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Draft Paper

Routed in Migration: Health, healthcare and mobilities in Asia

Contextualising medical travel in Asia

Medical travel from the Global North to the Global South continues to dominate the discourse of transnational mobilities for healthcare. The research in the domain of health and wellness-related travel is usually split across two disciplines, social sciences and tourism (Kemppainen et al., 2021). Studies on South-South or intra-regional medical travel continue to be underrepresented despite accounting for most health-seeking journeys across the globe. Although there has been a recent interest in studying South-South medical travel, especially in the contexts of Asia, Africa and South America, the literature continues to highlight the need for more evidence on the phenomenon from the patient's perspective, their motivations, decision-making, and safety.

In the early 2000s, when research on medical tourism began with a singular focus on patients travelling from the advanced and rich economies of the US and Europe to Asia for elective medical treatments along with 'sun, sand and the scalpel', the phenomenon was seen entirely from a business and tourism perspective (Connell, 2006; Turner, 2007). Many of the 'medical tourists' could not afford expensive elective treatments in their own countries, as in the case of the United States. In the European context, long wait-time for non-emergency medical treatments compelled patients to travel across borders. The moment was seen as a perfect opportunity for countries in Asia, particularly who were post-liberalisation in a position to offer 'First world services at third world prices '(Turner, 2007) mainly through the up-and-coming chain of corporate hospitals which had world-class medical technology, medical experts and professionals and services offered at a fraction of the cost in the US or Europe. National governments in these countries also saw this as an

opportunity to maximise profits and foreign earnings and designed policies to encourage medical tourism.

However, as the interest in medical tourism grew across disciplines, the phenomenon was exceedingly critiqued for its packaging of health inequalities and a neoliberal capture of a basic necessity like healthcare under the garb of 'tourism'(Qadeer & Reddy, 2010; Roberts & Scheper-Hughes, 2011; Sengupta, 2010). This critique of medical tourism opened a pandora's box of medical journeys, which did not conform to the conventional North-South flows of the so-called medical tourists. Scholars explored intraregional and South-South movements for medical care and other movements of medical treatments, bodies, organs, and experiments, among many other illegal/legal ways in which all things biomedical travel across the world.

South Asia has been central to the discourse on medical tourism and, increasingly, medical travel primarily because of its importance within the geographies of transnational medical care. In the last decade or so, the inflow of medical tourists has contributed significantly to the economies of many south and south-east Asian countries, and the governments have promoted medical tourism through attractive visa policies and other provisions to welcome health and wellness seekers from around the world.

Despite the recent spurt in medical travel research in the South-South context, little knowledge exists about intraregional medical care within the subcontinent. Except for the media coverage of Pakistani or African children getting heart transplants, we know little about the constant trail of medical travellers coming from the global south to India. In the Asian context, however, research on southeast Asia and transnational health-seeking behaviour has been studied in detail and tends to reveal themes and concepts which can be used to unpack interregional medical travel in the context of South Asia as well. In this paper, I attempt to untangle how more specifically, in the south Asian region, intraregional medical migrations and the many migrations of labour are intertwined, medical travel as rooted and routed in migration.

This paper emerges from my ongoing doctoral research on internal migration for healthcare in India, through an ethnographic study in New Delhi. While the participants for the larger

study are migrant and low-income Indian patients seeking healthcare in public hospitals in Delhi, during fieldwork, it was not uncommon to meet and interview patients and their caregivers who were transnational travellers for medical purposes. Their trajectories of care, experiences and everyday negotiations with infrastructures of mobility and healthcare form the core of this paper.

Emerging themes and trends in medical mobility studies in Asia

More than 80 per cent of medical tourists coming to India are of South Asian origin (Connell, 2011). South-South medical travel is not only growing rapidly but challenges conventional North-South models of the phenomenon. In the context of South Africa and its neighbouring countries, Crush & Chikanda (2014) argue that a vast majority of cross-border patients seeking healthcare in South Africa are what Roberts and Scheper Hughes (2011) refer to as 'poor and medically disenfranchised persons" who are "desperately seeking life-saving drugs and therapies and corrective surgeries that they cannot get at home" and are far removed from the 'sun, sand and surgery' discourse which seemed to dominate medical travel. India has been a medical hub in South Asia for long. Rahman (2000) estimated more than a decade ago that some 50,000 Bangladeshis annually were satisfying their medical needs in the neighbouring Indian state of West Bengal alone. These were largely lower-/middle-middle-income consumers that had money to travel to India but, unlike their upper-class compatriots, not enough for more 'desirable' destinations like Singapore or Thailand.

