Medical Travel Facilitation Between Oman and India: Articulating Spaces, Creating Smoothness and Negotiating Ethical Complexities

Thesis

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MEDICAL TRAVEL FACILITATION BETWEEN OMAN AND INDIA: ARTICULATING SPACES, CREATING SMOOTHNESS AND NEGOTIATING ETHICAL COMPLEXITIES

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Abstract

This thesis thinks through practices of medical travel facilitation in order to contribute to current conversations about transnational healthcare (TNHC) and care as sociotechnical practice. TNHC has gained significance in recent decades as a rapidly developing industry with shifting modes of health governance and the number of people seeking care abroad rising. Political, economic and social implications of TNHC are debated within the social sciences, whilst the transnational configuration of care is provoking conceptual reflection within and across the fields of ethics, policy, and Science and Technology Studies (STS).

Entering these conversations through an analysis of medical travel facilitation, this thesis contributes to them with an empirically-informed theorisation of the relationships between facilitation and care as encountered in ethnographic fieldwork in Oman and India. Having traced practices of medical travel facilitation in this context this thesis proposes that they are integral to TNHC in three interrelated ways. First, for how they articulate spaces and spatialities, proposing that medical travel facilitation relates, stretches and folds spaces to constitute the possibility of and a certain receptivity for treatment abroad. Second, for the way they make TNHC feasible in everyday practice following the exploration of smoothness as a disposition, spatio-temporal manoeuvre and outcome of medical travel facilitation. And third, for how they negotiate ethical complexities involved in TNHC, generating a compromise that makes TNHC ‘good enough’.

Working through these dimensions of medical travel facilitation in conversation with recent work on care in STS and the ethics of care, I propose that these practices are productively thought not just about setting up the possibility of care transnationally, but that relating, smoothing, negotiating are key forms of care in itself. I suggest that this conclusion potentially has implications not just for the geographical study of transnational healthcare, but also that of care and transnational phenomena more generally.
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1 Introduction

In 2018, the Ministry of Tourism in India counted about 644,037 Foreign Tourist Arrivals for Medical Purposes (Ministry of Tourism Government of India 2019, p.44); 27,501 of them were coming from Oman which is, along with Bangladesh, Iran and Yemen among the top four source countries (FICCI 2018, p.17). India and Oman are linked through medical travel, an industry which has become a “multi-billion dollar industry” (Sandberg 2017, p.281; Sen Gupta 2015, p.4; Dawn & Pal 2011a, p.185) over the past decades. A recent report of the World Tourism Organization and European Travel Commission give estimates ranging from 45.5 – 72 billion USD or 100 billion USD quoting different sources (UNWTO & ETC 2018, p.11). The range is considerable; reliable estimates of the market size of the medical travel market on a global level or data that allows for comparison between countries are difficult to find given the ambiguity of definitions and methods of what counts as ‘medical tourism’ – a term that originated from the industry and media and that has been critiqued by many scholars as it “suggests leisure and frivolity” (Kangas 2012, p.350) which is in stark contrast to the often particularly strenuous experience of international patients.

One the one hand, medical travel creates opportunities for patients in need of treatment that is not available or cannot be delivered or accessed in their country of residence for money, time or legal reasons; for governments looking into options to ease the pressure on the national healthcare system by outsourcing healthcare services to providers abroad, or alternatively, for them and also hospital groups to capitalise on their resources in the private sector by catering for international patients (see for example Ormond 2013b; Connell 2013; Smith 2012; Crooks et al. 2011). On the other hand, transnational healthcare spanning across different geographies, systems of medicine and conceptualisations of care comes with fractions and frictions and poses different sorts of challenges. International patients are often in great distress given their precarious state of health, the difficulty of finding adequate care abroad and the multi-dimensional challenges of realising medical travel. They face financial and logistical constraints, struggle with gauging the suitability of the treatment options and the trustworthiness of healthcare providers abroad, and experience discomfort navigating unfamiliar terrain, physically, medically, and culturally (for patient experience see Bochaton 2015; Whittaker 2015; Kingsbury et al. 2012; Kangas 2002).

Despite such impediments, medical travel has evolved as an established practice and transnational healthcare has become a relevant mode of healthcare provision in view of increasing
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health expenditures and aging populations (Allen 2020). But what mediations need to take place to realise treatment aboard? What does it take to create and navigate transnational spaces of healthcare? How is medical travel made into a practicable option that provides good care – and at what cost? And, after all, how did India become the preferred destination for Omani patients? In this thesis I will unfold some of the complexities of transnational healthcare and care as a sociotechnical practice, taking medical travel facilitation as a route into advancing some of the empirical and theoretical debates around care, its spatio-temporal configurations and ethical challenges in its mediation.

Medical travel facilitation between Oman and India constitutes a particularly interesting case to think through transnational healthcare for the multiple links that span between different actors, institutions and places and thus give insight into the complex spatiotemporal configurations of care in today’s globalised world: Additional to the different trajectories of individually travelling patients there is the government sponsored Treatment Abroad Scheme. This case allows to trace formal and informal ways of routing patients to certain countries and healthcare providers and gives insight into the complex articulations of national and transnational healthcare that have been produced by and are productive of particular spatialities and temporalities. Although the peculiarities of this geo-historical context and relations are relevant for understanding medical travel between Oman and India, I propose that the analysis brings aspects to the fore that are of wider interest and have implications for the conceptualisation of care and transnational phenomena within the social sciences and beyond. Attending closely to medical travel facilitation from a relational and practice-oriented perspective, this thesis sheds light to some of the intricacies of transnational spaces, healthcare and care, as both practice and ethic, and explores how medical travel is made possible, feasible and, eventually, ‘good enough’.

Conceptually, this thesis engages with and contributes mainly to reflections on care and its transnational spatial configurations within and across Science and Technology Studies (STS) (Lavau & Bingham 2017; Law 2015; Puig de la Bellacasa 2011; Law & Mol 2008; Mol et al. 2010a; Mol et al. 2010b; Mol 2008; Murdoch 2006b; Mol 2002) and the ethics of care (Raghuram 2019; Sevenhuijjsen 2018; Raghuram 2016; Bastia 2015; Held 2014; Robinson 2013; Tronto 2010; Noddings 2010a; Held 2006). The analysis of the practices of medical travel facilitation and the role they play in establishing and maintaining transnational healthcare, the thesis seeks to contribute to them by providing an empirically informed theorisation of the relationships between facilitation and care as encountered in ethnographic fieldwork in Oman and India. Analysing different ways in which medical travel facilitation was found to be integral to transnational healthcare, I propose that these practices are productively thought of as not just about setting up the possibility of care transnationally, but that such facilitation constitutes key forms or aspects of care in itself. This finding, I suggest, potentially
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has implications not just for the geographical study of transnational healthcare, but also that of care and transnational phenomena more generally.

