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Global therapeutic mobilities and cancer: a scoping review

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ABSTRACT

Introduction Research on therapeutic mobility is abundant but the field of cancer has not yet been investigated thoroughly. This scoping review aims to examine the existing evidence on global therapeutic mobility and cancer, providing a comprehensive overview of the subject.

Methods We conducted a scoping review and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses methodological guidelines. We developed a comprehensive search strategy and discussed it with the research team. We searched for peer-reviewed papers on Medline, Embase, ERIC and American Psychological Association via the Dialogue interface and Google Scholar and CAIRN bibliographic database for peer-reviewed articles. We also included grey literature, such as unpublished work and relevant reports from Érudit. We considered studies that employed quantitative or qualitative methods.

Results Among the 1615 references initially selected, 767 duplicates were excluded. Then, 849 studies were screened on title and abstract and 800 were excluded as they did not meet inclusion criteria. 49 studies were fully screened and 21 were excluded as they did not meet inclusion criteria based on full-text assessment. Ultimately, 28 references were included in the data synthesis. This scoping review has shown that publications on therapeutic mobilities have multiplied in recent years, with a turning point in 2019. A range of academic disciplines and research methodologies are currently employed to describe them. A significant proportion of fieldwork is concentrated in Asia, Africa, Europe and North America. Despite the heterogeneity of the approaches and fields, there are certain common features that emerge: first, the decision to migrate for healthcare is primarily made by the patient themselves and is perceived by them as being non-choice; second, the family plays a central role at all stages of the migration; and third, the migration has a catastrophic impact in terms of social and financial burden.

Conclusion In conclusion, this scoping review highlights the underexplored relationship between global therapeutic mobility and cancer, emphasising the need for increased research efforts to understand the global dynamics of cancer care mobility.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study followed Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines to ensure methodological transparency and consistency.
⇒ The search strategy was developed collaboratively and applied across multiple international and regional databases.
⇒ Inclusion and exclusion criteria were pretested and refined by five independent reviewers.
⇒ Data extraction and quality assessment were performed by multiple researchers using validated tools (mixed methods appraisal tool).
⇒ The restriction to publications in English and French may have led to the omission of relevant studies in other languages.

INTRODUCTION

Since the 2000s, there has been an intensification of mobility of patients around the world.[1–4] On the quest for effective treatment, as well as for economic and social reasons, more and more patients find themselves crossing national borders for very different types of treatments and medical procedures, such as surgery (cosmetic, dental, cardio, orthopaedic and bariatric), in vitro fertilisation, transplantation (organ and tissue) and cancer treatment.[5–8]

Recent research shows that the worldwide prevalence of cancer has been rising steadily over the past 20 years. The increase in the number of cancers is particularly strong in the under-50s: with 3.26 million cases detected in 2019, tumours rose by 79% in the last 30 years in this age group.[9] With new world-class private hospitals in cities across the global south, many cutting-edge medical treatments, such as oncology, are becoming affordable and accessible to more people.[10] Some specific locations are emerging as pivotal hubs, bringing cancer treatment into a global market where patients are mobile participants.

Therapeutic mobilities can be defined as movements of persons (as nurses, doctors and patients), of things (as pharmaceuticals or gifts) and of concepts (as narratives

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or information and diagnosis).[11] The circulations of patients at different spatial levels (cross border, regional and transnational) reveal the huge geographical disparities in the availability of care provision and, more broadly, the health inequalities between countries. The patients involved in these movements come from a wide variety of backgrounds, and the distances covered vary greatly, from a simple border crossing in a neighbouring country to a trip to the other side of the world. While many studies document the movement of patients from the north to the south, there is also a growing number of studies showing that healthcare mobility occurs within the global south.[11–15] These international medical travels lead to numerous health, economic, social, ethical and emotional challenges.[16–18]

While it is undeniable that since the 2000s, therapeutic mobility has greatly increased,[1] establishing categories of migrants for care and defining these categories is often complex.[19 20] Among the different terms found in the literature, 'medical immigration',[19] 'medical tourism',[6 21–25] 'therapeutic mobility',[26] 'medical exile',[27 28] 'transnational therapeutic itineraries',[2] 'transnational healthcare',[5 29] 'cross-border patient mobility'/'cross-border healthcare',[30 31] 'transnational health'[32] and 'medical travel'[11 18 33] exist and reveal the diversity of lived experiences. Among this mobility, a distinction must be made between formal movements (ie, organised medical evacuations occurring between states, medical referral system and outsourced patients) and informal movements (in which patients leave on their own), and sometimes a combination of both.

In this scoping review, we have chosen to use the term therapeutic mobility because we believe that it encompasses a wide range of experiences. We will look at the mobility of people (patients and carers) as well as the mobility of knowledge and things (eg, equipment and medicines). Even though research on therapeutic mobility is abundant, the field of cancer has not yet been investigated thoroughly.[10] As a result, little is known about what drives some patients to leave, how they choose where to go, what networks and resources they mobilise, the facilitators and the obstacles they face and the financial and social implications of these mobilities. This scoping review aims to examine the existing evidence on global therapeutic mobility and cancer, providing a comprehensive overview of the subject.

