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Biopolitics and neoliberal reconfigurations of the medical care system in Sfax (Tunisia)

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EDITOR'S NOTE

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Introduction

1 Tunisia has been welcoming numerous foreign patients to its medical facilities since the 1990s. What is referred to as the export of medical care takes place within dense exchange networks comprising a diversified and high-quality medical offer (Lautier, 2008). Largely concentrated in the country's major cities, this dynamic is above all an urban product that developed thanks to Tunisia's historically strong public health system. While the associated infrastructures are distributed throughout the country, it is in the urban areas boasting a Faculty of Medicine and a university hospital that the highest number of private medical services can be found (Jarraya and Beltrando, 2013). Foreign patients thus tend to converge much more on the country's private medical practices and clinics than on its hospitals and public clinics. The majority of foreign patients in Tunisia come from neighbouring countries, notably Libya, with patients from Western countries and from West Africa representing only a marginal percentage of the global numbers (Lautier, 2013).

2 As such, and at first sight, these mobilities fall within the framework of medical tourism. Patients seeking short-term medical care in a foreign country do indeed come under a dynamic that can be described as "tourism" (Hopkins *et al.*, 2010). Nevertheless, within the media framework of medical tourism, with its emphasis on North-South movements and the competitiveness of Southern countries, particularly in the field of cosmetic surgery, the reality of these exchanges is concealed. The geographical

literature that has examined the spatial framework of medical tourism shows that patients tend to travel much more within cross-border spaces. Additionally, this fact questions the "desirable" nature (Cazes, 2005) of medical mobility given that it is often more of an obligation than a choice for patients who do not have easy access to or an efficient healthcare infrastructure in their own country. The lack of possibilities in Libya, for example, causes large numbers of the country's nationals to seek medical care in Tunisia, while populations living in Southern Algeria are geographically closer to the clinics in Sfax than to those in their own country (Rouland and Jarraya, 2020). However, two phenomena in particular are relatively little discussed in this literature: the urban nature of medical mobilities is poorly documented, with the result that the offer is also little studied. Yet it seems to us that this medical offer, primarily private in the case of Tunisia, makes it possible to understand the strategies deployed by the stakeholders involved and the governance associated with the reception of foreign patients. This system governs bodies and their (im)mobilities (Lapointe and Coulter, 2020), and questions the concept of governmentality as developed by French philosopher Michel Foucault (Hardt and Negri, 2013). Our observations led us to a biopolitical interpretation of the situation. Understood as the administration and regulation of human life at the level of the population and the individual body (Foucault, 2004), biopolitics enables us here to contextualise both ordinary practices and the macro framework having supported their development.

3 Our study focuses on the private medical sector in Tunisia, in particular in the city of Sfax, the country's second largest demographic and economic hub. Our survey was conducted between 2018 and 2022 with investors and managers of private practices and clinics in Tunis and Sfax. We quickly extended our study to all the stakeholders, both formal and informal, participating in this economy. Our methodology was thus based on semi-directive interviews integrating a biographical component. Retracing the career path of the individuals interviewed, we reconstructed their increasing interest and subsequent investment in the private medical sector before questioning them about their strategic and political insight into this sector, their relationships, and the economic and political framework governing their practices. Within this context, we paid particular attention to the discourses employed to describe and justify the practices of our respondents. In all, forty interviews were conducted with physicians, twenty with stakeholders in the paramedical field, and ten in public establishments. Finally, we used observation when we investigated the informal sector, often very difficult to access. The interviews were first conducted separately in French and in Tunisian Arabic. These were completed by additional interviews conducted together and involving a mixture of both languages. Access to the respondents was facilitated thanks to the snowball effect, targeting specific categories of medical establishments. We then proceeded to code the interviews and cross-reference the quantitative variables with the data provided by the establishments, approaching their representatives when we wished to compare the scale of the data collected from the private sector.

4 The aim of this paper is to demonstrate the relevance of recourse to the biopolitical framework in defining the contours of medical tourism.

