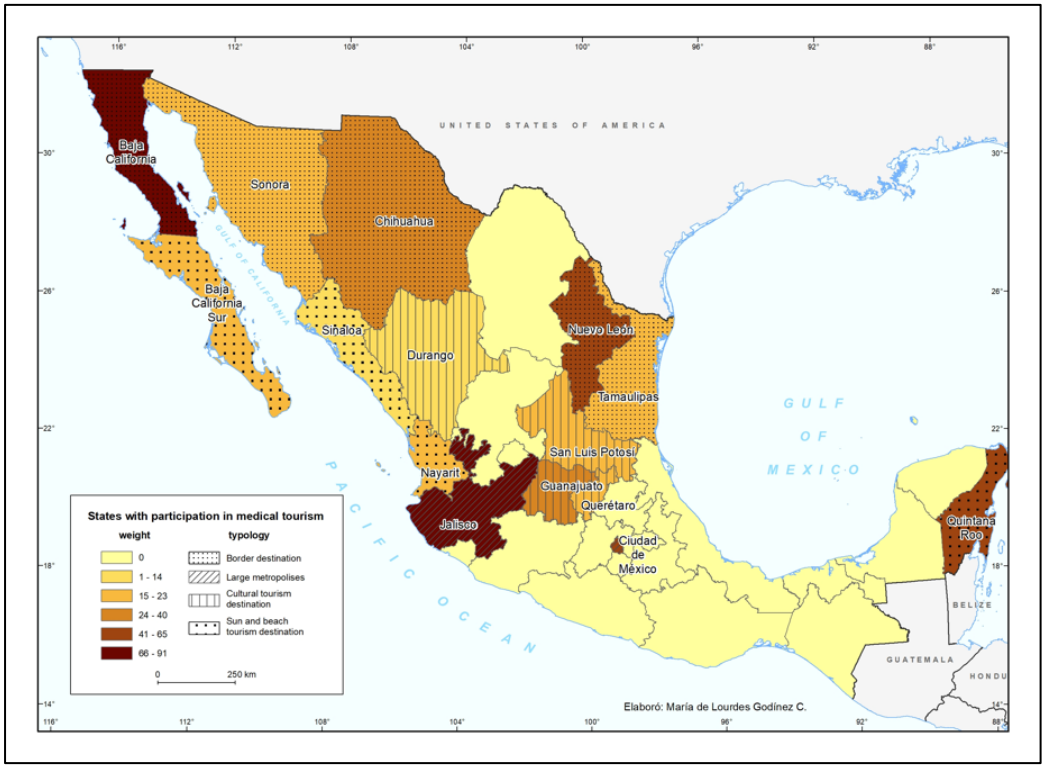

Figure 1. Territorial expression of medical tourism in Mexico (2021)
Source: elaborated by the authors, from the weighing matrix (Table 2).

Medical tourism in Mexico shows a tendency to dispersion (Fig. 1). This hinders the recognition of a regionalization on strictly spatial terms. However, it is possible to propose a typology of destinations according to the sort of tourism dominant in each state (Table 3).

Table 3. Typology of medical tourist destinations in Mexico by state (2021)

Main tourism orientation	Features	States
Border destinations	**Consolidated medical tourism**; geographical proximity allows interaction with flows of US patients	Baja California, Nuevo León, Chihuahua; in a lesser extent, Sonora and Tamaulipas
Large metropolises	**Consolidated medical tourism**; the historical concentration of hospital infrastructure has been offered recently to foreign patients	Ciudad de México, Jalisco
Cultural tourism destinations	**Emerging medical tourism** built on the orientation towards cultural tourism of touristic resources	Guanajuato, Querétaro, San Luis Potosí, Durango
Sun-and-beach destinations	**Emerging medical tourism** built on the orientation towards	Baja California Sur, Sinaloa, Nayarit, Quintana Roo

	massive sun-and-beach tourism of main touristic resources

Source: elaborated by the authors, based on the weighing matrix and ProMéxico (2016).

Some states were excluded from this study because they lacked an institutionalized offer of medical services for foreigners, but they do receive medical tourism in a less organized way; so, this activity can be expected to grow in the near future, remarkably in those states that are near to the USA (Coahuila) or already receiving a large number of international tourists from other segments (Guerrero, Oaxaca, Yucatán).