METHODS

Study design

We conducted a scoping review since it allows us to capture the broad nature of the research question and we followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses methodological guidelines (online supplemental appendix 1).[34]

Study design

The following question and statements guided the scoping review: what do we know about therapeutic mobility in the field of cancer? We sought to identify the areas and countries studied; the authors and institutions involved; the disciplines and methodology used; the types of cancer studied; the study focus: circulation of patients, health professionals and/or things; the stages of the mobility (departure, travel process and/or arrival) and the quality of the data published.

Identifying relevant studies

One investigator (AD) developed a comprehensive search strategy (online supplemental appendix 2) and discussed it with the research team. We searched for peer-reviewed papers on Medline, Embase, ERIC and American Psychological Association via the Dialogue interface and Google Scholar and CAIRN bibliographic database for peer-reviewed articles. We also included grey literature, such as unpublished work and relevant reports from Érudit. We considered studies that employed quantitative or qualitative methods.

To be included, the references had to meet the following criteria. (1) The text is written in French or English. (2) The papers relate to the international therapeutic mobility as we have defined it in the field of cancer (including all stages of cancer that is, diagnosis, treatment, follow-up and palliative care, but not screening in the general population as we wanted to focus on diagnosed cancers). (3) Studies must present empirical data (literature reviews were, therefore, not included). (4) The full text is available. (5) Studies have been conducted between 1 January 1998 and 5 February 2025 (when the comprehensive literature search was performed). We have excluded articles dealing with the health of migrants and articles dealing with national mobility (ie, within a country). The distinction between migrant health and therapeutic mobility was sometimes difficult to make and required reading the entire article to be sure it met the selection criteria (people who migrate to access healthcare).

Study selection

We included any published, preprint or grey literature in English and French that explored cancer and therapeutic mobility. Five investigators (CS, LP-L, AB, MB and EB) searched and screened the studies by titles and abstracts and then reviewed the full texts of potential studies using Covidence software. Five investigators carried out an initial test with 20 articles drawn at random from 844. This enabled us to reach a collegial agreement on the inclusion/exclusion criteria and to draw everyone's attention to points of confusion, such as the health of migrants.

The reference lists of the included studies were screened for relevant studies. Any questions around study eligibility were resolved through consensus between the five investigators. Editorials, commentaries, letters to the editor and reviews that did not involve primary data were also excluded.

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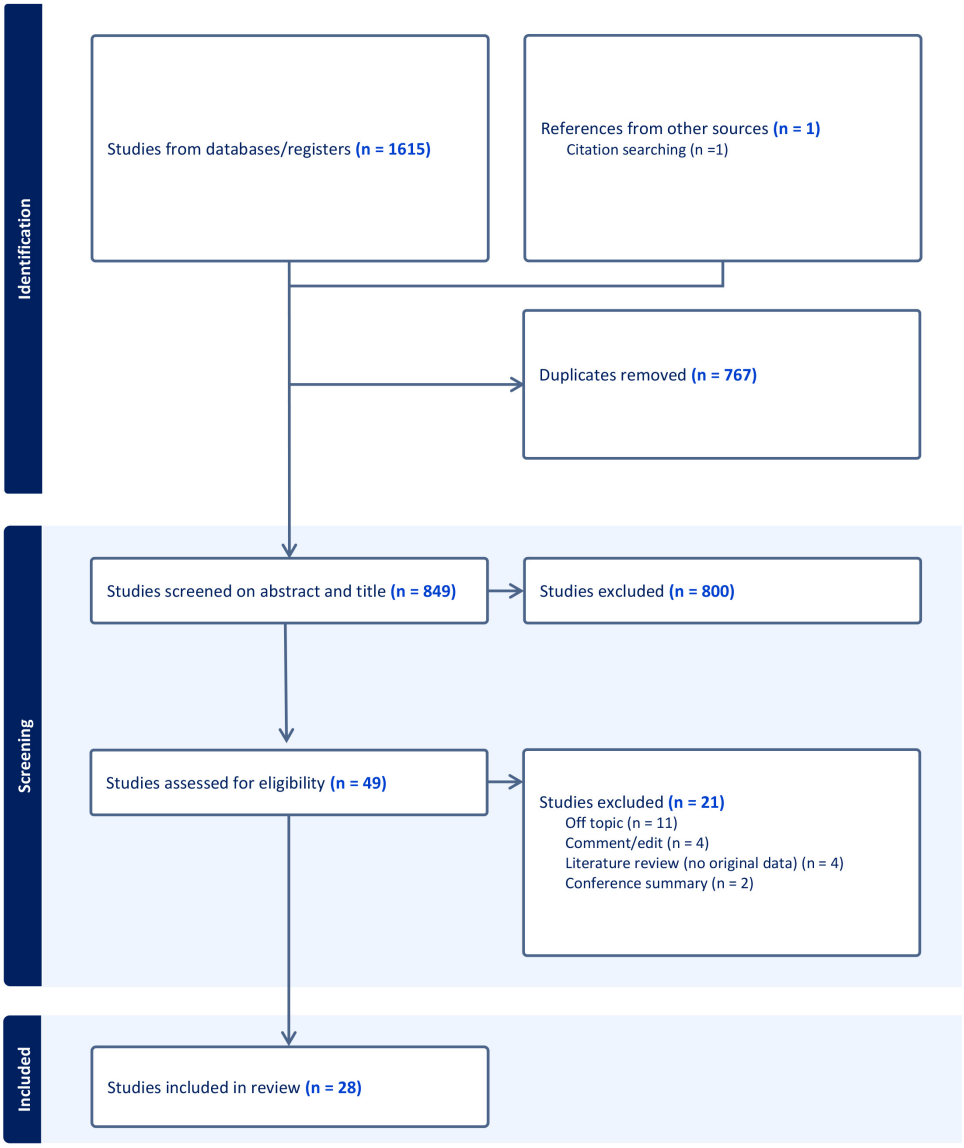


Figure 1 Flowchart.