5 We first review the theoretical discussion surrounding medical tourism and the potential contributions of the concept of biopolitics. Our discussion is then elaborated in two stages. Firstly, it is based on the empirical observation that tourism practices

develop on the fringes of medical services. While non-dependent on the mass tourism infrastructure, we show that these practices fall within a form of production of desire for the city of Sfax, aimed at Libyan patients in particular. This first analysis, centred on the stakeholders involved, demonstrates how they are part of a commercial dynamic between the medical and non-medical structures of private services. The second part of our discussion aims to link these observations to the broader context of the neoliberal restructuring of the Tunisian State since the presidency of Zine El Abidine Ben Ali and his fall from power in 2011. At the heart of this analysis is the history of the healthcare infrastructure, from its planning by the State to its later privatisation. We show that the biopolitical framework and the evolution of "technologies of power" offer a transcalar understanding of the Tunisian case and, finally, make it possible to generalise its relevance within the framework of medical tourism.

I. Medical tourism: a much-debated concept given the transnational reality of health mobilities

6 As a number of authors have pointed out, health and tourism issues have long been linked, with thermal cures, spas and other wellness services punctuating the history of tourism (Corbin, 2010).

7 The issue of medical tourism first appeared in economic literature to designate the global mobilities related to the availing of healthcare services in a foreign country. The concept took hold within a context of growth in international trade and the commodification of healthcare. Lauded as a vector of growth stimulating the local economy through its externalities, medical tourism is above all perceived and defined in terms of its media coverage (Ormond, 2019).

A. From medical tourism to transnational care spaces

8 Medical tourism is primarily perceived as a global market within which the countries of the South attract patients mainly from the North in search of less expensive medical care. In addition to offering treatments at a lower cost, the tourism argument especially refers to the pre- and post-operative periods, which are supposed to be spent in the host country and which can include more traditional tourism services (Hopkins *et al.*, 2010).

9 Nevertheless, one of the facts highlighted in studies that have examined these exchanges is that what patients primarily seek is geographical and, more especially, cultural proximity. As the medical field is highly standardised, patients prefer to be treated by practitioners with whom they share a set of values and in whom they have confidence (Connell, 2013).

10 This situation is conducive to the creation of more and more exchanges between neighbouring countries with sometimes very unequal economic and social realities. For example, while Thailand and Malaysia receive patients from all over the world, the majority come from other Asian countries, notably Laos and Myanmar (Bochaton and Lefebvre, 2018). Similar situations can be noted between South Africa and its neighbouring countries (Crush and Chikanda, 2015). These studies show a much higher intensity of South-South movements than North-South movements.

11 Moreover, these socio-economic imbalances between neighbouring countries highlight the existence of facilities that are considered to be insufficiently equipped, too far away or, for those countries with the poorest infrastructures, having excessively long waiting times. Libya and Tunisia are a case in point. Under the leadership of Muammar Gaddafi, Libya developed thanks to the redistribution of oil revenues and without major investments in the health and education sectors, unlike Tunisia (Abdelaziz, 2021). The deficit in the offer causes Libyans to seek specialised medical care in Tunisia or Egypt (Lautier, 2013; Rouland and Jarraya, 2020). In Tunisia, Libyans represent more than 80% of the foreign patient population (Lautier, 2008). While these figures have not been updated recently, they do correspond to statements made by the managers we interviewed.

12 Medical mobilities, which are significant in these situations, demonstrate a quasi-dependence by the populations on the neighbouring country, in much higher proportions than for distant populations who come for the supposed comparative advantages. In the patients' decision-making process, constraints weigh much more heavily than freedom of choice. In health geography studies describing these phenomena, the general consensus is to use the term "medical/therapeutic mobility" – tending to take place within "transnational care spaces" (Rouland, 2016; Whittaker, 2015) – to replace "medical tourism" (Bochaton, 2015), which today is considered too limited a notion.

B. From a limited literature on the offer and urban infrastructure to a biopolitical response

13 As Ormond (2018) points out, however, medical mobilities, in addition to taking place within cross-border spaces, mostly converge on urban centres. These centres boast a medical infrastructure that is sufficiently developed to receive foreign patients on a regular basis in addition to the local patient population. Behind the macro framework, some authors call for a more detailed description of the practices observed within this context, once the patients have arrived in the host structures (Connell, 2016).