It is therefore important to situate this research in the wider context of research on transnationalisation in healthcare and debates in policy literature. The political, economic and social implications of transnational healthcare have evoked critical debates in academia. Transnational mobilities of patients, health professionals, goods, services and money – as a result of different modes of trade in healthcare services (Woodward 2005; Blouin et al. 2006) – have transformed the political economy of care and suggest transnational (Williams 2011) or global (Yeates 2005) perspectives. The commodification of care (Bolton & Skountridaki 2017; Green & Lawson 2011; Folbre & Nelson 2000; Pellegrino 1999) and shifts in the institutional arrangement of care regimes promote debates about entitlements and responsibilities involved in care, and the (in)adequacy of national care regimes, both practically and theoretically (Whittaker & Leng 2016; Yeates 2011; Lawson 2007; Yeates 2005). More importantly, the transnationalisation of healthcare challenges conceptualisations of care and care ethics (Raghuram 2016; Kogtel & Orme 2011; Raghuram 2012; Robinson 1997) and calls for a focus on local specificities and care as practice. As a spatial concept, transnationalisation raises questions about the ways in which healthcare spaces are formed, how different actors, institutions, places and practices become connected across national borders and the qualities that allow for smooth circulations along these linkages.

In the following sections, I will introduce the research area of transnational healthcare and medical travel in more detail (1.1.1) with a particular focus on medical travel facilitation (1.1.2). By reviewing the existing literature, this highlights the gaps which this thesis will contribute to. This will lead to the formulation of the research objectives and questions (1.2.1), which will guide the different chapters of this thesis, briefly introduced in the last section of this chapter (1.2.2).

1.1 Setting the scene: health, care, space and facilitation

The nexus between health, care and space is fundamental and intricate; the current Covid-19 pandemic is just one of the latest, yet profoundly influential expression, demonstrating the extent to which one’s health is conditioned by spatiality of both, disease and care, reminding us of how valuable good health is and how spatial aspects become critical for both staying safe and accessing care. Whereas in this specific case, the rapid spread of a virus has rendered large parts of the population significantly less mobile, generally, the mobility of people in search for care and cure has a long history. Yet, international medical travel has been re-invented and
transformed over the past decades, in ways that take it to new dimensions in terms of numbers, modes, or the geographies it draws (Ormond 2011; Whittaker et al. 2010; Whittaker & Speier 2010; Herrick 2007; Caballero-Danell & Mugomba 2006), whilst also raising critical questions about how healthcare is conceptualised, practiced and constituted by powerful networks that operate across multiple countries, industries, welfare regimes, medical systems and institutions. The following sections situate this research within the bigger frame of transnational healthcare and medical travel facilitation as an important practice of mediating care transnationally and introduces the diverse scholarly engagement with it. This allows an understanding of the current state of the art, whilst also highlighting the gaps in the knowledge, which this thesis aims to contribute to.

1.1.1 Transnational (health)care and medical travel

‘Transnational’ as a spatio-political concept refers to a phenomenon which extends or goes beyond national boundaries (Merriam-Webster 2020). Although health mobilities (patients, medical professionals, medicine etc.) have always been a reality, healthcare has often been considered to be governed and analysed on a national level, with the state taking an active role in financing, providing and regulating healthcare in welfare states (Rothgang et al. 2010, p.11). The state is one of the four key institutions shaping care arrangements along with markets, families/households and the not-for-profit sector, illustrated as the four corners of the care diamond (Razavi 2007). The changes in the institutional arrangement of care and welfare services of nation states in the global North and South (Yeates 2012; Kofman & Raghuram 2015; Power & Hall 2018; Ormond 2013b; Yeates 2011; Smith 2012; Misra et al. 2006), along with processes with global reach, such as commodification and marketisation of (health)care and globalisation (Yeates 2011; Connell 2013; Green & Lawson 2011; Pellegrino 1999), transform the ways that care is conceptualised and practiced today. A ‘transnational’ reference frame for health and care has become more common that accounts for the interconnections beyond national borders in these matters. However, compared to the migration of care workers, cross-border patient mobility, along with some other “modes and expressions of care transnationalisation (…) have not yet enjoyed similar levels of scholarly attention with that literature or have been developed outside a care transnationalization theoretical framework” (Yeates 2011, pp.1110–1111).

Governments in different countries in the Global North and South have made efforts to provide favourable conditions to participate in the transnational healthcare industry (Snyder et al. 2011; Gan & Frederick 2011; Sobo et al. 2011; Smith 2012). Countries in the Global South and particularly Asian countries have positioned themselves as popular destinations for medical travel since the late twentieth century (Reddy & Qadeer 2010; Connell 2013; Connell
Entrepreneurial governments have become supporters and promoters, through national development planning and tourism campaigns. In India, Malaysia and Thailand, tax concessions were given to MT [Medical Travel] providers and tourism office campaigns for MT, alongside subsidies for land purchases and infrastructure. The availability of good quality treatment fosters intra-regional flows and South-South medical travel (Ormond & Sulianti 2014, p.2; Connell 2011a), which is considered to make up the largest part of medical travel (Crush & Chikanda 2015, p.1,9; Connell 2011a, p.113), contrary to much of the media coverage and studies on North-South medical travel. This is also the case for India, as the current data shows in chapter 4.1.3.

Research on the mobility and migration of (health)care workers is one of the areas that has contributed to a transnational or global perspective in social policy and a political economy of care. There is a well-established body of literature concerned with the transfer of care beyond national care regimes through the mobility of healthcare workers (Thompson & Walton-Roberts 2019; Ennis & Walton-Roberts 2018; Yeates & Pillinger 2018; Walton-Roberts 2015) and (domestic) care workers, often discussed under the prominent global care chain approach (Yeates 2012; Yeates 2004; Parreñas 2000; Arlie Russle Hochschild 2000). Recognising the multi-scalar connectedness and global interdependence in matters of care (Mahon & Robinson 2011, p.15), a transnational or global political economy of care is put forward (Mahon & Robinson 2011; Williams 2011; Yeates 2005). The transnational mobility of people as well as of policies and discourses around care, make a national perspective obsolete: “the treatment of ‘national’ care regimes as enclosed entities decontextualized from the global political economy in which they are embedded, is no longer justifiable, if it ever was” (Yeates 2005, p.323) – or is at least “profoundly shifting” (Bell et al. 2015, p.285).