Data analysis

Three reviewers (CS, SB and AB) developed a data extraction table form that the research team later discussed and agreed on. The three reviewers extracted data from included studies. The data extraction form included the authors' names, year of publication, journal, method, exclusive focus on cancer, type of cancer, country involved in circulation, type of circulation, stage of circulation described, lack of technical facilities in the country of origin, financial, administrative and linguistic problems and the influence of the family. We used a thematic content analysis using narrative descriptions of the extracted data.

Quality assessment

All included articles were independently assessed for methodological quality by three reviewers (CS, SB and EB). We used an adapted mixed methods appraisal tool (MMAT) for quality assessment.[35] This tool is suitable to be used in qualitative, quantitative and mixed method reviews, as it shows substantial validity and reliability. The MMAT used in our evaluation contained three sets of criteria: (1) a qualitative set for qualitative studies and qualitative components of mixed research; (2) an observational descriptive set for observational descriptive quantitative studies and observational descriptive components of mixed methods research and (3) a mixed methods set for mixed methods research studies. Each study type was judged within its methodological domain. For each criterion, the evaluation was based on three response modalities: yes, no and do not know. 'Yes' means that the criterion has been met. 'No' means that the criterion is not met. 'Do not know' means that there is not enough information to assess whether or not the criterion has been met.[36]

RESULTS

The electronic search strategy identified 1615 records through database searching (figure 1). One reference

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Figure 2 Countries mentioned in articles included in the scoping review. Sources: World Bank (2023); SENOVIE Research Project (2025).

was added from another source (citation screening). Among these 1616 references initially selected, 767 duplicates were excluded. Then, 849 studies were screened on title and abstract and 800 were excluded as they did not meet inclusion criteria. 49 studies were fully screened and 21 were excluded as they did not meet inclusion criteria based on the full-text assessment. Ultimately, 28 references were included in the data synthesis. Online supplemental table 1 presents the characteristics of the 28 studies included. The MMAT's assessment of the quality of the articles shows that only ten articles pass all the quality criteria, and in general, whatever the method used, the quality of the articles evaluated remains limited. Overall, articles using quantitative methodology are of higher scientific quality.

We found 28 articles addressing therapeutic mobility and cancer, reflecting the low level of interest among academic researchers and/or funders. However, the issue has recently gained more attention. Online supplemental table 1 shows that 2019 marks a pivotal year for publications on this topic: while 9 articles were published in 20 years (1998–2018) and 19 articles were published in the last 6 years of our systematic review (2019–2025).

Spatial disparity: research fieldworks concentrated in Asia, in Europe and in Africa; authorship concentrated in northern regions

In order to categorise countries into north and south, we used the list of economies—World Bank Classifications[37]—Income classifications established on 1 July 2022. We have classified low-income countries (LIC), lower-middle-incomecountries (LMIC) and upper-middle-income countries (UMIC) as Southern countries and high-income countries (HIC) as northern countries.

Figure 2 shows the countries mentioned in the articles included in the scoping review. Fieldwork was conducted mainly in Asia (n=7),[10 38–43] Europe (n=7)[19 44–50] and Africa (n=6).[47 51–55]

Research in Asia includes fieldwork documenting patients arriving in India,[10 39] arriving in Thailand,[38 42] arriving in Pakistan,[41] arriving in Taiwan,[43] arriving in Japan,[40] leaving Lao PDR[38] and leaving Afghanistan.[41] Asian countries represent both departure and arrival points, and represent also arrival points in India, for example, for patients from Africa.[51] Only one article[56] tackles mobility from China to North America.

In Europe, the majority of articles deal with patients coming to metropolitan France for treatment (n=6).[19 44–49] The profile of Ukrainian patients with cancer in Poland is explored in the other fieldwork in Europe.[50]

The scoping review identified six articles documenting therapeutic mobility for patients with cancer with fieldwork in Africa.[47 51–55] Five documents on outgoing mobility: one globally from sub-Saharan Africa and the others more specifically from Benin, Kenya, Réunion and Madagascar.[47 51 52 54 55] One article documents incoming mobility in South Africa.[53]

North America (n=4)[56–59] presents the cases of border mobility between USA and Canada and between USA and Mexico[58 59] and destinations for some Southern countries like China[56] and Liberia.[57] The issue of access