14 In addition to the diversity of urban practices, we add to these proposals the need to visit the medical care establishments receiving these foreign patients. Indeed, the existing literature being primarily interested in the patients, we wanted to reverse the prism through which this subject is considered by taking a closer look at the framework established by the stakeholders behind the offer.

15 It is this shift from demand to supply that led us to suggest a biopolitical framework. According to Foucault, biopolitics is the way in which power structures have rationally managed human beings throughout history. Biopolitics questions the ways in which power is exercised over humans, with a resulting work on the establishments that embody this "governmentality" over individuals and their bodies. Considering that medical care establishments constitute a "technology of power" over individuals (Foucault, 2004), if only by their necessary recourse to this infrastructure, it appeared relevant to us to link the issue of biopolitics to the debate on the definition of international medical mobilities. Our problematic raises issues of the mobilities of individuals between territories for both (geo)political and economic reasons. Moreover, the mobility and immobility of bodies, as much as the major place of hospitals within the territorial structure, are central theses in the production of biopolitical theory

(Campbell and Sitze, 2013). It thus seemed obvious to us to link Tunisian medical practice to these issues.

16 Without discussing the place of private infrastructures in the power exercised over humans or in its production of normality (Hardt and Negri, 2013), biopolitics proposes a theoretical framework that enables a better understanding of the complexity of the phenomena observed and of their qualification as a form of medical tourism. Additionally, tourism can be perceived as a phenomenon that oscillates between regimes of constraints or desires centred on bodies, their mobility responding as much to a political and moral framework as to a framework of the structuring of space (Minca and Ong, 2016). Moreover, the production of tourism spaces is not necessarily the product of voluntarist or mass policies. Market logics can produce a perceived value of a region that is disconnected from its material reality (Lapointe and Coulter, 2020). Within this context, neo-liberalism represents the appropriate economic and political medium for the development of informal tourism economies, with the State restructuring itself to protect the market by organising the conditions necessary for its operation, particularly within urban contexts (Pinson, 2020).

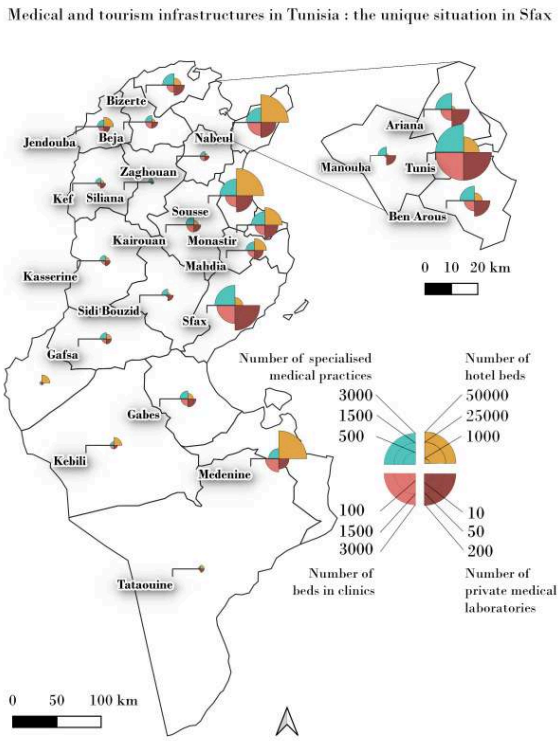
17 We therefore use the issues of governmentality here as a transcalar prism through which to examine both the daily and ordinary practices of this sector as well as the major structural trends that govern its functioning. Discourses on and practices in the city of Sfax as well as the medical economy provide a diversity of points of view on this subject, testifying to the semantic possibilities that can be used to qualify this phenomenon.

II. The urban resources of Sfax as a medium for medical tourism

18 Through its presence in urban areas, the private medical ecosystem draws on the city's resources. The development of new practices resulting from these urban opportunities, also related to the specific context in Sfax, constitutes our first argument, empirical in nature, in favour of medical tourism. We show that these practices are as much the product of their environment as of external stakeholders. The aesthetic framework of the medical offer in Sfax, as well as the less orthodox religious practices in Tunisia, contribute to "creating a desire" for this city built on its medical economy (Gerbal-Medalle, 2020). The city's resources combined with its aesthetic and cultural setting thus place the medical practices observed within a framework compatible with tourism.

