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Title	Interrogating medical tourism: Ireland, abortion, and mobility rights
Authors	Gilmartin, Mary;White, Allen
Publication date	2011
Original Citation	MARY GILMARTIN & ALLEN WHITE 2011. Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights. Signs, 36 (2), 275-280. doi: 10.1086/655907
Type of publication	Article (peer-reviewed)
Link to publisher's version	http://www.jstor.org/stable/10.1086/655907 - 10.1086/655907
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Download date	2026-11-16 05:23:06
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Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights
Author(s): Mary Gilmartin and Allen White
Reviewed work(s):
Source: *Signs*, Vol. 36, No. 2 (Winter 2011), pp. 275-280
Published by: The University of Chicago Press
Stable URL: http://www.jstor.org/stable/10.1086/655907
Accessed: 17/01/2013 06:19

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Comparative Perspectives Symposium: Gender and Medical Tourism

Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights

Mary Gilmartin
Allen White

The border between Northern Ireland and the Republic of Ireland has long provided opportunities for people in search of medical bargains. Cosmetic surgery clinics advertise widely in Ireland for treatment abroad. Irish consumers have sought integrative tourism products, with treatment followed by a recuperation period that doubles as a holiday (Coles 2008).

Structural difficulties in the Irish health care system have also led to medical tourism. The Irish government pays for patients in the public health care system to receive treatment in the United Kingdom and elsewhere through its National Treatment Purchase Fund. The Treatment Abroad Scheme allows patients to receive treatment in another country (usually within the European Union) if the specific treatment is not available in Ireland and assists them in obtaining it. Private health insurers in Ireland are often happy to fund treatment outside the country, which can be considerably cheaper. And there is some evidence that EU migrants living in Ireland often return to their home country for medical treatment because of the cost of treatment in Ireland and delays in accessing it (MCRI 2008, 75–76). Seen from this perspective, medical tourism in the Irish context mirrors that from other Western countries, "where the costs of medical care may be very high, but where the ability to pay for alternatives is also high" (Connell 2006, 1096). Treatment is available in a medical tourist's home country, just not as quickly, cheaply, or responsively as he or she might wish. In other words, in this model medical tourism

[*Signs: Journal of Women in Culture and Society* 2011, vol. 36, no. 2]
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emerges as a consequence of informed choice on the part of the patient-consumer.

The use of the term "tourism" to describe this international movement in search of health care emphasizes individual agency, choice, and possibility, and it draws on the emerging "mobilities paradigm" that celebrates the emancipatory potential of mobility (Cresswell 2010, 17). Yet not all medical tourism emerges from these conditions. One such form, so-called abortion tourism, usually develops when abortion is not legally available in a particular territory. Abortion tourists traveled from Canada during the 1960s, from Mexico during the 1990s, and continue to travel across state boundaries in the United States. In Europe, abortion continues to be illegal or highly restricted in a number of (predominantly Catholic) countries, such as Ireland, Poland, and Malta, and women from these countries cross international borders to gain access to abortion services elsewhere. In Ireland, abortion is illegal in all circumstances other than to save the life of a pregnant woman, and abortion tourism has developed steadily since abortion was legalized in Britain (Oaks 2003, 1973).[1] Between 2001 and 2008, 45,645 women with addresses in the Republic of Ireland visited abortion clinics in Britain.[2] The annual number has decreased each year since 2001. However, it is likely that not all women from Ireland provide Irish addresses to abortion clinics, and thus this is probably an underestimate.

The status of abortion in Ireland has long been a contentious political issue. The ban on abortion was made explicit by a constitutional referendum in 1983. That referendum, passed by a two-thirds majority, stated that "the state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."[3] The practicality of this position has been tested in a variety of ways, most poignantly by the X case that came before the Supreme Court in 1992.[4] The X case involved a fourteen-year-old girl, pregnant as a

[1] We use "Britain" to refer to the island of Britain (i.e., England, Scotland, and Wales). Abortion was legalized in Britain as a result of the 1967 Abortion Act. This act does not extend to Northern Ireland (which is part of the United Kingdom).

[2] See the Crisis Pregnancy Agency press release, "Number of Women Giving Irish Addresses at UK Abortion Clinics Decreases for Seventh Year in a Row according to Department of Health UK," Dublin, May 21, 2009, at http://www.crisispregnancy.ie/pressrelease.php?id=95.

[3] Eighth Amendment to the Constitution, approved by referendum on September 7, 1983, and signed into law on October 7, 1983.

[4] In order to protect the identities of the young women involved, the court rulings referred to them as X and D, and thus cases became known as the X case and the D case.

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consequence of rape. Her parents wished her to have an abortion in Britain, but the Irish state attempted to prevent her from traveling. The Supreme Court of Ireland subsequently overturned this action later in the same year. The right to travel to obtain a termination was secured by constitutional amendment later in 1992. However, since 1992, a number of legal cases have challenged this right. Most recently, in the D case in 2007, the state unsuccessfully attempted to prevent a pregnant seventeen-year-old in its care from getting a passport: she had expressed a wish to terminate her pregnancy because the fetus had anencephaly. In both instances, then, the right to travel was upheld by the courts.

