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M o b i l e F o r H e a l t h

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Introduction

In this note on health and well-being I'd like to approach health from a mobilities perspective. Shaw, Dorling & Mitchell (2002: 156f.) note, that the "importance of mobility has been largely overlooked in studies of health to date". This is a noteworthy research gap, as "people rarely stay still. They move both between places and between social groups" (ebd.) and these movements are likely to have an impact on health. On the other side, health can be the very reason why people become mobile.

The latter is the starting point of my own research on medical tourism in India, which among other looks deeper into the reasons and circumstances why people travel to India for health indicated treatments and how they experience care and hospitality at a place, which is more often than not an unfamiliar terrain in many ways.

I'm only starting fieldwork right now, this is what actually brings me to India and this is also the reason why despite being from Switzerland, I probably will talk more about India than about Switzerland. However, I have some findings, that I'm happy to share.

Overview: Before I do so, I will briefly sketch some of the fields, research on mobility and health consists of. These issues seem to be shaped against a common backdrop, which is the marketization of health and care. Healthcare and medicine are increasingly seen as motors for individual profit as well as national economic growth. This is actually the starting point of India's role in the medical tourism market and I'll shortly elaborate on that. Then, I zoom in by analyzing the rhetoric through which the industry and media are working towards mobilizing patients to travel for medical treatments. I conclude by suggesting for further research a closer look at how emotions work in commercialized healthcare.

Mobilities and health: a sketchy overview

The observation that people rarely stay still – and actually never did so in the past – is the starting point of the new mobilities paradigm, proclaimed in 2006. Protagonists such as Kevin Hannam, Mimi Sheller, John Urry, Tim Cresswell argue that in these days probably more than ever, but generally throughout human history, sedentary is the exception, rather than the normal. Furthermore, they claim, that a more differentiated view on mobility is needed: there is a myriad of different forms of mobilities, including migration (short and long term, permanent or circular), travel and tourism as well as small and smallest scale mobilities such as everyday movements through a town.

Furthermore, drawing on actor-network theory's claim for a less human-centric perspective, it is not only human beings that constantly are on the move, but all kinds of other animated or unanimated entities, too.

I'd like to give a couple of examples to indicate the breadth of issues that constitute the field of health and mobility:

- Of course, we first think of viruses and bacteria that spread from body to body and eventually cover long distances. Critical scholars highlight the political economy behind the spread of diseases, which is far from being arbitrary, but often occurs in disprivileged regions and within marginalized social groups. The case of Ebola is a recent example.
- Also, semi- or formerly animated things such as body parts – tissues, fresh organs, frozen eggs, etc – travel. Body parts are dislocated and re-assembled. This includes a transaction, which is sometimes referred to as a gift, but more often so as a business; the respective body part and a bunch of bills change its proprietors. A rampant liberal discourse frames this transaction as a win-win-situation, in which both involved gain a new life (Cohen 2010). The deathly ill person regains health and the poor and indebted donor gets a new chance through the earned money. Yet, medical anthropologists like Lawrence Cohen, Nancy Scheper-Hughes and others belie this win-win-discourse by showing that these kinds of transactions clearly benefit the privileged and in the end result in a transfer of health from the Global South to the North, from the disprivileged to the privileged.

Furthermore, research interested in health and mobility could also focus on

- unanimated, material things related to health such as drugs, nutrients, medical equipments, prescriptions, etc.

Also,

- unanimated, immaterial things such as information, ideas and concepts, policies and regulations are mobile and mobilized. For instance, patient experiences are put out on consumer platforms in the internet or are used in marketing to further mobilize people to travel for cure. I'll come back to this example later in my talk.

Traveling to distant places for cure: recent developments in medical travel in Switzerland and India

Indeed, health has been a motive for travelling since centuries. Pilgrimage and spa tourism, e.g. are ancient forms of tourism (e.g. Burkett 2007: 226; Menvielle 2010: 149f.). In previous centuries, health tourism destinations were chosen according to specific environmental qualities (Connell 2006: 1093; Roberts & Scheper-Hughes 2011: 13), such as the clean air in alpine environments or the mineral content of the Black Sea. Davos in Switzerland, for instance, was the first place in the Alps to be developed as a health resort for patients to recover from consumption and respiratory diseases in the second half of the 19th century (Barton 2009). People from Europe travelled arduous hours, even days in trains and horse coaches to get to small villages, that had little comfort to offer at these times (ebd.: 7). In recent years, elderly people have been increasingly migrating to regions with a climate providing relief to their ailments. For example, in 2005 an estimated amount of 800'000 elderly people – so called snow birds – temporarily migrated to Florida to escape cold (Smith & House 2006), Spain has become a popular destination for Germany's and Great Britain's seniors to spend the last third of their lives (Huber 2003) and Thailand has begun to build apartment complexes that include medical services catering to the needs of the elderly at much lower costs than in the West.