A. Stakeholders and conditions for the emergence of the healthcare market in Sfax

Figure 1: Map comparing medical and tourism infrastructures



Annual Report on Infrastructure Indicators. National Institute of Statistics (INS), Tunisia, 2018.

19 The cities of Tunis and Sfax concentrate the medical infrastructure necessary for the reception of foreign patients, ahead of Sousse-Monastir and Djerba. While the latter two cities represent Tunisia's main hotel and tourism destinations, Sfax has only a very limited hotel accommodation offer, despite being the country's second largest economic and demographic hub. Essentially reliant on business tourism, its hotels are not very active compared to the complexes built further north along the Sahel coastline (Annual Report on Infrastructure Indicators, INS, 2018).

20 A gap therefore exists between the private medical sector and the tourism sector, and raises the issue of the urban resources necessary for the development of an activity of this nature and the registration of foreign patients in the city.

21 Where physicians are concerned, Sfax boasts the only Faculty of Medicine in the south of the country as well as its three main university hospitals. By concentrating medical students in this centre, Mounir Jarraya and Gérard Beltrando (2013) show that young graduate physicians remain in the urban area to work, both in the public sector and in their own practices. Sfax also boasts a nursing school that provides qualified and inexpensive human capital for the private medical sector. The local clinics take on the majority of young graduates pending their recruitment in the public structures.

22 Moreover, setting up a private practice is a laborious and risky process for physicians with little training in management. This crucial stage of their career is largely facilitated by the resources that the city of Sfax offers for young specialist physicians. Indeed, with a significant number of property opportunities and adapted financial and real estate products, the city provides a globally favourable environment for the liberal professions.

> Physician #26 – "Once you have your degree, you apply to the Board of the College of Physicians. Then you find an apartment, preferably on the lower floors. You have to check that no-one is already offering your speciality in the building. At the beginning it's very difficult, you have to advertise your services, purchase your equipment, find your first patients. I was well known after three years."
> Banker #2 – "We granted FONATRA loans [author's note: public guarantee fund] and leasing loans for a car, all equipment, etc. I offered them a loan, a personalised service. I specialised in doctors. I advised at least 300 doctors over my career, only private practices."

23 Where the creation of a clinic is concerned, the entire urban legal system is designed to facilitate matters. Moreover, projects concerning the construction of private practices grouped together within medical centres or clinics are a means for the families of the Sfaxian bourgeoisie to increase the value and profitability of their real estate assets or property capital. We observed first-hand several projects of this nature, in which the practices were perceived as both a real estate product and a guarantee of the financial viability of the project. In addition to ensuring the sale or rental of the property, the practices have tended to reinforce the development of new activities around them. The growing medical centres are gradually becoming full-service patient care platforms. Given the high profitability involved in renting out accommodation located in close proximity to private practices and clinics, some groups of physicians have begun to design more ambitious medical centres to combine all the services that patients should have at their disposal during a medical stay.

> Clinic General Manager #1 – "A medical centre is going to be built on this land. We intend to build a kind of medical residence. On the one hand, for the accommodation of family members accompanying the patients and, on the other, for those patients who require convalescence. We find it more advantageous to keep patients within their family environment. I'm currently taking the time to discover what the situation is elsewhere to help me decide whether I want individual rooms or whole apartments, for example."

24 Nevertheless, the majority of Libyan patients prefer a rental system offering large living areas, in line with their family accommodation requirements. Within this context, the hotel sector proves to be anything but competitive, as a whole apartment accommodating ten people can be rented for the same rate as a double-occupancy room in a hotel. From our observations, the rates charged by lessors ranged from 50 DT to 100 DT per night depending on the size and the level of standing of the apartments, compared to an equivalent price for a hotel room accommodating only one to two people.

25 Such services are offered by stakeholders that operate on the periphery of or even completely outside the medical sector, and who ensure that patients can benefit from all the services related to their stay. These stakeholders generally fall into two categories: Libyan ambulance drivers and Tunisian *samsara* or "go-betweens".