The X and D cases, as well as the failure of a constitutional effort to further restrict women's mobility rights in 2002, have relied in part on assumptions about, and interpretations of, mobility as a right for all pregnant Irish citizens. It is possible to understand these developments as highlighting the progressive possibilities afforded by mobility rights for Irish women—after all, the right to be an abortion tourist is guaranteed by the 1992 constitutional amendment. In this way, "abortion tourism" may suggest choice and possibility, in the manner of other forms of medical tourism. Yet such an interpretation ignores the differentiated politics and mutual constitution of mobility and gender in Ireland. Women differently located within contemporary Ireland's socioeconomic hierarchies experience this mobility in different ways. While every Irish woman has the right to travel, not every Irish woman has the means to do so. A trip to Britain for a termination is expensive. It involves travel costs, accommodation costs, and the cost of the procedure, estimated at between 965 and 1,750 euros in total in 2005 (FGS Consulting and Boyle 2005, 14); it may involve taking time off work; and it may also involve secrecy and lies if the woman feels she will be stigmatized for taking this action. The burden of cost is placed on the woman, who in some instances may not be able to shoulder it—some women have to resort to illegal moneylenders to pay for an abortion. Because women have "won" the right to travel, the Irish state has been excused from any responsibility to provide safe, legal, and affordable abortion services in the years since 1992. The publication of a (discussion only) Green Paper in 1999 and a Constitution Progress Report in 2000 represent the state's only foray into these issues.[5] In the meantime, Irish women are forced to pay the emotional and financial costs of traveling to the United Kingdom to secure an abortion—to become "abortion tourists."

[5] A Green Paper is a government report on a proposal to change the law that does not hold any commitment to action.

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However, the pregnant female body moving over international borders is interpreted as problematic and deeply threatening to the Irish state, even when pregnant women travel *to* Ireland. Indeed, the only pregnant women who have guaranteed mobility rights are pregnant Irish women. For other pregnant women either living in Ireland or traveling to Ireland, these rights are far from certain. Citizens of EU nations can move freely between Ireland and Britain, but other nationalities do not have this ease of movement. For example, a Chinese woman living legally in Ireland as a student has to apply for a UK visa to travel to Britain and then needs a reentry visa to return to Ireland. There is no guarantee that she will be granted either one. An undocumented woman living in Ireland does not even have this option. Since abortion is also illegal in Northern Ireland, she has no legal means of accessing abortion services on the island of Ireland. From time to time, Irish newspapers report on backstreet abortions, and Irish service providers believe that women without the option to travel are using backstreet abortion services (Human Rights Watch 2010). There have also been attempts to restrict the mobility of pregnant women traveling to Ireland, labeled "citizenship tourists" by an Irish government minister (White and Gilmartin 2008, 393). A series of Supreme Court decisions and the Twenty-seventh Amendment to the Constitution (known as the Citizenship Referendum, passed in 2004) reorganized Irish citizenship around the principle of bloodline rather than place of birth (see White and Gilmartin 2008). The change in citizenship law was framed as a means of preventing pregnant women from traveling to Ireland with the express purpose of obtaining Irish citizenship for their soon-to-be born children. Pregnant African women in particular have reported verbal and physical assaults when traveling to Ireland (Shandy and Power 2008).

We see, then, how mobility rights for pregnant women in Ireland are contingent on nationality, class, and race. The protection of (some) women's right to travel is at the expense of a more general right to medical treatment in a woman's country of residence. This paradox is at the heart of the latest challenge to the Irish state's policy on abortion. Three women (known as A, B, and C to protect their identities) have made submissions to the European Court of Human Rights that they have suffered discrimination and that their human rights have been breached because they were forced to travel out of Ireland to have an abortion.[6] Their reasons varied,

[6] See the Irish Family Planning Association's "Abortion in Ireland: Media Briefing Document," London, December 7, 2009, available at http://www.ippf.org/en/News/Press-

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from being at risk of an ectopic pregnancy (applicant B) to difficult personal circumstances (applicant A). It remains to be seen how this latest challenge will fare, but it lays bare the fact that "abortion tourism" is a masculinist construction, the result of (rather than resistance to) Irish patriarchy. One of the three women taking their case to the European Court of Human Rights (applicant C) is a Lithuanian national. As a labor migrant from an EU-10 country, her move to Ireland was facilitated by an immigration policy that was constructed around the needs of the Irish economy and labor market.[7] These immigration policies have ignored the complex needs and motivations of female migrants, who often weigh both reproductive and productive labor demands in their migration decisions.

Mobility rights in the context of Ireland are highly differentiated. This becomes very clear in the context of abortion tourists, a group that only includes women who are Irish nationals or citizens of another EU member nation and who have the means to travel outside Ireland to access abortion services. Their discursive framing as tourists links them to other medical tourists with the ability to travel and pay for treatment. However, the use of the term "tourism" to describe their journeys is not unproblematic, since many women "routinely experience unnecessary risk, stigma, shame and anguish" (Human Rights Watch 2010, 10). Yet the differentiated nature of mobility rights becomes even clearer in the case of women living in Ireland who—whether because of nationality, immigration status, or class—cannot access abortion services elsewhere. The framing of Irish women's right to travel as a victory of sorts masks the ways in which these rights come at the expense of the well-being of others; it displaces the broader question of access to abortion services across international borders. Rather than a proliferation of political possibilities, the Irish experience shows how mobility rights become a means of creating and enforcing social distinctions and challenges the discursive construction of medical tourism as universally positive.

Department of Geography
National University of Ireland, Maynooth (Gilmartin)

Department of Geography
University College Cork (White)

releases/Landmark+Irish+abortion+case+to+be+heard+by+European+Court+of+Human+Rights.htm.

[7] EU-10 refers to the ten countries that joined the European Union on May 1, 2004. Ireland has allowed EU-10 nationals unrestricted access to its labor market since that date.

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I

Fertility Tourism: Circumventive Routes That Enable Access to Reproductive Technologies and Substances

Sven Bergmann

Jeanne Moulin traveled from France to an in vitro fertilization (IVF) clinic in Barcelona in order to have implanted two cryopreserved embryos that had been left over from another IVF treatment.[1] She ex-

[1] All names used are pseudonyms. I use the acronym IVF here as a metonym for all reproductive technologies.

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