Contrary to common belief about lack of availability at home and cost differentials constituting the principal drivers for medical travel, only 15% of his respondents travelled to India because treatments were not available in Bangladesh and the cost of treatment in both countries was found by respondents to be comparable (Rahman, 2000). Physical and linguistic proximity, travel ease (though a significant proportion would resort to entering India clandestinely), and perceptions of better service, bedside manner, specialities and facilities in India were most important in decision-making. Similarly, another Asian medical tourism giant, Thailand, attracts most medical travellers from within the region and its

neighbouring countries like Laos. Studies note that there has been an epidemiological transition to lifestyle diseases, and yet, many of home health systems continue to struggle to manage fundamental public health challenges. Moreover, various regional alliances and trade agreements facilitate these movements for medical care. For example, in south East Asia as well as Africa. It is a fact that south-south intra-regional medical travellers cannot be lumped into a single homogenous category as they come from diverse socio-economic circumstances and political/ visiting statuses, which condition their choice of destination, treatment facilities etc. (Ormond & Sulianti, 2017). Beth Kangas (2002)(Kangas, 2010) provides a rich ethnography of Yemeni patients sent by their governments overseas to Jordan and India to avail themselves of expertise and treatments unavailable in Yemen. Such intra-regional travel for medical care – where people commute regularly for treatments, prescriptions and check-ups – is increasingly becoming how Indonesian patients manage chronic care needs (Ormond & Sulianti, 2017).

Andrea Whittaker et al. (2017) further try to problematise the notion of 'exit' and asserting a need to contextualise the movement of patients within the historical and social ties between places, specifically in the case of Indonesia and Malaysia. The study situates the circulation of people, services and care within its socio-historical and cultural context and argue that this movement is not just an 'exit' from a failing and untrusted health system in Indonesia but an extension and continuity — of movements and exchanges that have long existed (Whittaker et al., 2017). According to Kaspar et al. (2019) there are 3 kinds of transnational therapeutic mobilities, movements of patients across borders, Migration of health professionals and service providers and flow of health products. In their paper on the 'spaces of connectivity', Kaspar & Reddy (2017) also highlight that a lot of medical tourism actually is repeated many times rather than a simplistic, generic understanding of a movement from the global north to the south. The nuanced processes of producing a medical travel destination (Kaspar & Reddy, 2017).

Crossing borders, for healthcare: Narratives located in New Delhi

18 years old Khushboo, a cancer patient, was undergoing treatment at the AIIMS in New Delhi when I met her in 2020. Khushboo and her mother, her primary caregiver in the city, come from Bihar's Supaul district, and are in Delhi only after seeking medical care in

multiple locations over a year and a half. At the time of my initial interaction, Khushboo was recovering from one of the many surgeries she had undergone, and was living in one room rented tenement in Gurgaon. Her father, who worked as a floor manager in an Amritsar-based factory, would visit them once a month in Delhi, while her two younger siblings continued to live in the village under the care of extended family. The realities of seeking medical care in the country, with long bus and train journeys to hospitals, healing in unfamiliar, strange place, families stretched across geographies and the financial and emotional burdens of everyday life, hold true for many low-income families like Khushboo's, coming from regions with inadequate public health infrastructure.

The crossing of borders, knowing and unknowingly, in the pursuit of better medical care is also fairly common in the context of the subcontinent. Interestingly, Delhi was not the first option for medical care for Khushboo and her family. After a few months and rounds of diagnostic tests, and rapidly worsening health situation, a private doctor in the district headquarters asked the family to urgently head to Patna, the state capital as he very indecisively hinted at something 'serious like cancer'. However, moving to Patna did not seem an easy task for the family, who did not have any relatives in the city or any familiarity with the place whatsoever. Moreover, the father had heard from other villagers that the hospitals in Patna were not good at all, and only made money and gave wrong treatments.

The family ultimately decided to travel to Nepal for further diagnosis and treatment after contacting one of their acquaintance in the neighbouring country. Khushboo's father worked in Nepal for 4 years in wood factory and Khushboo and the rest of the family had also visited and were familiar with the place. Rakesh was also familiar with some local health institutions and trusted the hospital and doctors. In their village, it was quite common to travel to Nepal for medical treatment, especially for surgeries and orthopaedic procedures.