26 The ambulance drivers have become real experts in crossing the border and avoiding checkpoints on the Libyan territory (Sebei, 2017). In addition to medical evacuation, their knowledge networks make them key players in the mobility of Libyan patients coming to Sfax. Their expertise ranges from recommending a specific practitioner or a clinic to acquiring a SIM card, finding accommodation both for patients and any accompanying persons, and ensuring food provisions. This expertise is complemented by the commercial skills acquired through experience in prospecting several patients at the same time and working closely with the clinics.

> Clinic Financial Director #5 – "The ambulance driver is the one who deals with the family. It's important that he develops this relationship because he's also the interface with the doctor, the nurses. Sometimes he is the only point of contact for the family, whom he can also occasionally take along with him. He buys medicine for the patient, or telephone credit!"
> Field notes following a visit to an apartment renter in Sfax – "Twelve ambulance drivers work with him. They regularly bring him patients and their families. The ambulance drivers are also lodged in a small room he has set up on the ground floor of his building."

27 The COVID-19 health crisis also revealed the importance of the ambulance drivers in maintaining this transnational medical activity. Holding permits authorising them to cross borders that were closed during the pandemic, they also took on the role of smugglers, moving various goods and services back and forth across the border in addition to the transport of patients.

28 The *samsara*, "go-betweens" in Tunisian Arabic, have emerged as a result of the very large concentration of medical practices in the city centre. Libyans, used to coming to Sfax since the 1990s, have become very visible in these areas, as evidenced by the large numbers of their vehicles parked along the city's main avenues and in its public car parks. For more than a decade, the presence of families sometimes desperate to find medical care for one of their family members has attracted people who have been excluded from the job market as a result of the economic difficulties experienced under the dictatorship and the Tunisian Revolution.

> Physician-investor #18 – "You see, the intermediaries create the need. Not for medical care, in that respect the Libyans don't have a choice. Rather, for a whole package that goes beyond treatment. You can tell him that he wants to go out partying, find a prostitute, and so on."

29 These actors have become institutionalised in the medical districts and now form part of the social and economic landscape. In return for a percentage payment, as described in our interviews with physicians, they direct patients – who are in theory free to make their own choices – to one or more specialists, clinics or laboratories, as these activities cannot exist within the same establishment. By recourse to luring and manipulation techniques, they render the patients captive by immediately offering to provide them with everything they could possibly need during their medical stay. The intermediary will find accommodation, take care of parking or groceries, purchase a SIM card, and handle luggage. More recently, the *samsara* have strengthened their offer to meet the growing number of whole families accompanying Libyan patients. "Package deals" have thus been developed for these family members and include numerous services ranging from making a hairdresser's appointment to providing information on venues offering alcohol or even prostitutes.

B. Behind the informality, a moral and aesthetic framework at the service of the desire for Sfax

30 The geopolitical crisis that Tunisia has suffered due to the instability in Libya since 2011 – not to mention the COVID-19 health crisis between 2020 and 2022 – has raised the awareness of all these stakeholders. While the physicians reject the presence of the ambulance drivers and *samsara*, considered as "intruders", they nevertheless recognise their usefulness and the frequent recourse to their services.

31 To address this issue of informality, other stakeholders have appeared in recent years, explicitly offering to organise medical stays by means of intense promotion online and at an international level (see Figure 2). Although these companies are also managed informally by one or two people at most, they seek to reassure a hypothetical patient base from the North or from Sub-Saharan Africa.

32

Figure 2: Screenshot of the hamicalmedical.com homepage

hamicalmedical.com

33 In view of these modalities, we believe that the urban nature of medical mobilities encourages the emergence of tourism practices. The increasing shift of physicians towards a wider medical infrastructure, with the help of intermediaries seeking to maximise the gains made possible by the presence of Libyan patients, testifies to the process of commodification of the medical sector. Thus, both the physicians and the intermediaries reproduce a desire for the Sfax area that extends beyond the perceived quality of its medical care. This desire is also materialised within a moral framework that is more flexible than in Libya, with the authorisation of certain practices (alcohol and prostitution) considered deviant there, while nonetheless providing a conservative cultural framework oriented towards the Muslim religion. Finally, the architecture and toponyms linked to the private medical infrastructures represent a form of rupture with the Tunisian modernist aesthetic. The latter glorifies the figures of independence, whereas the private sector tends to employ distant historical references, anchored in Carthaginian or Aghlabid heritage. Some establishments built in a sober style in the 1990s were thus renovated in the 2010s in line with this new aesthetic standard (see Figure 3).