Processes such as the commodification of care and the marketisation of healthcare services are closely entwined with the transnationalisation of healthcare. Bolton and Skountridaki (2017, p.507) summarise these profound shifts saying: “Arguably, the globalisation of healthcare provides fertile ground for the transformation of health into a commodity; of healthcare provision into trade in services; of hospitals into commercial organisations focused on exports; of medical professionals into entrepreneurs (Skountridaki 2015); and patients into consumers (Ormond and Sothern 2012:935)”’. Medical travel is often considered as “a function of the growing privatisation and commodification of health care” (Connell 2013, p.6). The General Agreement on Trade in Services (GATS), implemented in 1995 by the World Trade Organisation, is one of the instruments through which transnational trade in health services is regulated (Woodward 2005, p.513). This treaty contributed to the liberalisation of international trade within health, a sector that “has been relatively unaffected by trade, as it remains a predominantly service-oriented sector” (Blouin et al. 2006, p.1). The GATS agreement defines four modes of trade in health services: cross-border provision of services, cross-border movement
of consumers, commercial presence of providers and cross-border movement of providers (Woodward 2005, p.513). Medical travel refers to the second mode where patient become mobile as health service consumers. These modes coexist but so far there has been relatively little research on the nexus between them (Bell et al. 2015, p.289). This thesis focuses specifically on the mobility of patients and by exploring how this is being facilitated, I will also show how medical travel is interlinked with other modes of cross-border mobilities in health services.

One of the themes debated within the literature on medical travel evolves around national spaces of healthcare, citizenship and entitlements with regards to the responsibilities involved in care. Much of the literature assumes a Westphalian nation state which allocates, funds and directly provides healthcare through a national welfare model. From this perspective, medical travel can be considered as a result of the shortcomings of states in making the direct provision of healthcare available to their citizens (Whittaker & Leng 2016, p.295; Pennings 2007, p.505; Kangas 2012, p.353; Inhorn et al. 2012, p.250). Unavailability, inaccessibility, or unaffordability of certain treatment and care options due to limited expertise, technology and infrastructure, as well as legal restrictions or lengthy waiting times, are common reasons for patients to seek medical care abroad (Hanefeld et al. 2015; Connell 2013; Yeoh et al. 2013; Cormany & Baloglu 2011; Lunt & Carrera 2010; Connell 2006). This may have negative consequences for the patients, rendering them vulnerable by disconnecting them from their social and institutional webs of support (Bolton & Skountridaki 2017, p.509). These circumstances raise questions about whether medical travel should be seen as a choice or a practice, forced upon patients who have no other option, but to seek care in a medical ‘exile’ (Kangas 2012; Ormond 2011; Whittaker 2008; Inhorn et al. 2012). In the latter sense, medical travel “challenges the notion of health care as a responsibility of a nation-state to its citizens, tied to the territory of a nation-state” (Whittaker & Leng 2016, p.287). However, Kofman and Raghuram (2015, p.90) make an important point by differentiating modes in which the state provides services and by criticising that “equating these processes [such as neoliberalisation and marketisation of service provision] with the withdrawal of the state (…) is too simple”. Although the state may not render direct provision of healthcare locally, it may still have an important role in terms of funding and regulating services (Kofman & Raghuram 2015, p.90). The modes through which the state and other institutions provide care are diverse and they vary across different geographies. The narrative of the retrenchment of the welfare state in the Global North (Kofman & Raghuram 2015, p.72) and of it being the driving force behind medical travel may therefore not be applicable in other parts of the world. Alternatively, funding medical travel as a way of outsourcing certain healthcare services to providers located outside the national territory, may also constitute a way for certain states to provide care to its citizens. Analysing the case of Oman in this thesis and thinking through the constitution of national and
transnational healthcare spaces will contribute to this gap in the medical travel literature, by providing empirically based insights into the multiple ways in which the state and market actors co-constitute healthcare beyond the national territory.

Transnationalisation of care does not only show the variegated forms of institutional care arrangements, but also raises awareness of the differences and diversity in the conceptualisation of care and care ethics. The framing of transnationalisation of care, as “processes of heightened connectivity revolving around consciousness, identities, ideas, relations and practices of care which link people, institutions and places across state borders” (Yeates 2011, p.1113) points out the multi-dimensionality of care. This can be made visible by attending to local contingencies and shifts in the conceptualisation of care and caring relations and how these shape the ways in which care is established, as a social, economic and political practice. The commodification and transnationalisation of care, outlined above, “creates new and unprecedented challenges for considering the ethics and social politics of care” as Mahon and Robinson (2011, p.14) state and they suggest care ethics as a “a lens through which to focus and organize our thinking about the ways in which care is delivered at the local, national, and global levels” (Mahon & Robinson 2011, p.16). Looking at care from a global vantage point, however, does not mean that the heterogeneity of care arrangements and local variations in the ethics of care are any less important (Raghuram 2012, p.135). Instead Raghuram (2016, p.525) suggests attending to those variations and thinking through such “located care ethics (…) in relation to each other”. This is important in multiple ways: “Taking the locational specificities of the genealogies of care as a concept, and observing how care is organized, can help us to enrich global analyses of care conceptually and improve policymaking around the responsibility and rewards for caring” (Raghuram 2012, p.136).

Analysing medical travel facilitation between Oman and India will illustrate ethical implications involved in providing and mediating healthcare abroad, both in terms of national and transnational level articulations of healthcare spaces and in everyday practice.

Although the role of the local government is important in shaping the healthcare sector, international organisations and specifically market actors are considered to be among the main drivers of the medical travel industry. International organisations, such as the World Trade Organisation, and associations like the Medical Tourism Associations or international accreditation schemes in healthcare, contribute to the promotion of medical travel (Whittaker et al. 2010, p.339). Multi-specialty corporate hospitals, international hospital groups and the insurance sector, as well as medical travel companies, individual facilitators and other service providers from the hospitality and tourism sector, have contributed to this industry (Connell 2011a; Heung et al. 2010; Ehrbeck et al. 2008). Medical travel facilitation, mostly understood as the work and business of medical travel companies and individual facilitators in the medical travel literature, has emerged alongside the medical travel industry: the aim is to facilitate
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transnational healthcare by connecting healthcare providers and patients transnationally and making healthcare abroad a more feasible and comfortable option for patients considering treatment abroad. Although described as “crucial connectors” (Wagle 2013, p.28), medical travel facilitators only recently came into the focus of academic research. The next section reviews the relevant literature on medical travel facilitation as this practice constitutes the conceptual and methodological pivot of this thesis.