In the past centuries, people traveled to distant places, because it was believed, that these places are intrinsically linked with curative qualities. In recent years, the healing powers of places have been complemented with or replaced by biomedical knowledge and technology as pull factors for patients ready to travel in search of health, renowned high-tech, super-specialty hospitals such as the Cleveland Clinic in Ohio, USA, attract patients from all over the world.

This international travel was mostly limited to relatively wealthy patients from lower wage countries to prestigious medical centers in the West (Alleman et al. 2011: 492). However, in recent years growing number of reports is pointing out an alternative mobility pattern (Alleman et al. 2011: 492): People from the Global North leave their home countries and world-class healthcare systems, to get a needed medical treatment at a destination in the Global South. In the media, this has been referred to as medical

tourism, in academic writing the term medical travel has been privileged to acknowledge for the seriousness of the endeavors.

Whereas in Switzerland, medical tourism has suffered severe losses (with the exception of spa and wellness and the so called suicide tourism), it is expanding at fast pace in India. People from all over the world travel to India and other countries of Asia, which has become the hub of medical tourism, particularly for cardiology treatments, standard joint replacements, organ transplantations, stem cell therapies, assisted reproductive technology (ART), including surrogacy.
The Economist (2004) mentions that in 2003 an estimated number of 150,000 medical tourists had visited India. For 2008 this number had increased to 450,000 (Smerdon 2008: 23; see also Reisman 2010: 172). However, Gahlinger (2008: 201) mentions the figure "1.5 million people traveled to India to receive medical treatment" for the year 2004.

For the largest hospital chain in India, the Apollo Hospitals Group, Reisman (2010: 173) states that 30% of its revenues stem from medical tourism. India expects revenues from medical tourism up to 2 billion US$ by the year 2012 (Connell 2006: 1095f.; Shetty 2010) and the growth rate of the revenues is estimated at 30% per year by business analysts and stakeholder (Ehrbeck et al. 2008; Reisman 2010: 172; Shetty 2010; Woodman 2008: 239). Yet, as these figures are all provided by the industry, they need to be consumed with caution.

India as a key player in the market of transnational healthcare

A couple of factors have secured India one of the top positions in this expanding market. Foremost: strengthening of the private healthcare sector. This is the result of national and international policies tailored to strengthen the private healthcare through liberalization policies (such regarding trade in service and foreign direct investments in the 1980ies), tax relief and subsidized land prices, improved airport infrastructure and reduced requirements to get credit (Reddy & Qadeer 2010: 70; Smerdon 2008: 23).

But why would a country with such a high rate of under-supply in primary care for its population subsidize the formation of corporate, foremost tertiary care institutions catering to a foreign clientele (though not exclusively)?

Strengthening private health care in India was deemed necessary for two reasons:

- First, it is believed that private health care step in for the inefficient and insufficient public health care, improving health care delivery in India.
- Second, private healthcare is seen as a modernization project, boosting India’s economy. International patients bring foreign currency and symbolic capital. Furthermore, the investments made in healthcare will benefit all.

Both rationales are based on trickle-down ideas for which no evidence exists so far. Rather, as Sunita Reddy (forthcoming) shows, strengthening the private sector is closely linked to the weakening of public sector health care, draining professionals and finances to urban centers and tertiary care. But privatization of India's healthcare has also been pushed by individuals, who identified the potential of healthcare as a profitable business, such as Prathap Reddy, founder of the renowned Apollo Hospitals.

So, global competition to treat patients is on. A lot could be said about competition and markets working or not working in healthcare. But for today, the question I'd like to ask is: How do different social actors operate rhetorically to mobilize patients – mobilize both in the marketing, as well as the geographical sense of the word.

Rhetorics that work towards mobilizing patients

There are different actors one could look at to approach this question: healthcare providers and medical travel intermediaries' marketing material, media reports and documentaries, business analysts' studies – even academic literature.

Ormond & Sothern (2012) analyzed medical travel guidebooks and stated that they consist of a narrative that invites readers to become pro-active subjects, that don't content themselves with the unsatisfying healthcare they get at home, but investigate their options on the global healthcare market and make a savvy decision.

Healthcare providers' and medical travel intermediaries' marketing material tie in with the notion of the patient as a consumer. Beside from nicely presenting their services in 'health packages', they present data a patient-consumer would need to know in order to make that well-informed decision.