Figure 3: (From top left to bottom right) “Mahsouna” medical complex (feminine noun for beauty); “Chams International” polyclinic (“sun” in Arabic); “Ibn Khaldun” polyclinic and medical centre (Arab philosopher of the Middle Ages, born in Tunis).

Author photographs

34 The case of Sfax demonstrates that the export of medical care is not limited to the strict practice of medicine by caregivers. Rather, it depends on a wider social, economic and moral ecosystem that has recourse to stakeholders outside medical practice. The integration of the medical care market into the rental market and the extra comforts offered by intermediaries testify to an offer geared to the Libyan demand, which finds in Sfax a specific and adapted territorial “desire” (Cazes, 2005).

35 These various activities are facilitated by the urban resources possible in Sfax, an emerging metropolis boasting significant air, road and sea connections (Bennasr, 2006). Sfax has long operated a narrative of independence with respect to the centrality of Tunis, and fully claims its commercial and entrepreneurial heritage. Within this context, the city can be seen as the vanguard of the neoliberal reconfigurations that Tunisia has been experiencing since the 1990s. These were particularly accelerated by the Revolution in 2011, the fall of the dictatorial power, and the advent of a democratic government.

III. The medical system at the heart of the neoliberal reconfigurations of the Tunisian State

36 Tunisia’s independence in 1956, led by Prime Minister Habib Bourguiba against the French protectorate, occurred within a context of an alliance between the urban intellectual bourgeoisie and the nationalist forces. It was by capitalising on the support of these liberal fringes of the population that the country’s future first president was

able to build the strategy founding the Republic of Tunisia. As part of a process of urbanisation of the population and rising living standards, health and education constituted two of the political pillars of the first decades of the regime (Bessis, 2019). Industrialisation and the need for a growing workforce pushed the Tunisian State to discipline bodies through the promotion of a strong health and education infrastructure, before gradually observing a transition towards a neoliberal structure.

A. Disciplinary biopolitics: the construction of the independent Tunisian State

37 This historical perspective sheds light on how, initially, the Tunisian State provided the country with schools and hospitals with the biopolitical objective of disciplining the working-class body in accordance with the imperatives of production (Domin, 2018). Governmentality through this system also integrated a broad reclassification of dilapidated urban areas through social housing production policies (Ben Fguira, 2020).

38 In short, and to continue in Foucauldian terms, the Tunisian State adopted a technology of disciplinary power (Foucault, 2004) to meet these challenges. Moreover, democratic expression was marginal in this Republic subject to its victorious separatist leader. The economic bourgeoisie was brought to heel and remained largely excluded from the political bodies until 2011 (Hibou, 2008).

39 The Tunisian public medical sector was then broken down into a hierarchical structure distributed throughout the country, with the public clinics constituting the last level and the university hospitals being concentrated in the country's few large urban centres (Achour, 2011).

40 Following the same movement, the Tunisian tourism infrastructure developed under the direct control of the State with the creation of urban tourism centres. By targeting mass Mediterranean tourism, the State operated similar logics by disciplining bodies of tourists through tour itineraries and restricted areas, notably in Sousse, Monastir and Djerba (Miossec, 1996).

41 The disciplinary biopolitics of the Tunisian State also produced major disparities through its disinvestment in the country's interior. At the end of the 20th century, the level of infrastructure throughout Tunisia was very uneven. Sfax, while still the country's second largest demographic and economic hub, was gradually marginalised by a government that was more centred on Tunis and the Sahel. Its infrastructure was undersized, and it suffered from a lack of investment on the part of the State in such promising sectors as tourism (Signoles, 1985) (see Figure 1). By leaving major gaps in local biopolitics, the central State effectively left Sfax in the hands of its bourgeoisie, which progressively took over the land and production opportunities to its advantage (Bennasr, 2003). While mostly absent from the heavy industrial sector controlled by the State, the bourgeoisie was very involved in agriculture and increasingly in the services sector. Through these areas, the dominant class produced and reproduced a discourse of merit, centred on work and the entrepreneurial identity of the city's population. This discourse, which presaged a control over bodies dominated by the obsession with sacrifice in the face of work, emerged in almost all our interviews, whatever the social status of the respondents.