1.1.2 Medical travel facilitation

Medical travel facilitation is typically understood to be the work carried out by a designated medical travel facilitator, a person who either works for a registered medical travel company, is self-employed or who works informally, on an individual basis. The lack of a clear job definition and the wide range of operational modes and forms of medical travel facilitation resonate with a number of different notions. Depending on their mode of operation, their set-up and/or the perception of their professionalism, medical travel facilitators are also referred to as healthcare facilitators, patient navigators, case-managers and patient advocates or in more general terms, they are brokers, agents or ‘touts’, all of which have different connotations. In the literature, medical travel facilitators are most commonly conceptualised as brokers and service providers, who connect patients with doctors or hospitals abroad, give information and advice on treatment options and destinations, and they may also coordinate the medical travel journey (Hanefeld et al. 2015; Snyder et al. 2012; Mohamad et al. 2012; Sobo et al. 2011; Gan & Frederick 2011; Crooks et al. 2011). For building connections and facilitating a ‘hassle-free’ experience (see for example Abubakar & Ilkan 2015, p.194; Padiya & Goradara 2014, p.272; Connell 2011b, p.101), these facilitators are found to play an important role in setting up medical care.

The scope of practices performed by medical travel facilitators varies and depends on whether they are based in patient sending countries or at the medical travel destination site. Dalstrom’s typology (2013, p.28), for example, describes a “full service medical facilitator” operating from the patient’s home country and providing a comprehensive service and facilitating logistical and cultural issues. If required, a ‘medical concierge’ supports the patient on site. The second type is the “referral service provider” (Dalstrom 2013, p.29), who is mostly based in the destination country and whose service is usually limited to building the connection between the patient and the doctor abroad. The third type is the “individual service facilitator” (Dalstrom 2013, p.30), referring to “foreign medical providers who directly market their medical services to patients”. This typology is based on research in the US/Mexico context and it is noteworthy that many studies focus upon medical travel companies operating from countries in the Global North, serving ‘Western’ medical travellers. Thus, there is scope for research
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with respect to the actors working in a South-South medical travel context. By considering different types of facilitators, some who are located in sending contexts and others based at the medical travel destination, this thesis will contribute to a better understanding of the entire circuit and different modes of facilitation, and the relevance of the specific geographies in constituting transnational healthcare.

Apart from this typology, the literature also identifies different roles and services, which are taken, and carried out, by medical travel facilitators. Snyder et al. (2012, p.2) argue that “brokers can play an essential role in facilitating communication, providing information, and securing overall quality control by assessing the reputability and reliability of international facilities”. As facilitators may take such an authoritative and controlling role, they are also referred to as ‘patient advocates’ (Hartmann 2017; Hanefeld et al. 2015; Ormond et al. 2014; Dalstrom 2013; Snyder et al. 2012; Sobo et al. 2011) who stand with the patients, defending their interests and rights. Another role ascribed to medical travel facilitators is the one of a ‘cultural broker’ (Hartmann 2017; Dalstrom 2013; Lee et al. 2014; Ormond et al. 2014), although there is not much detail about what this entails in practice. There is evidence of facilitators taking the role of a companion to the patients, providing personalised support for the patients’ emotional and physical needs (Ormond et al. 2014). Thereby they “may engage in formal emotional labour to provide medical travellers with companionship and support” (Ormond et al. 2014). Findings from my previous study on the work of medical travel facilitators in Delhi suggests that some facilitators are “not only caring for the overall well-being of the patients, but they are also caring about the patients in a particularly concerned, devoted and affectionate manner” (Hartmann 2017, p.3) as they become emotionally attached to patients and convey a sense of friendship and familiarity in their relations. The “under-examined role and dimensions of formal and informal care work involved in international medical travel” (Bell et al. 2015, p.288) suggests that the contribution of medical travel facilitators may go beyond simply setting up medical care abroad and it offers scope for further research. Thinking about practices of medical travel facilitation through the lens of care will allow to discuss some of the ethical complexities involved in this work. Considering debates in the care literature against the transnational setting offers an opportunity to think about the ways in which transnational healthcare escalates or mitigates certain issues, highlighting what sorts of mediations are necessary to make healthcare work transnationally. Going beyond care work and the facilitator-patient relationship, and taking care more generally as an optic though which to think about the variegated practices of medical travel facilitation, offers different theoretical routes into analysing the relationship between facilitation and care, which has implications for thinking about care in more general terms, and for transnational phenomena specifically. This impetus, to question the contribution of medical travel facilitation towards transnational (health)care, can also be directed towards their efforts in terms of building and mediating
transnational healthcare spaces. Aside from the various practices, carried out to directly support international patients, it is important to remember that in order to operate the building of an operational set-up and network connections are also an important aspect of their work (Hartmann 2017, p.47). Although the literature stresses the facilitators role as intermediaries and “crucial connectors between foreign patients and host countries” (Wagle 2013, p.28), there is little known about the specific ways in which medical travel facilitators establish and maintain transnational connections and how this differs in specific geographical contexts. From a patients-centered perspective, networks were found to be important in shaping medical travel trajectories; Hanefeld et al. (2015, p.356) for example, look at “the role of networks, defined as linkages – formal and informal – between individual providers, patients and facilitators to explain why and where patients travel”. Among other factors, the authors find that the patients’ networks including relations with friends and family, but also former medical travelers and medical travel facilitators, play an important role in the patients’ decision-making processes. The authors specify the nature of these relations stating that “while these [relationships] are commercially exploited by some, in the case of facilitators or clinician networks, the informal nature of many of these means they are not a purely commercial undertaking” (Hanefeld et al. 2015, p.362). Bochaton’s (2015) work on cross-border patient mobility between Laos and Thailand finds that “social capital embodied in social networks appears as a pivotal factor of cross-border movements” (Bochaton 2015, p.366). Focusing on the ways in which medical travel facilitation creates transnational networks on the ground can contribute to the literature in two ways. Firstly, it allows a better understanding of the contributions of medical travel facilitators in establishing transnational healthcare. Secondly, it brings a spatial sensibility towards the articulation of transnational spaces of health and care. Such empirical depth can add to the study of transnational healthcare spaces and transnational phenomena more generally.

1.2 Outlining the contribution

In the previous section on transnational healthcare and medical travel facilitation, I have pointed out where the current literature is limited, and I have indicated some of the areas of contributions of this thesis. The following section will summarise the research objectives and formulate the research questions that drive analysis in the empirical chapters. This is followed by an overview of the chapters, to give the reader an indication as to the direction and the structure of this thesis.
1.2.1 Research objectives and questions

Transnational healthcare presented itself as a fascinating phenomenon to me from the very beginning, for the level of complexity it holds, spanning across health and care, space and the transnational, mediation and brokering; for the ambivalence, transnational healthcare offers opportunities and threats to individuals, simultaneously, and the actuality and relevance of transnational healthcare globally. The initial objective of this research project was to better understand how practices of medical travel facilitation act to set up care transnationally and what this tells us about transnational space, care and practices of mediation. For an in-depth understanding, research that considers the entire circuit of facilitating medical travel, as it spans from the patients’ country to the destination site, was projected. Moreover, reviewing the literature on medical travel and its facilitation and having some research experience within this field, an important move, conceptually and methodologically, was to shift from a focus on the persona of designated medical travel facilitators to the practice of facilitation. This approach of tracing the action and a sensibility to different sorts of ‘doings’ is considered to be more encompassing, as it is not limited to a specific actor.