> 'Nepal was not like this, not so big and busy. The weather was cool too. The doctors were also nice, but the hospital was not so big. It was not very different from our village, actually. I did not feel so away from home there, as I had been there before a few times.'
>
> Khushboo

After over three months in Nepal, the doctors recommended Khushboo to return to India and try treatment at Banaras or Delhi as this was a cancer which needed immediate treatment.

> 'the doctor said the operation would take around 10 lakh rupees there. We were already spending close to 2-3 thousand every day on medicines and tests. Plus, my father had to leave his job and be with us. So we decided to return."
>
> Khushboo

After an equally indecisive stopover in Varanasi, another familiar city, through previous pilgrimage trips, Khushboo had to travel to Delhi and start treatment.

The case of Khushboo and her family and their meanderings as health-seekers in the region offer a fascinating vantage point to delineate the nuances of the many mobilities for healthcare. The pursuit of better medical care very often merge with trajectories of migrant labour, tapping into infrastructures, resources and networks in and in between destinations and origins. Khushboo's family's sense of familiarity with Nepal as a migrant destination where Rakesh lived and worked for some years became an important reason for their choice. Also, for the family, crossing over to Nepal did not quite mean a transnational journey but more as an extension of their own space, owing to migrant connections, but also as a medical destination popular in the region for certain medical conditions, a kind of cultural familiarity of the phenomenon.

In a migrant's world, the idea of the home as a space of care and recuperation is challenged and reframed at multiple levels. With mobilities of labour, the centres of care and caregiving shift as well, deeply intertwined with migrant labour regimes.

For Sushmita, a 24 year old woman, working in a reputed salon franchise in South Delhi, the constant health complaints from her 55 year old father, who lived alone in Nepal, making frequent trips home was proving difficult along with her job.

> "every test took 3-5 days for the results to come, sometime even longer in Nepal. All samples were sent to India. I thought it was best to get my father to Delhi for treatment. managing the whole thing is expensive, but the treatment is better and I can keep up with my job."

Sushmita

Working in a rather informal, precarious work regime, Sushmita finds it difficult to cater efficiently to her caregiving responsibility as her father is across borders. For the family, the centre of care has to be shifted to Delhi not so much because of the unavailability of treatment for gastroenterological conditions, but because of patterns of migration for labour. The problems of inadequate medical infrastructure, people's aspirations for access to latest medical technology and procedures along with migrant bodies already in motion and familiar health systems in cities with relatively improved infrastructure result in localised, yet transnational and cross-border medical mobilities of the 'medically disenfranchised' but also bodies and communities embroiled in precarious labour regimes. While Sushmita, as the only earning member in her family, cannot afford private medical treatment for her father in Delhi, she feels her choices in the city are many.

> *"My father's condition is not very serious, it's not like he requires a surgery. One good doctor, regular medication and good care at home is all he needs…it is possible here with me. He is getting treatment right in the local hospital, the doctors are good and the rush is not much like the big government hospitals. Initially we got some tests from outside but once the case was clear, its minimum expense for good treatment. and I'm here to look after and manage everything."*
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> *Sushmita, Nepal*

Contrary to the formalised transnational movements for medical treatments, in this particular context, journeys are not organised as often by agencies and private hospitals, and people through their own spaces of agency, social networks and familiarities, make choices and seek better healthcare. In many cases, the South Asian medical traveller, often always with the use of migrant and social networks, tries to negotiate access to public hospitals, making it possible to receive quality care without immense financial burdens.

Yet, medical travel trajectories, even within India from its neighbouring countries vary highly based on people's experiences and expectation and obviously on people's ability to pay for the treatment. Akhtar came to Delhi as a medical tourist with his brother, seeking treatment

at a reputed private hospital. The duo came through formal medical tourism channels, paying a hefty amount to an agency offering a package deal including treatment, accommodation, and interpreter, among other services. However, both Akhtar and his brother were so dissatisfied with the diagnosis and treatment that they decided to return after about a month in Delhi.

> *"If we had more money, we could have gone to Singapore or maybe a better hospital here. But the treatment we got at a private hospital here was the same, if not worse, than in Dhaka. Then, why bother so much? We are trying to meet a doctor at AIIMS before returning; if that is possible, it's best. Let's see."*
>
> *Akhtar, Bangladesh*

As in the other two cases, the access to migrant networks and connections to the medical destination play an essential role in the extent to which spaces can be accessed and opportunities for quality medical care be negotiated. As evident from Akhtar's narrative, organised transnational care can be full of dissatisfactions for those who cannot afford the '*hospitels*' and the large private chains of multi-speciality private hospitals. For the brothers, the journey to India is a compromise, as more and more middle and high-class Bangladeshi now turn to Singapore for their healthcare needs.