Basically, what is offered is world-class medicine at a fraction of the price it would cost in high-income countries. This claim is found on all examined provider and intermediary websites. It is prominently placed in the headlines or in one of the key texts of the landing page or featured as the company's motto. Treatment Assistance, an Indian based medical travel agency, for example, titles on the landing page of its website: "Travel to India for World-class Medical Care at Unbelievably Low Cost. It just takes few steps and we will make it Easy for You". HealthGlobe, a US based company, advertises "top notch treatment and coordination", "making healthcare affordable" and "modern & clean facilities" on its landing page.

While quality is presented as being at par with renowned Western institutes, the general claims of low, lower and/or lowest prices is backed up with substance by putting a precise price tag to offered treatments. Comparison between different providers is made easy through price tables.

The prominence of cost and prize comparison clearly invokes a notion of health care as a commodity that can be shopped around the world.

At the same time, regarding quality – the other key criteria to select a health provider – it is assured that the destinations are at par with facilities at high-income countries at all offered destinations (see also Burkett 2007: 230). However, unlike with cost, no basis for direct comparison is provided and hence there is little evidence or information that would allow assessing quality.

I argue that being very explicit about cost while at the same time implicit about quality does two things:

First, quality is presented as a taken for granted. The patient is invited to expect nothing less but world-class medicine wherever she or he might go. Hospitals show key features of hospitals such as operation theatres and other machineries, waiting lobbies, etc to indicate similarity with Western institutions. But… when quality is just the same – why should you pay as up to ten times more?

This establishes cost as the key criteria to select a health care provider, rather than quality. In this light, for North Armerican and West European patients, staying at home for care appears as an irrational choice, misguided by wrong assumptions and an anxious heart. But also for those traveling because they lack facilities at home, according to this rationale, cost becomes the bottom line of choice.

But do patients simply believe and trust providers' marketing claims? Would you? Probably not. Regarding costs, the numbers displayed prominently on agencies' and providers' websites give evidence of the comparative advantage. Regarding quality, in contrast, figures are very rare. Instead, emotions are deployed to give evidence. The emotions displayed to proof the quality of care are packed into personal stories of former patients. They are proudly featured on websites.

Patient testimonials: touching emotions that work towards mobilizing patients

Patient stories seamlessly weave into the websites narrative of world-class care at low cost. They give a tangible, personal and supposedly authentic repetition of the website's content of top care at bottom cost. But most of all, they emphasize a quality of care beyond expectations. I would like to highlight two things that according to these narratives render being an international patient into an unforgettable experience:

1. **Medical skills of surgeons**: the patient stories give testimony of successful surgeries, often including speedy recovery with less pain than expected. But on top of giving evidence of top quality care, personal stories say that while healthcare in their home country was unable to help them, India could. Indian surgeons are portrayed as saviors and patients as being rescued from pain and being blessed with nothing less than a new life. Deep gratitude is expressed.
2. **Patient-centered care**: Patients note with surprise that the hospital's staff from surgeon to housekeeping cares with compassion. This is reflected by surgeons who take an unusual amount of time to talk to them, look at their files, answer questions, explaining the treatment in detail and call them even months after surgery to inquiry about their recovery. Compassionate care is further reflected by the speedy response to requests and simple details as knocking on the door before entering. Furthermore, there is a couple of extra benefits mentioned, which would never be included in a hospital stay in the US and are, as Susan says in the quote, rather associated with five-star hotels than hospitals, like doormen, who know your name, tea service in the hospital room, special diets, organization of transportation and so forth.

So, while listening to or reading the patient stories provided on healthcare providers' and intermediaries' websites, a patient informing her- or himself hears or reads countless amazing stories of hopeless patients who regain life. She or he senses the deep gratitude towards the caring hospital staff. I argue that the repeated gratitude and happiness is used to give evidence of top quality of care that is convincing, although figures, such as infection or success rates, for rational comparison are not provided.

So, in this case, gratitude is not only a moving, touching emotion, it is a potentially mobilizing momentum. Actually, I'd like to argue that former patients' emotions do the lion's share of the work it takes to build trust and eventually mobilize patients.

Affective economies and commercialized healthcare

Feminist and postcolonial scholar Sara Ahmed (2004) analyzes in her article "Affective Economies" how emotions are attached to things and how these attachments are accumulated and finally capitalized. I suggest we could see the gratitude and healer status attached to health professionals catering for international patients hospitals as such an accumulation. I think that tracking emotions attached to different things – staff, architecture, etc. – and follow their sideways movement could be a fruitful lens to build a bridge to the experience of care of patients with less purchasing power. These two patient groups are usually seen as separate groups. Often, they are even spatially separated on different wards within the hospital. I think, we need to think more about linkages between them.