The focus on practices of medical travel facilitation was thus a conscious move, which is underpinned by theoretical reflections within the social sciences and Science and Technology Studies in particular, which is one of the main frameworks this thesis engages with. There are different understandings of ‘practice’. For sociologist Reckwitz (2002, p.249) it describes “a routinized type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, ‘things’ and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge”. Philosopher and geographer Schatzki (2012, p.14) takes it to mean “an open-ended, spatially-temporally dispersed nexus of doings and sayings”. A focus on practice allows a better understanding of how medical travel facilitation is established, through the interplay of routinised but also improvised social actions, doings and sayings that come into play in everyday life and that are constitutive of particular spatio-temporal configurations. Practices that “bring about site-specific arrangements of entities of all kinds” (Everts et al. 2011, p.331) are thus productive of spatial arrangements, such as transnational spaces of healthcare. With respect to Science and Technology Studies, “the practice orientation is simultaneously analytical – in the form of various practice theories – and empirical, in that research objects are often defined as ‘practices’” (Gad & Jensen 2014, p.698). This will be further explicated in the methodological and theoretical sections of this thesis (Chapters 2 and 3). An understanding of practices as “relations that are heterogeneously material and semiotic, filled with social and technical tensions and politically performative” and a practice-oriented approach, put forward by Actor-Network Theory, that is about “tracing the patterns of relations embedded in and reproduced in practices” (Law & Singleton 2014, p.380), shape this project. The research
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questions thus provoke reflections on patterns found in practices, but also in their socio-material realities and the power involved in it.

The myriad of interesting episodes and data that the empirical study offered allows many different ‘stories’ to be told. By considering the data and in consultation with areas in the literature to which this material can productively contribute, the ‘story’ that this thesis tells is about the relationship between facilitation and care, as encountered in ethnographic fieldwork in Oman and India, and what we can learn from it about transnational healthcare, care as socio-technical practice and transnational phenomena more generally. This thesis revolves around the three core themes that have crystallised from the empirical research and the engagement with the conceptual frameworks of STS and ethics of care and is guided by the following three research questions:

I) How do practices of medical travel facilitation act to relate/ articulate different kinds of spaces and spatialities involved in transnational healthcare?

II) How do practices of medical travel facilitation act to create a quality of smoothness in order to mediate healthcare transnationally?

III) How do practices of medical travel facilitation negotiate ethical complexities involved in transnational healthcare?

Question I focuses on the articulation of different kinds of spaces and spatialities of transnational healthcare and how this contributes to making transnational healthcare possible. To ‘articulate’ here means “to make connection and to join” (Law & Mol 2008, p.142). The focus is on the connecting work, the spatial effects and configurations of healthcare this generates: “the work of articulation” is “to build connections that lead towards a set of new configurations and possibilities” (Clarke 2015, p.281). A relational understanding of space underpins the analysis of this research question and sets the focus on transnational linkages and the work involved in establishing and maintaining them. Space, not as a container but, “made by relations” (Murdoch 2006b, p.21) also means that it is dynamic and “constantly in the process of being made” (Massey 1999, p.265). Transnational spaces span across different nation-states and also constitute what is in between; they are “configurations of social practices, artifacts [sic] and symbol systems that span different geographic spaces in at least two nation-states without constituting a new ‘deteritorialized’ nation-state” (Pries 2001, p.18). In migration studies, Faist (1998, p.216) defines transnational social spaces as “combinations of social and symbolic ties, positions in networks and organizations, and networks of organizations that can be found in at least two geographically and internationally distinct places“ and stresses the importance of developing “concepts that can be applied not only in either the sending or the receiving regions but also refer to emerging transnational linkages” (Faist 1998, p.216). The aim is to take a close look at how such linkages are being made, the different spaces they form
and how they relate, as well as how ‘national’ and ‘transnational’ healthcare spaces are established and how they become entwined, stretched, and folded into one another through practices of medical travel facilitation. This will contribute to a better understanding of articulations of transnational spaces in general and the specificities of healthcare spaces in particular.

Question II is based on the assumption that there is a significant amount of mediation work needed to establish medical travel and provide healthcare transnationally, not only in terms of creating spaces but of enacting them in everyday practice, handling different types of logistics and providing support for the individual patients. The formulation of the research question is a hybrid of the initial interest in the mediation work involved in medical travel facilitation and smoothness as an inductively found category and particular quality associated with that work. Drawing on the conceptualisation of facilitators as brokers and the conceptualisation of mediation in STS research shifts the attention to the mediations that need to take place in order to overcome difficulties posed by the transnational setting, the continuous tinkering as a response to ever-changing situations in healthcare and medical travel, and the collaborative effort of different actors who make transnational healthcare feasible. Smoothness is introduced as a relevant theoretical concept and explored as a disposition, spatio-temporal manoeuvre and outcome of such mediation, drawing upon accounts of medical travel facilitation in everyday routines. Working through the nexus between facilitation, smoothness and care, this research question gives the impetus to explore and deepen the argument that medical travel facilitation is not only about setting up medical care, but it is also about those practices which constitute care in itself in some meaningful ways.

Question III is concerned with different types of ethical complexities involved in transnational healthcare and how practices of medical travel facilitation handle them. Evolving from the previous research questions, this analysis is interested in how different ‘goods’ of care are being negotiated, such as the four principles of attentiveness, responsiveness, competence and responsibility, which are discussed in relation to care ethics, and also other values such as patient choice and autonomy. Moreover, the configuration of care in between different countries, between benevolence and business interest, and between familial and commodified caring relations allows interesting insights in how medical travel facilitation relates and prioritises these ‘goods’ in a process of working towards a ‘good enough’ compromise. The care practices and care ethics that negotiations of these complexities bring to the foreground have implications not just for the geographical study of transnational healthcare, but also that of care and transnational phenomena more generally.

These three research questions are held together by the interest in how medical travel facilitation makes transnational healthcare possible, feasible and ‘good’, whilst also exploring the nexus between facilitation and care throughout these three dimensions of articulating, smoothing and negotiating.
1.2.2 Chapter outline

The next three chapters are going to provide the platform for the following three empirical chapters that are aligned with the three research questions presented above.