Territorial analysis is crucial for understanding the evolution of so-called medical tourism, whose growth responds to a series of factors associated with the capitalist model; this is illustrated by the case analyzed here (Mexico's close geographical and economic relationship with the USA). The geographical principles of location, distribution, causality and connection (Santos, 2004; Moreira, 2007) are here applied to medical tourism in Mexico:

i. Location and distribution. Although medical tourism occurs throughout Mexico, the concentration is higher along the northern international border. In cities such as Tijuana, Mexicali and Ciudad Juárez, this activity can change the arrangement of territory. To a lesser extent, littoral destinations that already attract many international tourists (Los Cabos, Cancún, Riviera Maya) have developed medical tourism as a complement to that of mass sun-sand-and-beach tourism, taking advantage of the existing tourist flows. Similarly, metropolitan destinations (Mexico City, Monterrey, Guadalajara, León) that receive and distribute millions of international tourists annually own the necessary infrastructure to incorporate medical services into their diverse tourist offer.

ii. Causality. In Mexico, the private sector has been responsible for the opening of corporate hospitals (multispecialty or single specialty). This has been of considerable importance in the development of medical tourism in several states, with varying degrees of development. The variety of destinations that have consolidated medical tourism as a source of income (and those intending to do so) is a function of the specificity of the tourist activities that exist in them, as well as their history and the degree of promotion by the different levels of government and the existing resources. Territorial fluidity (Santos, 2004) is a resource, although this fluidity exists only in a North-South direction; a South-North fluidity is impeded by a series of obstacles. Entry of foreign nationals into Mexico across the northern border is very lax, and the attention to the medical needs of foreigners (including the provision of pharmaceutical drugs) exploits the existing permissibility and legal loopholes. The historical economic gap between the USA and Mexico has worked to the benefit of the USA, with Mexico finding itself in a relationship of dependence. For instance, during the ongoing sanitary emergency arising from the COVID-19 pandemic, Mexico has not restricted the entry of US citizens, whereas the USA has limited entry of visa-holding Mexican nationals to strictly mandatory causes (Kido-Cruz & Kido-Cruz, 2021).

iii. Connection. The factor that has favored the most the development of medical tourism in Mexico has been contiguity. Journeys to the Mexican border from locations in the USA are relatively short and easy, and US patients constitute the majority of customers in

Mexico's medical tourism market. The territorial fluidity resulting from the growing connectivity developed between Mexico and the USA —but also between Mexico and other countries— enhances to this. Global network connectivity has contributed to the diversification of medical tourism in Mexico in the past twenty years, in terms of both services offered and territorial reach; medical tourism is no longer restricted to the northern border area, but has spread to various cities and tourist destinations across the country.

The availability of data in studies about medical tourism is a great problem. Few has been done in order to state if this niche makes a real tendency on deepening inequalities in health access for the local populations, especially because indicators that address those problems are hard to build with few data. For example, in Mexico the literature does quite higher emphasis on marketing and merchandising studies (Guzmán, 2015) rather than the possible consequences that population may suffer, as a lack of access to those health private services that are offered exclusively for foreigners with a better income, or a shortage of health professionals whom may prefer to work on the private sector rather than the public system, due to the high differences on earnings (Rodríguez-Blanco, 2020).

In sum, medical tourism in is built upon territorial fluidity, demonstrated by the flows of international patients that seek medical attention in Mexico, with varying degrees of participation and consolidation in the states in which it takes place. Its diversity is a function of the local historical and social factors, as well as the presence of other tourist resources to which it may be associated. Neoliberal rationality generates its own territorialization of medical care relationships based on the transference of costly procedures to countries on the periphery.

Conclusions

This article has envisaged four types of Mexican destinations of medical tourism at a region/state scale, with their own characteristics and different forms of articulation of flows of people, information and materials for the provision of medical services to foreigners. This is a global tendency that seeks to alleviate the shortcomings in the national health systems in wealthy countries by transferring part of their load to countries on the periphery (Sengupta, 2011); in the case of Mexico, this transference involves mainly patients from the USA.

The presence and typology of medical tourism in Mexico varies regionally. It is more established in the north, especially in the state of Baja California (where human resources and hospital infrastructure abound and there is a high number of corporate hospitals and clinics for foreigners), but it also tends to consolidate or deepen in other regions and cities that have a concentration of specialized services (Mexico City and the state of Jalisco). In other states with important tourist activity, its consolidation tends to be gradual.

Medical tourism in Mexico is heterogeneous and offers a niche of opportunity for the tourist and medical service markets to enter a symbiosis of varieties. However, as social and economic differences between countries have favored the emergence of medical tourism nodes all over the world, this kind of tourism may arise the inequalities that already exist in the receptor country. Although the existing flows of patients do include some who travel from a low-income country for treatment in a high-income country, most of the flows are middle-class people from high-income countries who are dissatisfied with both available options, unaffordable private service and an insufficient public service (Sengupta, 2011). Thus, inequality is responsible for the international flows of patients in their search for proper medical treatment.

This geographical overview of medical tourism in Mexico until 2022 may be used by decision makers not only to reactivate influx of travelers once the COVID-19 crisis is overcome, but also to analyze the distribution of this segment throughout Mexican territory, especially related to previous tourism activities, as the sun-and-beach or cultural segments. Although the review here presented is indeed general, it allows for the design of a geographical research agenda in which specific case studies are considered, in both national and local levels, and the unique relationship between Mexico and the USA, that has become the framework of development of medical tourism in Mexican territory.

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