The three cases reflect divergent mobility experiences of cross-border medical treatment in the region. Yet, they provide a glimpse of the range of micro, everyday, individual, and collective journeys people, especially those on the lower wrung of society, might undertake to negotiate absent and inadequate healthcare infrastructures in their places of origin and their aspirations for good care.

Health, People, Borders and Labour: in a flux

As evident from the cases, more specifically in this geographical context, which is mobile despite restrictions and borders, mobility for access to medical care overlaps with migrant lives and work. While the region's shared historical, cultural and linguistic context gives a sense of familiarity, migrant experiences create a sense of belonging for people, even when their primary reason for mobility is to access medical care. As highlighted in the case of south-east Asia, medical travel is influenced and shaped by migrant networks across borders.

In the case of Sushmita and her ailing father, the local Nepali community in Delhi, with its sizeable population, many of whom are employed in informal jobs like Sushmita herself, support such journeys through raising emergency funds, food and shelter, blood donations and contacts in hospitals and labs.

> *"When we come to Delhi to work, we cannot ignore our responsibilities towards our family, friends and community. People from our region stay connected through WhatsApp and messages; if there is a need or an emergency, many of us show up and support. When I cannot take my father for hospital visits, my friends from Nepal do it for me. We are not related but depend on one another to survive this life".*
>
> Sushmita, 24

Such communities of care make migrant destinations relatively more amicable spaces for healing and recuperation, even when the comfort and solace of the home remain elusive for most. In Khushboo's pursuit of medical care, the initial journey from India to Nepal was motivated by searching for a place that felt 'more like home' with open spaces, clean air and nature. However, in Delhi, the family chose to live with migrant construction workers in Gurgaon so that the two women feel safe and secure in an unfamiliar city.

In the production of destinations of migration for healthcare, labour migrant networks play a key role. As Khushboo's narrative highlights, in the absence of formal referral systems, and brokers and agencies directing patients to medical institutions, it is the community and the word of mouth which shapes decision-making, and hence the very formation of what becomes and what doesn't become a possible destination for medical health seeking. Instead of travelling to Patna, the state capital, based on migrant networks, and the WOM, the family chose Nepal as their preferred destination of care. While the literature on transnational medical travel highlights the role of word of mouth and circulating narratives of patients, in most cases, the perception of these medical destinations is manufactured by patients and medical professionals who are already part of transnational medical networks. The feedback and word of mouth are carefully curated and regulated in many cases by medical tourist agencies.

Locating the specificities of medical travel in Asia

As India emerged as a top medical tourism destination, many studies have focused on transnational medical travel from beyond the region into India. The discourse, in this case, has been shaped by and through organised medical agencies, private hospitals, medical staff and professionals. However, data has shown, for a long time, that these medical tourism destinations have been focal points of medical mobilities in the region, and yet there have been hardly any attempts to conceptualise and understand these movements, especially in the case of South Asia. Studies in South East Asia and Africa have unpacked the potential of studying intraregional and cross-border medical travel to understand health systems, informal brokering, social and migration networks, and questions of contested citizenships.

The narratives analysed for this paper point to a relatively localised construction of medical mobilities in the region and how the 'migrant' navigates the absence/ presence of healthcare infrastructure, borders and labouring regimes to access healthcare for themselves and their families. An empirical enquiry into intraregional medical travel within South Asia can further nuance the discourse on medical travel globally. It poses an interesting vantage point to understand the shifting epidemiological burden of India and its neighbouring countries and how public healthcare infrastructure is able or unable to cater to these shifts. Through a mobilities paradigm enmeshed with labour mobility, how people use migration networks to cope with these inadequacies of the healthcare systems at home enables one to see migration and access to healthcare in novel ways.

It also alerts one to the limitations of understanding medical travel within formal travel regimes mediated by borders, legality, and citizenship discourses. In the case of the present study and various other studies on intraregional medical travel, there is an unmistakable sense of flux, perhaps like migrations for labour. Patients seem to be in and out of different medical travel regimes as well- often compelled to shift from private hospitals to public medical institutions, also between locations, often based on proximity, social and migrant networks, and religious-cultural affinities.

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