Chapter 2 introduces the main theoretical frameworks with which this thesis engages. It starts with some conceptual thoughts around brokerage, which is a common way of understanding medical travel facilitation. Following on from this, care as conceptualised in STS and care ethics literature is introduced, as these are the two main conceptual frameworks with which this thesis engages. Despite their differences, the two approaches have some common ground in conceptualising care as a practice and the following discussion of the empirical material will highlight how they complement each other productively, both theoretically and methodologically.

Chapter 3 focusses on the methodological practicalities of this research project. It explains why multi-sited fieldwork and a combination of ethnographic data collection methods was found to be the most adequate approach for this research project. It provides details about the realisation of this study in Oman and India, the different sites and events visited for fieldwork, and details about the collection, processing and analysis of the data. A critical appraisal of the researcher’s positionality concludes this chapter.

Chapter 4 provides contextual information, which the following chapters build upon. It is a combination of literature-based information and empirical findings, which provides ‘groundwork’ on medical travel facilitation in the specific context. The chapter will provide an overview of Oman and India in terms of the developments of the healthcare sector over the past fifty years, how they became involved in transnational healthcare and more specifically, the relation between the two countries, fostered through health mobilities and other geo-historical connections. The second part introduces the informants who participated in this study by presenting some of the findings of who is specifically facilitating medical travel in Delhi, Kerala and Muscat. The last section then provides a simplified and more schematic overview of the different actors and stages of medical travel facilitation, as it was found to be typically practiced in the given context.

The interlude signals the transition to the three main empirical chapters of this thesis, by presenting a vignette which provides an in-depth and real-life view of on-site medical travel facilitation in a hospital in Delhi. It sets the scene for the three main aspects – articulation of transnational healthcare spaces, mediation of transnational healthcare and negotiation of ethical complexities – around which the analysis revolves in the following.

Chapter 5 is concerned with the first research question, regarding the articulation of different spaces and spatialities involved in transnational healthcare. It analyses three sets of practices of medical travel facilitation, each starting off in one of the three fieldwork locations (Muscat, Kerala, Delhi). The first case looks at the relation between national and transnational spaces
and how they are co-constituted and co-produced by different types of mobilities, in particular with regard to the Treatment Abroad Scheme in Oman. The second case looks at how health and location become entwined in the example of Ayurveda travel to Kerala and how the Kerala-Gulf diaspora is involved in coupling spaces of labour migration and healthcare. The third example, centered around international events such as Advantage Healthcare India, provides an additional take on spaces of transnational healthcare, exploring how such events fold spaces together, to create a version or miniature composition of the transnational healthcare market, and what transformative power such events hold. By observing the different topological spatialities (such as regions, networks, fluid and fire spaces) and spatial operations such as relating, stretching, coupling or folding, this provides a new take on the spatialities and temporalities of healthcare spaces and the importance of ‘care-ful’ practices in articulating them.

Chapter 6 is aligned with the second research question, which explores smoothness as a relevant quality of mediating transnational healthcare and making it feasible, for patients and actors on the provider side. Drawing on vignettes, to explore the everyday practice of medical travel facilitation, this chapter centers around connecting, communicating, and coordinating, as three central sets of practices for their contribution in dealing with frictions and roughness of transnational healthcare and for generating smoothness respectively. Conceptually, this chapter contributes to the understanding of how associations are made, by looking more specifically at qualities that are produced by and productive of such connection-work. Smoothness is explored as a disposition, spatio-temporal manoeuvre and outcome of medical travel facilitation, which seems to be not only critical for the feasibility of transnational healthcare in everyday practice, but also an expression of care.

Chapter 7 discusses the third research question and it is concerned with the negotiation of ethical complexities, that are involved in facilitating medical travel. Two aspects of medical travel facilitation are scrutinised against the four ethical values of care (attentiveness, responsibility, responsiveness and competence) discussed in care ethics and the logic of care, as developed in STS research. The first section is about the practice of giving advice on healthcare providers abroad and approaches the different ethical issues at stake in this process. The second part focuses on the relationship between patients and medical travel facilitators and analyses how facilitators negotiate tensions around their positionality, within the transnational configuration of the market and the logistics of care. Working towards ‘good’ care, or rather working towards a ‘good enough’ compromise as a form of care, is established as an overarching theme and its implications for making transnational healthcare possible are discussed.

Chapter 8 concludes by summing up the findings of the three empirical chapters and turning towards the overarching question about how practice of medial travel facilitation acts to set up transnational healthcare. Working through the dimensions of space, everyday mediations, and negotiations of ethical complexities of medical travel facilitation in conversation with care
literature in STS and ethics of care, allows the conclusion that these practices are not just establishing healthcare transnationally, but that they are also forms or aspects of care in itself. The final discussion outlines some of the implications this has for thinking about care such as taking practice seriously and developing adequate methods for studying it, taking the tinkering character of care practices on board, with regard to the ethics, whilst also being more sensitive about normative assumptions and spatio-temporal variations in conceptualising care. Furthermore, the lens of care brought to the foreground some interesting dimensions of transnational phenomena, such as the new spatio-temporal formations of space and medical care.
2 Conceptual approaches

This chapter introduces the conceptual frameworks which this research draws on and engages with. I shall highlight the gaps in the existing literature, which this study aims to contribute to, and presents the main ideas, which this thesis will refer to, and develop further, throughout the empirical chapters. Firstly, I briefly introduce brokerage, as usual way in which medical travel facilitation is conceptualised, questioning what it is able to offer, and which aspects of this practice may be missed by this approach. Supporting this theoretical endeavour and providing methodological guidance, the rich body of literature of Science and Technology Studies (STS) is drawn upon to further conceptualise medical travel facilitation. In particular, reflections on network building with a spatial sensibility and conceptualisations of care provide productive entry points for this thesis. In order to expand thinking through medical travel facilitation more thoroughly in terms of the ethical complexities it poses to care as an everyday practice but also care relations that span different places and institutions, the ethics of care literature is consulted. By discussing these theoretical approaches and bringing them into conversation serves multiple purposes: firstly, it provides a thorough underpinning for furthering the conceptualisation of medical travel facilitation as a form of care, and secondly, it allows the exploration of the synergies of these approaches, for thinking about care in more general terms, and for transnational phenomena, specifically.

2.1 Brokerage

Medical travel facilitation is often conceptualised as some form of brokerage in the sense of connecting and mediating between different parties (Ormond et al. 2014; Mohamad et al. 2012; Casey et al. 2013a; Dalstrom 2013; Spece 2010; Turner 2010; Lee et al. 2014). Brokerage as a concept is discussed in different disciplines and thematic areas and often evolves around the persona of the broker (see for example Lindquist 2015b; Kern & Müller-Böker 2015; Lindquist 2015a; James 2011; V. L. Smith 2001), their function in terms of networking, connecting and handling its logistics (see for example Thieme 2017; Lindquist 2017; Casas et al. 2011; Lindquist et al. 2012; Spaan 1994), and brokerage in the sense of socio-cultural
mediations (see for example de Jong 2016a; Salazar 2015; Michie 2014; V. L. Smith 2001; Lee 1998; Gentemann & Whitehead 1983; Salovesh 1978).