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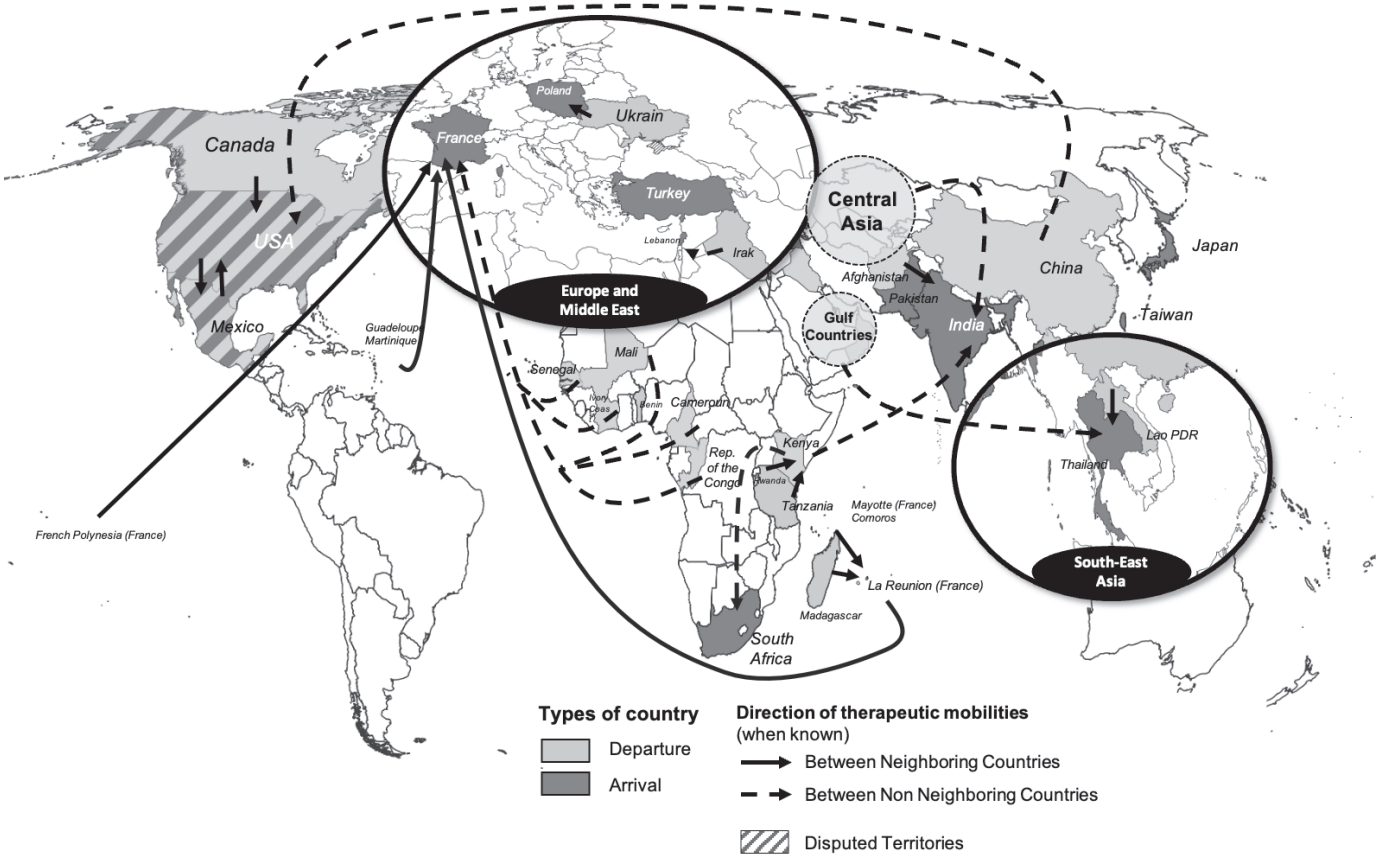


Figure 3 Directions of therapeutic mobilities. Sources: World Bank (2023); SENOVIE Research Project (2025).

to healthcare for Latino immigrants in the USA and the issue of cross-border healthcare between Mexico and the USA are well documented, but did not meet the strict inclusion criteria for the systematic review on therapeutic mobility because they mostly documented the health of migrants living in the country prior to their cancer diagnosis. With the exception of the article by LaPelusa *et al.*,[59] which focuses specifically on Mexican patients seeking cancer care in the USA and North American patients seeking cancer care in Mexico. Apart from Mexico, no Latin American country is mentioned in our review. Only one article studies global mobility in the whole world: a survey conducted in 153 countries to estimate how many patients travelled abroad for the treatment of retinoblastoma[60] (figure 3).

Finally, 20 research fieldworks are located in Southern countries (LIC, LMIC or UMIC) and 16 research fieldworks are located in northern countries. Despite this, most of the articles were published by a first author based in an institution in a high-income country (n=19).[10 19 40 42–50 56–62] Figure 4 shows the country of academic affiliation of the authors of the articles. Only three articles were published in an upper middle-income country (Iraq,[63] South Africa[53] and Thailand[38]). There are also only six articles whose first authors are from low-middle-income countries (India,[39] Pakistan,[41] Kenya,[51] Madagascar,[52] Benin[54] and Rwanda[55]). The main countries conducting this research are France (n=7)[19 44–49] and the USA (n=4).[56 57 59 62]

Diverse disciplines and methodologies used in research on therapeutic mobility

The disciplines and methodology vary considerably from one article to another. For example, there are papers with an anthropological approach, using participant observation and formal and informal interviews to question the categories of 'medical tourism' and 'therapeutic immigration' and the terms to be used to describe these mobilities.[19 45] There are also quantitative epidemiological articles, such as the one carried out in Kenya on patients with cancer to identify the factors that lead patients to stay or go for treatment in India.[51] In total, 16 articles used a quantitative methodology,[38–41 44 47 48 50–52 54 55 58–60 62] 11 a qualitative methodology[10 19 42 43 45 46 49 56 57 61 63] and 1 a mixed methodology.[53]