42 When Ben Ali overthrew Bourguiba in 1987, he was faced with structural difficulties and, under pressure from international agencies, began a vast neoliberal restructuring of the entire State apparatus. While privatising and massively deregulating entire sectors of the economy, this former intelligence officer strengthened the State's political and biopolitical control mechanisms (Hibou, 2006). We observe here a paradigm shift in State governmentality, from a post-socialist strategy to a State guaranteeing good market conditions, under the good governance of its dictatorial apparatus. The disciplinary society gradually gave way to a society of control through market standards, changes that were all the more necessary within a context of submission to the IMF and World Bank agendas. As such, the imperatives of production were less guided by the centrality of the State.

B. The transition to the market economy and the society of control

43 Within this context, the medical sector proved to be a catalyst for these transformations. The 1990s were thus also marked by the rise of private medical practices in Tunisia. By discovering the possibilities offered by setting up practices and clinics, physicians, who already represented a very powerful professional body in the country, gained access to much higher remuneration than in the public sector.

44 Moreover, the lack of foreign patients treated by the public health sector was a biopolitical fact. As Libyan patients are only partially covered by "logics of productive adequacies with bodies" (Domin, 2018), it was much more logical for the private sector to take charge of their requirements. The development of private medical practices was thus concomitant with their arrival in Sfax (Jarraya and Beltrando, 2013).

> Physician #21 – "The younger generation [author's note: doctors] are arrogant, they don't care at all about the moral standards of the older generation. The medical oath is sacred, normally trade is prohibited in medicine. I see these gigantic signs promoting a doctor, it's not normal!"

45 Private practices developed massively in Sfax in the 1990s, supported by the resources described above. The first groups of shareholders (initially from the financial sector and then from the medical sector) invested in the first clinics opened with Tunisian capital. By freeing themselves from the public infrastructure while nevertheless retaining a place there for their reputation and the poaching of a clientele selected from among the public sector's patients, the physicians progressively produced a two-tier offer. This distinction between bodies treated positioned itself within the logic of the biopolitics of control through a governmentality creating a rapprochement with the colonial era, with medical establishments such as the Clinique Meignié in Sfax reserved for settlers. The dominant categories extracted themselves from the public sector, which was sometimes perceived as violent, slow, or involving too much red tape. This transition occurred at the cost of the commodification of medical resources and the imperatives of profitability. It was within this context that large numbers of Libyans began to seek medical treatment in Sfax, with its infrastructure calibrated to their needs and that avoided saturating the public sector in Tunisia.

46 This commodification also conferred a financial aspect on the medical economy and produced a diversification in the offer or the portfolios related to the medical establishments, the latter backed by a real estate company or a family holding company investing more widely in the health sector (laboratory, pharmacy), especially

considering that investments in the medical sector are only little regulated by law. Investors are thus not obliged to belong to the medical profession, and the health map, which regulates the establishment of public medical facilities, does not concern private establishments. Private clinics also have recourse to accreditation companies, the legitimacy of whose conclusions is called into question for some of them.

> Physician-investor #12 – "The problem is that these paid accreditations are a scam! They just have an office in Paris, you call them, you pay them and they give you the certificate. No, what is needed is independent experts, from the State. We implemented this process here, but out of all the clinics that applied, only two in Sfax obtained the 80% necessary for accreditation!"

47 The urban space itself also constitutes a weak regulator since, apart from the value of building land, few standards govern the location and size of private health establishments. It is not uncommon for pressure to be exerted on the municipality to authorise the coefficients provided for in the city's Urban Development Plan to be exceeded.

48 Finally, the Tunisian Revolution in 2011 completed the process of transition from the disciplinary State to market control. Biopolitics extended to the borders, widely opened after the fall of the dictatorship. Informality started to be seen in many fields. The business community stormed the political bodies as soon as the seats were vacated (Kchouk, 2017). Stakeholders on the fringes of the medical sector took refuge in these niches of opportunity made possible by the arrival of foreign patients, while entire economic sectors put thousands of Tunisians out of work, pushing governmentality to its paroxysm through *El Khobza* ("bread" in Tunisian Arabic, a way of euphemising the legitimisation of informal economic practices) (Meddeb, 2012).