Holding an intermediary position in connecting different parties and shaping the development of relationships are central to brokering. This mediating role is discussed, for example in the context of labour markets where intermediaries connect workers and employers (Benner 2003; Collet et al. 2014), also in terms of internationally operating recruitment agencies (Lindquist et al. 2012; Faist 2014; Kern & Müller-Böker 2015), or in tourism where travel agents and tour guides mediate between tourists and host societies (Reisinger & Steiner 2006; Evans 1976), and development contexts (Smith & van Naerssen 2009; Mosse & Lewis 2006; Bierschenk et al. 2002). Similarly, connections between patients and healthcare providers and other stakeholders are fostered by medical travel facilitators. This ‘being-in-the-middle’ is an ambivalent and powerful position: “[a]lthough intermediaries may mediate or facilitate between groups of actors, they are never neutral in dealing with others and are capable to translating, redefining and fundamentally changing what they transport” (Hiteva & Maltby 2014, p.120). It is this transformative capacity, that differentiates mediators, from more passive intermediaries, a distinction that Latour (2005, p.39) elaborates carefully in the context of actor-network theory. An intermediary is “what transports meaning or force without transformation” (Latour 2005, p.39); input and output are the same. In contrast, mediators “transform, translate, distort, and modify the meaning or the elements they are supposed to carry” (Latour 2005, p.39), which is why their “input is never a good predictor of their output; their specificity has to be taken into account every time”. The flexibility that is built in and the capacity to make adaptions renders mediation particularly agile and responsive but also precarious and unpredictable, all qualities that medical travel facilitation also holds and that resonate with brokerage more general. In both conceptualisations there lies power in shaping relationships and the agendas of the actors involved may be indicative of the ways in which this power is used. Exploitative ways of enacting this powerful position, moral ambiguity, questionable ways of making profit, and the lack of regulation in some industries in which brokers are active, lead to criticism around the persona of the broker and even its “demonization” (Lindquist et al. 2012, p.12). Some studies, however, counterbalance this image pointing out the positive effects of brokerage work; for example, in terms of making mobilities safer (see for example Kern & Müller-Böker 2015) or facilitating them by taking an “infrastructural role” (Lin et al. 2017, p.172).

Brokerage also allows a route into the exploration of logistical infrastructure, which involves networking and mediating mobilities of different sorts. Within the context of migration, Xiang and Lindquist (2014, p.122) propose a focus on brokers as a productive route into better understanding infrastructures, defined as “the systematically interlinked technologies, institutions, and actors that facilitate and condition mobility”. Another take on infrastructure is
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presented by Simone (2004), who elaborates on the idea of “people as infrastructure” looking at the ways in which people form conjunctions of “complex combinations of objects, spaces, persons and practice” (Simone 2004, p.408). For Simone (2004, p.410) “people as infrastructure” shows that the “process of conjunction” in the articulation of spaces, such as the inner city of Johannesburg in his case study, is “tentative and often precarious” (Simone 2004, p.411). Moreover, this perspective traces how social collaboration and inter-dependencies between people shape ways of claiming spaces within the city, the market and informal economies. Focusing more explicitly upon the ways in which medical travel facilitators articulate spaces, and how they themselves become infrastructures for health mobilities, will enhance the understanding of the importance of these facilitators in bringing transnational healthcare into being. In return, the empirical material and methodological approach could add some depth to a spatial conceptualisation of brokerage.

Socio-cultural mediation is another aspect of brokerage, describing different types of practice, whereby mediation occurs in multi-cultural contexts. A cultural broker may be conceptualised as “one who thoroughly understands different cultural systems, is able to interpret cultural symbols from one frame of reference to another, can mediate cultural incompatibilities, and knows how to build bridges or establish linkages across cultures that facilitate the instructional process” (Gay 1995, p.100). Migrants, who are familiar with two or more cultures, seem to be well-placed for taking the role of socio-cultural brokers given their specific skills, knowledge and experience (de Jong 2016b; Yuniarto 2015; Rahman 2011; Lee 1998). In the context of medical travel, different studies refer to the efforts made to familiarise patients with the socio-cultural peculiarities at medical travel destination sites (Hartmann 2017; Ormond et al. 2014; Dalstrom 2013), however, the literature remains relatively unconnected to the concept of socio-cultural brokerage. Individuals from a migration background are known to take a mediating role but this tends to be more in terms of building trust and connections, rather than mediating cultural differences. Ormond (2013a) discusses how members of the Philippine and Indian diaspora become consumers and ambassadors of healthcare in their country of origin. Additionally, elements of my previous research indicate that migrants residing in Delhi take an active role in helping their fellow citizens in accessing healthcare in India (Hartmann 2017, p.38). The mediation of cultural aspects of health and care, which feature in healthcare, nursing and in some social science literature, often discussed in relation to the notion of cultural competence (Gunaratnam 2008; Betancourt et al. 2002; Campinha-Bacote 2002; Schwab et al. 1988), seems surprisingly unrelated to the medical travel context, besides language interpretation. Language barriers and translation work have been identified as important aspects for medical travel (Suryanarayan 2017; Kaspar 2015). However, discrepancies in culturally contingent understandings of care, for example, remain understudied and there is limited understanding of its role within health care. There are existing studies concerned with different
understandings of care in arrangements in which the carer has migrated (Bastia 2015) or in which migrants receive care in their country of residence (Gunaratnam 2009). However, the important question of “what happens when different meanings of care come into contact and have to be negotiated” (Raghuram 2016, p.523) has so far received little attention in the context of medical travel. In contrast to the expectation that medical travel facilitation may be concerned with brokering and mediating different understandings of care, the data of this study found that it does not appear to be at the forefront of the concerns discussed by the interviewees. Care itself, however, became a central theme of medical travel facilitation and approaches other than brokerage are considered to be more productive in terms of furthering the conceptualisation of medical travel facilitation. The insights, however, can contribute to the re-evaluation of brokerage within this context.

2.2 Conceptualising care

Care has become a relevant concept in different thematic areas and disciplines in the social sciences. This section briefly locates care in geography and then introduces the two main theoretical approaches towards care that this thesis engages with: care in STS and in the ethics of care.