Research focused almost exclusively on cancer

Except for four papers,[42 47 54 62] all studies[10 19 38–41 43–46 48–51 53 55–61 63 64] focus specifically on cancer and do not consider other reasons for care or surgery. Among the four studies investigating various medical reasons for therapeutic mobility, one examines all international patients seeking treatment at a private hospital in Turkey and shows that the primary reason for their arrival is the demand for oncology services.[62] Another paper examines nine families of patients from the Gulf States who were met in a hospital in Bangkok.[42] These were 'outsourced' patients evacuated by their

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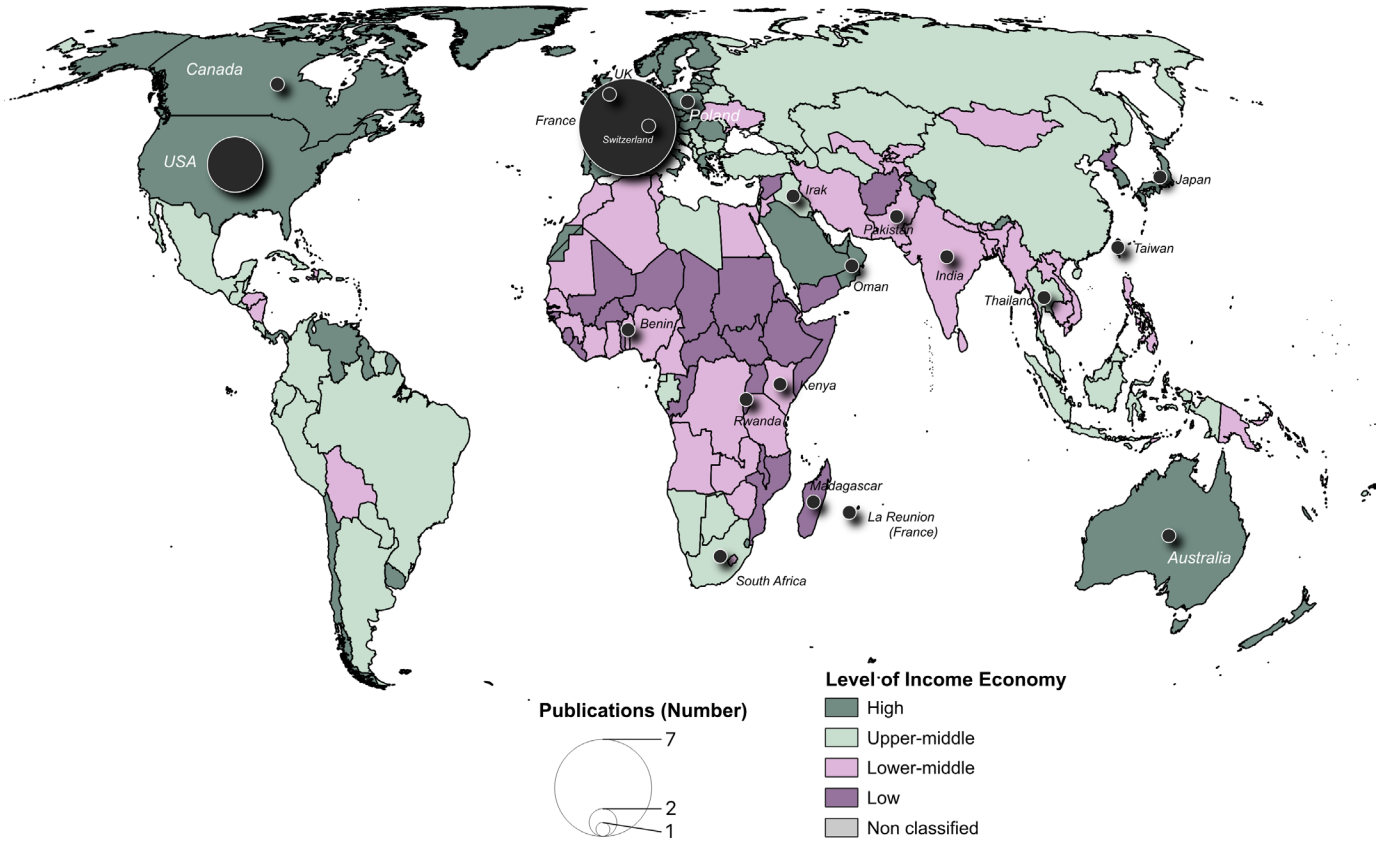


Figure 4 Concentration of scientific publications on global therapeutic mobility and cancer. Sources: World Bank (2023); SENOVIE Research Project (2025)

governments or insurers through contractual arrangements to a hospital in another country for treatment. Three out of these nine families were evacuated because of cancer. Another study documented all the medical evacuation indications from Benin to France between 2006 and 2010 and showed that the indication of scintigraphy and radiotherapy concerned 229 evacuated patients, that is, 29.8% of all cases.[54] Finally, a single-centre, retrospective study documents all paediatric medical evacuations to mainland France that took place between 2015 and 2019 from the paediatric oncology and haematology department in Réunion.[47]

The majority of studies focus on various cancer types

Most of these publications deal with all types of cancer (n=17),[10 38–43 50–52 54–56 59 61–63] although some deal with female cancers (n=2),[19 45] breast cancer specifically (n=2),[46 53] cervical cancer (n=1),[48] cancer in children, adolescents and young adults (n=1),[44] paediatric cancers (n=1),[47] breast and prostate cancer (n=1),[58] head and neck cancer (n=1),[57] retinoblastoma (n=1)[60] and haematological cancer.[49]