Furthermore, I think we also need to pay much more attention on what kind of new or old relations between care giver and care receiver in a broader sense are articulated through global commoditized form of healthcare. For example, the highlighted tender, compassionate care of Indian nurses clearly reproduces the stereotype of Asia's hospitality and caring nature. There is a clear need to reveal these processes of 'othering' and look at who benefits from it.

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Bibliography

Ahmed, Sara. 2004. "Affective Economies." *Social Text* 22 (2 79): 117–39. doi:10.1215/01642472-22-2_79-117.

Alleman, Brandon W., Tana Luger, Heather Schacht Reisinger, Rene Martin, Michael D. Horowitz, and Peter Cram. 2011. "Medical Tourism Services Available to Residents of the United States." *Journal of General Internal Medicine* 26 (5): 492–97. doi:10.1007/s11606-010-1582-8.

Burke Barton, Susan. 2008. *Healthy Living in the Alps. The Origins of Winter Tourism in Switzerland, 1860-1914*. Manchester: Manchester University Press.

Burkett, Levi. 2007. "Medical Tourism. Concerns, Benefits, and the American Legal Perspective." *Journal of Legal Medicine* 28 (2): 223–45. doi:10.1080/01947640701357763.

Cohen, Lawrence. 2010. "Where It Hurts. Indian Material for an Ethics of Organ Transplantiation." In *A Reader in Medical Anthropology. Theoretical Trajectories, Emergent Realities*, edited by Byron J. Good, Michael M. J. Fischer, Sarah S. Willen, and Mary-Jo DelVecchio Good, 254–99. Malden, Oxford: Wiley-Blackwell.

Connell, John. 2006. "Medical Tourism. Sea, Sun, Sand and ... Surgery." *Tourism Management* 27 (2006): 1093–1100.

Ehrbeck, Tilman, Ceani Guevara, and Paul D. Mango. 2008. "Mapping the Market for Medical Travel." *The McKinsey Quarterly*.

Gahlinger, Paul M. 2008. *The Medical Tourism Travel Guide: Your Complete Reference to Top-Quality, Low-Cost Dental, Cosmetic, Medical Care & Surgery Overseas*. North Branch, MN: Sunrise River Press.

Huber, Andreas. 2003. *Sog Des Südens. Altermigration von Der Schweiz Nach Spanien Am Beispiel Costa Blance*. Zürich: Seismo.

Menvielle, Loick. 2010. "Medical Tourism. Paradoxes of Globalisation and Ethical Issues." In *The Paradoxes of Globalisation*, edited by Eric Milliot and Nadine Tournois, 145–65. Houndsmill: Palgrave Macmillan.

Ormond, Meghann, and Matthew Sothern. 2012. "You, Too, Can Be an International Medical Traveler. Reading Medical Travel Guidebooks." *Health & Place*.

Reddy, Suntia, and Imrana Qadeer. 2010. "Medical Tourism in India: Progress or Predicament." *Economic and Political Weekly* 45 (20): 69–75.

Reddy, Sunita. forthcoming. "Medical Tourism in India. Misplaced Priorities and Public Health Implications." In .

Reisman, David. 2010. *Health Tourism. Social Welfare through International Trade*. Cheltenham, UK: Edward Elgar Publishing Limited.

Roberts, Elizabeth F. S., and Nancy Scheper-Hughes. 2011. "Introduction: Medical Migrations." *Body & Society* 17 (2-3): 1–30. doi:10.1177/1357034X11400925.

Shaw, Mary, Danny Dorling, and Richard Mitchell. 2002. *Health, Place and Society*. Singapore: Prentice Hall/Pearson Education.

Shetty, Priya. 2010. "Medical Tourism Booms in India, but at What Cost?" *The Lancet* 376 (9742): 671–72. doi:10.1016/S0140-6736(10)61320-7.

Smerdon, Usha Rengachary. 2008. “Crossing Bodies, Crossing Borders. International Surrogacy between the United States and India.” *Cumberland Law Review* 39 (1): 15–85.

Smith, Stanley K., and Mark House. 2006. “Snowbirds, Sunbirds, and Stayers: Seasonal Migration of Elderly Adults in Florida.” *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences* 61 (5): S232–39.

The Economist. 2004. *Get Well Away. Medical Tourism to India*, October 7. http://www.economist.com/node/3276422/print.

Woodman, Josef. 2008. *Patients Beyond Borders. Everybody’s Guide to Affordable, World-Class Medical Travel*. Second. USA: Healthy Travel Media. http://www.patientsbeyondborders.com/.