49 The inclusion of the history of the Tunisian medical sector in the process of privatisation, coupled with the territorial specificities of Sfax, allows us to structure the practices that we observed in the field with the development of a biopolitical framework. The evolution in governmentality explains the conditions of their implementation and the gradual acceleration of market logics in the medical sector as a witness to the profound transitions in Tunisian society. Biopolitics shows that the informality of practices not developed by the State within a tourism framework that it governs nevertheless represents a form of tourism, this tourism offer being developed through the neoliberal reconfiguration of governmentality.

50 The patient-caregiver relationship is thus placed at the heart of the logic in which one meets the needs of the other within a framework defined by market conditions, themselves dependent on the broader reconfigurations mentioned above. It is no longer a case of a response by the State to the problems of managing productive bodies, but rather of a relationship between a physician-investor and a patient-client. It is the emergence of this relationship that leads us to reconsider the transnational care space between Libya and Tunisia as a tourism space. Moreover, the terms "client" and "patient" were often used interchangeably during our interviews. While some respondents used only one or the other for the sake of consistency in their discourse, others employed both depending on the context or the question asked by the interviewer.

Conclusion

51 The development of the medical care export economy in Tunisia is based on a private infrastructure. Clinics and medical practices represent the core of this activity which attracts a patient base from neighbouring countries, notably Libya. Through its presence within both an urban context and a neo-liberal political framework, this economy has progressively responded to specific needs for its patients, outside of medical practice alone. The place of medical tourism within this context appears relevant, even though the literature that has studied these medical mobilities demonstrates that "tourism" is too narrow a framework for understanding them. However, we have noted that this criticism is based on a reading at the scale of transnational spaces and focused on the patient experience. By observing the dynamics of the offer within an urban context, we propose an interpretation that ultimately favours the emergence of a specific form of medical tourism in Sfax.

52 The practices observed and the multiple stakeholders involved show that medical care, a constrained requirement for patients, forms part of an economic and social process of "desire" for the city of Sfax. This city offers a moral framework and services specifically sought after by patients and their families. Moreover, the privatisation of the offer pushes the stakeholders towards logics of profitability and the standardisation of a patient-caregiver market. This privatisation falls within a context of neoliberal transition of the structure of the Tunisian State. A biopolitical perspective offers a theoretical framework for understanding both the specificity of the governmentality of bodies within the medical economy and the macro framework that supports the emergence of this market.

53 The medical care system is thus a witness to the reconfiguration of the biopolitics of the State and of Tunisian society. In the final analysis, the figures of the patient-client and the physician-investor show that the material framework described in health geography is indeed that of a constraint. Nevertheless, insertion in market logics nuances the place of these stakeholders within the production of standards and, ultimately, outlines a form of medical tourism.

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ABSTRACTS

The reception of foreign patients in Sfax (Tunisia) in exclusively private healthcare facilities raises questions about the place of medical tourism in patient-caregiver relationships. While medical tourism is a decried notion, it is above all part of an economic and globalized vision of health exchanges. Mobilities for medical reasons are local and constrained rather than chosen, within a global market. However, the case of Sfax shows that medical tourism is also a specific governmentality, constructed by supply and demand, outside the standards of mass tourism. First of all, informal practices surrounding care produce a form of "desire" for Sfax, also embedded in the neoliberal context surrounding the development of this activity. This gives the biopolitical reading a transcalar and analytical force of the phenomenon of medical tourism, within transnational care spaces.

INDEX

Keywords: Tunisia, biopolitics, medical tourism, transnational care space, mobility, geography

AUTHORS

THÉO MAURETTE

Théo Maurette is a PhD student with the UMR 5194 PACTE Joint Research Unit at Grenoble Alpes University. Covering the fields of health geography and urban geography, his thesis examines the relationship between the city of Sfax and its private medical care system.

SAMI BEN FGUIRA

Sami Ben Fguira holds a PhD in Geographical Sciences from the Faculty of Arts and Human Sciences at the University of Sfax. A postdoctoral fellow at the SYFACTE laboratory, his work focuses on evolutions in ways of living, housing policies and social housing in Tunisia.