Emphasis on patient movement and variety in patient profiles

All the articles included in this scoping review focus on patient mobility. None were found on the other types of mobility (eg, healthcare professionals and medical equipment). However, while the majority interviewed patients or medical records directly, four interviewed health professionals about patient mobility. These health professionals were, therefore, asked about patient mobility (rather than their own mobility, eg, for training purposes). In Lai *et al*.'s article,[43] 19 healthcare professionals were surveyed regarding the movement of patients seeking medical treatment at a hospital in Taiwan, and the effect of this patient mobility on their professional practices was examined. Another study interviewed 52 oncologists, surgeons and any other physicians from 17 African countries to gain knowledge on the prevalence and patterns and to understand providers' perspectives of cancer medical tourism in Africa.[55] By interviewing 66 Mexican oncologists, LaPelusa *et al*.[59] documented the type of care that patients with cancer living in the USA and Mexico seek outside their home country, the reasons why patients travel across the border to receive care and the barriers they face when seeking cross-border care. Finally, for triangulation purposes, Franchina *et al*. interviewed health professionals in France, as well as patients and their families coming from Reunion island.[49]

In the articles focusing on patients, a variety of economic and social contexts as well as administrative and legal situations are being examined: some are refugees or live in countries facing armed conflict.[41 50 63] One article[39] looks at patients with cancer coming to India for treatment and shows that three quarters of patients come from low-income countries, and that 86.4% of patients reported moderate to extreme financial distress. Among

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them, 304 (35%) patients said that they had sold off their land/house, ornaments and other assets; the other 447 (51.4%) patients received returnable/non-returnable financial assistance from friends, relatives, colleagues or money lenders.[39] On the other side, some articles document the journey from patients with a higher socioeconomic status.[51 61] We will go through these points below.

Two categories of therapeutic mobility: autonomous and state-organised medical evacuation

The present study has revealed that medical evacuations organised by states (n=7)[42 47–49 52 54 58] are less documented than autonomous mobilities (n=21).

In 21 of the selected papers, the patients themselves chose to go abroad for treatment, even if their choice was structurally constrained by the context. In the other seven studies, mobility is offered by the government or hospital where the patients are cared for. This is the case, for example, of an article[58] that looks at patients in a hospital in Southern Ontario, Canada, who have breast or prostate cancer and are evacuated by the hospital to northern Ontario or the USA for cancer radiation therapy. Other papers study patients evacuated from a Gulf State (GCC) to Thailand for treatment,[42] from Benin to France,[54] from Reunion island to metropolitan France,[49] from overseas France to metropolitan France[48] and from Madagascar to another country, with France topping the list of countries to which these Malagasy patients were evacuated for cancer treatment (44%).[52] The majority of mobilities are, therefore, independent, decided by the patients, but also very often by the family.

Incoming mobility and mobility from one country to another are the most documented

Although cross-border mobility is found (n=5),[38 41 50 58 59] the majority of integrated studies focus on long-distance mobility (n=21)[10 19 39 42–44 46–49 51 52 54–57 60–64] and sometimes both (n=2).[40 53]

On the whole, the majority of the articles document mobility specifically from one country to another (n=12)[10 38 41 42 47 49–51 56 58 59 63] but also inward mobility with a specific point of arrival in a single country with different countries of origin (n=11).[19 39 40 43–46 48 53 57 62] For example, regarding incoming mobility, Gaudichon *et al*.[44] describe care given to children, adolescents and young adults who came to France for cancer treatment and search to determine whether their geographical origin had an influence on decision making.[44] Of these 11 articles dealing with incoming mobility, 3 of the points of arrival were constituted by a middle-income country (Turkey, India and South Africa[39 53 62]), and 8 by a high-income country (Japan, France (n=5), Taiwan and USA[19 40 43–46 48 57]). Regarding articles documenting the mobility of patients specifically from one country to another (n=11), Chaleunvong *et al*. aim at determining some of the parameters of the cancer burden in Lao PDR by analysing records from a University Hospital in Northeast Thailand.[38] Among these 11 articles, 6 articles document south–south mobility[10 38 41 42 51 63]; 3 articles document north–north mobility[47 50 58] and 2 articles document patient mobility from south to north (from China to the USA[56] and between Mexico and USA[59]). Apart from that, one article looks at outward mobility from a country in the north (Oman[61]) and one article covers 153 countries on the basis of a disease (retinoblastoma[60]). Thus, incoming mobility mainly concerns northern countries, while mobility from one country to another mainly concerns south–south mobility (figure 3).

All stages of mobility captured in the selected papers

More than one-thirds of the articles describe the three different stages of mobility (departure, journey and arrival, n=12),[10 39 46–50 53 54 57 58 63] while one-thirds describe only one specific stage (arrival, n=4[38 40 41 62] or departure n=5)[51 52 55 59 61] and one-thirds describe two different stages (departure and arrival (n=4)[19 43–45]; departure and journey (n=2)[42 60]) and journey and arrival (n=1)[56]).

Data on departure relate to the description of health facilities in the country of origin, such as the existence of a radiotherapy machine, the cost of treatment, having started treatment before departure or administrative difficulties. For example, Ludet *et al*. document the long delays for sub-Saharan African women in obtaining visas to enter France, leading to delays in treatment.[46] Sarkar *et al*.[39] describe the conditions and reasons for the departure of patients arriving in India: the need to sell off land/house, ornaments and other assets before departure; the returnable/non-returnable financial help from friends, relatives, colleagues or money lenders; the different issues in the home country like unreliable medical practice or insufficient cancer or (and) radiotherapy facilities; and available instruments and inadequate training of the healthcare providers, high treatment costs and/or social stigma related to cancer in the home country. Data regarding the journey could be related to the travel time and cost.[39] On arrival, the data are most often related to the stage of the cancer and the treatment in place, for example, the article from Chaleunvong *et al*.[38] reported that the most common types of treatment received by the patients travelling from Lao PDR to Thailand for cancer were supportive care from family and relatives (27.3%), surgery (26.5%), radiation (23.3%) and chemotherapy (19.5%).

Therapeutic mobility and armed conflicts

Three articles look at the therapeutic mobility resulting from armed conflict: patients from Afghanistan seeking treatment in Pakistan,[41] patients from Iraq seeking treatment in Lebanon[63] and patients from Ukraine seeking treatment in Poland,[50] highlighting the disastrous indirect effects of armed conflict on civilians. These three articles show that conflict-related deficiencies in healthcare at home are forcing patients with limited financial resources to seek cancer treatment in neighbouring countries, and that this is a phenomenon distinct from medical tourism.

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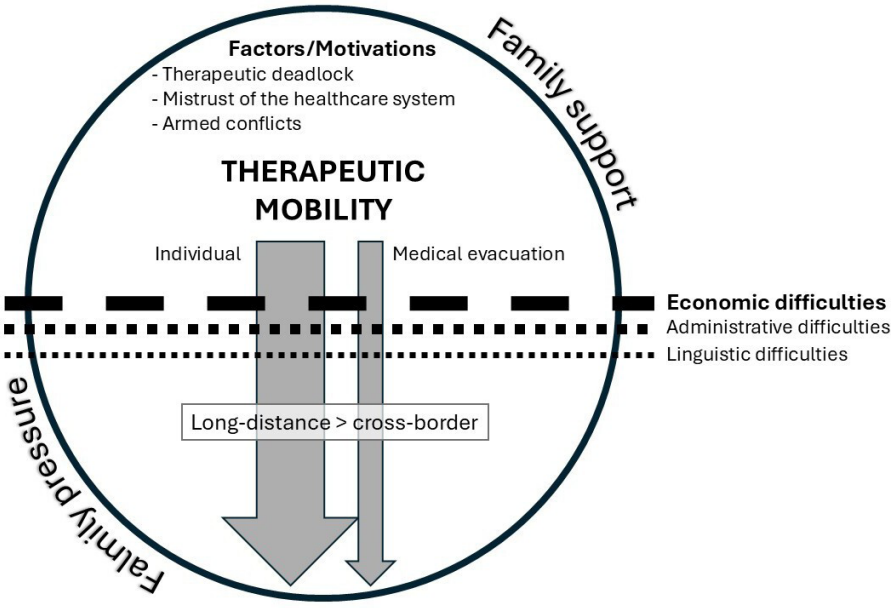


Figure 5 Conceptual framework—therapeutic mobility: key drivers, difficult pathways and the power of family support.

Limited access to essential treatments: moving to survive

Our conceptual framework (figure 5) provides a schematic of the key thematic findings from the articles included in the scoping review. As explained above, the range of therapeutic mobility types is evident across the articles; however, patterns and models that are particularly salient can be identified in the majority of articles, irrespective of the study area and mobility type.

Apart from the situations of armed conflict (n=3),[41 50 63] the same factor triggers therapeutic mobility: patients encounter significant obstacles in obtaining adequate cancer care within their own country. The restricted access to vital but resource-intensive treatments such as radiotherapy, in addition to a shortage of skilled healthcare professionals, often engenders a lack of confidence in the local healthcare system (n=24).[10 19 38 39 41–44 46–49 51–56 59–64] The notion of choice in relation to therapeutic mobility is highly contested because of these structural constraints faced by patients. Kaspar's work demonstrates that the notion of 'choice' often entails the arduous process of information collection and evaluation, the onerous responsibility of decision-making and potentially significant biographical transitions, such as migration to be proximate to loved ones or the relinquishment of educational prospects in favour of remunerative employment to cover the costs of therapeutic interventions.[10]

Mobility associated with economic and administrative burdens

Once the mobility has been initiated, the paths are not straightforward. The patient and the family (whether the family remains in the country or also migrates) go through many difficulties or obstacles. The difficulties are mainly economic and administrative. Sarkar *et al.* show how many patients and their families exhaust their finances in the process of coming to India, leading to lifelong financial hardship.[39] Among Iraqi patients coming to Lebanon, Skelton *et al.* show that the cost of treatment far exceeded monthly household incomes, forcing patients to sell homes and property, with 90% of respondents reporting high levels of financial hardship.[63] The economic burden of this healthcare-related mobility is mentioned in 22 articles.[10 19 39 41–44 46 47 49 51 53–60 62–64] Difficulties in obtaining a visa are often the cause of administrative difficulties. These visa issues have been mentioned in France,[19 44] Taiwan,[43] Pakistan,[41] Lebanon,[63] a country in Central Asia[10] and USA.[59] Not understanding the language of the country of destination can also be a major problem, although some patients choose to migrate to a country where they speak the same language. In their article describing the lived experience of patients with haematological cancer who undergo therapeutic mobility between Réunion Island and mainland France for treatment, Franchina *et al.*[49] clearly demonstrate that state-organised medical evacuation does not entirely protect patients from the financial and administrative burden of this mobility.

At all stages of mobility, the family is present

In all stages of therapeutic mobility, family protects and surrounds the patient. The patient goes through the treatment, but often the relatives or carers play a buffer role by carrying out administrative procedures, collecting money and sometimes providing translation. The significant role of the family is mentioned in 20 articles.[10 19 38–44 46 47 51 53 56 58 60 61 63 64] With regard to the international travel for the treatment of primary retinoblastoma, Bowman *et al.* explain that families often seek treatment that is not available in their home country at any cost and will raise money from any source to do so.[60] Kaspar demonstrates that the patient migrates, but that it is a collective endeavour in which the family plays a central role and suffers enormously.[10] Although travel offers patients the

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chance to save their lives, 'there is a considerable human toll for patients and their families'.[42] Family caregivers who accompany patients abroad have to drop everything for several months, including their personal lives and potentially their jobs, resulting in a loss of income.[49]

DISCUSSION

This scoping review has shown that publications on therapeutic mobilities have multiplied in recent years, with a turning point in 2019. A variety of academic disciplines and research methodologies are currently employed in an attempt to provide a comprehensive description of the subject. Fieldwork is concentrated in Asia, Europe, Africa and North America. Despite this diversity of approaches and fields, certain common features emerge: they are essentially autonomous mobilities, perceived by patients as a 'non-choice', the family plays a central role at all stages of the migration, and this migration has a catastrophic impact in terms of administrative, social and financial burden.

South–south migration: Asia a hub for international medical travel

In terms of research areas, one of the main findings is the importance of south–south mobility, which seems to be perfectly in line with the migration work of recent decades, in which the phenomenon of south–south migration in the world is considered to be of paramount significance.[65 66] Moreover, over the past few decades, private healthcare providers in the global south have increasingly positioned themselves as competitors to those in the global north, attracting patients dissatisfied and marginalised by domestic healthcare systems.[14] Among the countries studied, the dominance of south and Southeast Asia highlights the early development of a medical travel industry in the late 90s–early 2000s. This matches with the Asian economic crisis when several countries sought to use excess capacity in their private health sectors and develop new sources of export earnings. In Thailand, Malaysia, Singapore and India, governments endorse and promote medical tourism by implementing policies, easing regulations and providing infrastructural support for private hospitals to expand their international patient markets.[67] This explains why some Asian countries are considered the biggest players driving international medical travel in affordable and high-quality care.[7] Nevertheless, there is a growing pool of Africa's middle class who have the financial means to undertake international medical travel whether in Asia or more recently in South Africa where the market is expanding. Therapeutic mobility requires further investigation across cross border and transnational scales and across all continents to better understand its scope, evolution and health, economic and social implications.

Financial issues and human challenges of therapeutic mobility

Despite the diversity of settings, methods and approaches in the included articles, the financial drama caused by this therapeutic mobility is ubiquitous. At the level of the individual patients and families, therapeutic mobility can impose severe financial burdens on middle- and lower middle-class families, often leading to resource depletion and deepening social inequities. These catastrophic expenditures, also called financial toxicities,[55] warrant further investigation to assess the multidimensional impoverishment caused by therapeutic mobility: economic but also the human cost of long-distance and long-term travel for loved ones left behind. The central issue of inequalities must be systematically addressed. In departure countries, there are inequalities between mobile and immobile patients, who are excluded and marginalised by a failing health system. In host countries, particularly those with neoliberal governments that support international medical travel as a means of economic growth, there are significant inequalities in care between wealthy international patients and local populations. This can sometimes lead to a two-tier medical system within a single country.[68 69] Scholars and policymakers should, therefore, give more attention to hierarchies and power imbalances created by therapeutic mobility.

The need for research into the mobility of oncology caregivers on a global scale

Although we had included the movement of people, things and concepts in our search, we only found articles dealing with the movement of patients. This exclusive focus on patients confirms that the movement of health professionals is still largely invisible. And yet, in many parts of the world, this mobility is a major public health issue, as it is at the root of the circulation of practices and protocols, the new attractiveness of certain medical centres and also the shortage of health services. Therefore, there is a great need for research into the therapeutic mobility of oncology caregivers and, more broadly, into health professionals and pharmaceuticals.

Conclusion

In conclusion, this scoping review sheds light on the underexplored intersection of cancer and therapeutic mobility. Despite patient mobility having increased globally since the 2000s, particularly in pursuit of advanced medical treatments, including cancer care, scholarly attention to this phenomenon remains limited.

This scoping review is simply a reflection of what has been published on this subject. However, it clearly identifies two types of therapeutic mobility: medical evacuations organised by states and mobility undertaken independently by patients. The latter attracts greater interest among researchers. Nevertheless, this scoping review also reveals that all types of therapeutic mobility cause suffering for patients and their families due to significant financial and administrative difficulties.

This research contributes to a deeper understanding of the complex dynamics of cancer care mobility, highlighting the need for collaborative efforts with healthcare professionals, stakeholders and communities to address

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the multifaceted challenges of providing global cancer care. However, most of the studies published are isolated and of limited quality. We encourage larger, broader studies with robust methodology to document these types of mobility in a world where movement is only increasing.

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