2.2.1 Health geography and care mobilities

In the discipline of geography, a concern with health and care, has a tradition within the fields of medical geography (Parr 2003; Mayer 1984; Paul 1985) and health geography (Kearns & Collins 2010; Kearns 1994). From its foundation in disease ecology and strength in quantitative analysis, spatial mapping and modelling (Emch et al. 2012; Bian et al. 2012) a more diverse field of research has developed within the discipline over the past decades, evolving around the nexus of space and place with health and care. One area, for example, is concerned with health-promoting qualities of places and therapeutic landscapes (Buzinde & Yarnal 2012; Williams 2010; Gesler 1996), another with public health and the spatialities of inequalities (McLafferty et al. 2012; Weeks et al. 2012). There is extensive literature around care and its socio-political and spatial organisation (Power & Hall 2018; Atkinson et al. 2011; McEwan & Goodman 2010; Milligan & Power 2009; Lawson 2007), and different sorts of health or healthcare related mobilities, such as therapeutic mobilities of patients and pharmaceuticals for example (Kaspar et al. 2019; Bochaton 2019; Quet et al. 2018; Gatrell 2013) or the migration of health and care workers (Thompson & Walton-Roberts 2019; Ennis & Walton-Roberts
2018; Beladi et al. 2015). This has led to the conceptualisation of global care chains (Yeates 2012; Yeates 2004; Parreñas 2000; Arlie Russle Hochschild 2000).

The concept of global care chains (Yeates 2012; Parreñas 2012; Yeates 2004; Arlie Russle Hochschild 2000) describes a particular pattern of care worker mobility and care transfer between the Global South and North, which points out the interrelations and implications it has for the sending and receiving contexts of migrants on multiple levels. The migration of domestic care workers (Arlie Russell Hochschild 2000; Parreñas 2000) and health professionals, such as nurses (Thompson & Walton-Roberts 2019; Ennis & Walton-Roberts 2018; Walton-Roberts 2015), raises questions about the organisation of reproductive labour and gendered work (Kofman & Raghuram 2015; Parreñas 2012; Kofman 2014; Kofman & Raghuram 2009), the transnationalisation and marketisation of care (Yeates 2011), transformations of a global political economy of care, and the implications for the governance of health worker migration (Yeates & Pillinger 2018; Ennis & Walton-Roberts 2018; Yeates 2005). The global care chain approach and medical travel are related, in practice and in theory, although different health-related mobilities are taken into account. Practically, they are related because patient mobility may require some health professionals being mobile, as well. Theoretically, they are concerned with a changing political economy of care on multiple levels, the care that is provided at the destination site and the lack thereof in the sending country, as a cause for or consequence of the mobility. Geographers, among other social scientists, have made important contributions to debates about the governance of health related mobilities and the spatially-inflected conceptualisation of mobilities, connectivity, and transnational networks.

This body of research along with the concept of brokering provides the general frame and starting point for the research of this thesis. For an in-depth analysis of medical travel facilitation and how it relates to care, however, this thesis works with conceptualisations of care in STS and the ethics of care literature in geography and beyond for the before mentioned reasons. The next two sections reflect on the main conceptual ideas that this thesis works with and to which it will contribute.

### 2.2.2 Care and Science and Technology Studies

Coming from medical travel facilitation as some sort of brokerage, Science and Technology Studies (STS) offers useful approaches to further conceptualise the work of connecting, infra-structuring, and mediating from a constructivist and relational perspective. Moreover, conceptual thinking around health and in particular, the theorisation of care, put forward by Annemarie Mol and colleagues (Mol 2010; Mol et al. 2010b; Mol 2008; Mol 2002; Law & Mol 2001) offers interesting ground for reconceptualising medical travel facilitation. This literature thinks care differently from most literature into transnational healthcare and medical travel
facilitation and thus has potential for novel contributions. At the same time, moving some of the insights of STS research into care to the transnational setting of medical travel brings certain aspects of this practice to the fore that are less apparent or omitted in more localised contexts and yet become relevant for furthering reflections about care, e.g. by relating the notion of smoothness to care and probing what this quality has to offer conceptually.

The project of following practices of medical travel facilitation is theoretically and methodologically informed by some of the guiding principles of STS research. In line with the impetus of Actor-Network Theory (ANT) to trace associations (Latour 2005), the circuit of medical travel facilitation is followed, along the actors and practices as a way of illuminating articulations of transnational healthcare spaces. Focusing on the connections and the ways in which actors “mobilise, juxtapose and hold together the bits and pieces out of which they are composed” (Law 1992, p.386) shifts the focus onto the work involved in keeping networks together, which are “composed not only of people, but also of machines, animals, texts, money, architectures – any material that you care to mention” (Law & Singleton 2014, p.381). Advocating strongly for the inclusion of non-human actants and the recognition of their agency in mediating action and the heterogeneous materiality (Law & Singleton 2014; Latour 2005; Law & Mol 1995; Law 1992) is an important contribution of this body of literature. Medical travel is greatly facilitated by non-humans, thinking information and communication technologies, for example, means of transport, and of course all the medical devices, machinery, medicine etc. The relevance of non-human entities will become obvious in the presentation of the data.

Nevertheless, practices of human actors will be in the foreground in this thesis for being the methodological entry point and for offering particularly interesting insights with respect to the research questions. Thereby, the focus is on the relations and their modalities, and on the effects that they, and their patterning into networks, generate. Then, “society, organizations, agents and machines are all effects generated in patterned networks of diverse (not simply human) materials” (Law 1992, p.380). With “patching together” as a “leitmotif” (Hinchliffe et al. 2016, p.137) of STS, such an approach “permits accounting for the fluidity of multiple types of relations“ (Bosco 2006, p.142) and the different realities that coexist (Law & Singleton 2014; Mol 2002).

Out of this body of literature, an influential engagement with ‘care’ evolved over the past few years. For care, “foremost described as the work of arranging, modulating and resolving bonds” (Turrini in Mol et al. 2011, p.75), the beforementioned attention to the (un)making of relations and the different forms and qualities they take is important. Since theory and methodology are closely entwined in STS, those principles are reflected in the methodological approach. Focusing on practices and following an ethnographic approach, generates a rich and “fine grain description” (Piras & Zanutto in Mol et al. 2011, p.80) of a phenomenon. The close attention to practices and the acknowledgement of their multiplicity (Law & Singleton 2014;
Conceptual approaches

Mol 2002) and messiness (Law 2007) are seen as productive ways of approaching care, methodologically and theoretically. This means attending to the “details and subtleties of practices that are local, embodied and responsive to a variety of heterogeneous and unpredictable elements” (Turrini in Mol et al. 2011, p.75). Moreover, this involves tracing different versions of the same thing (Mol 2012) and how these versions relate to each other, which may be complicated and contested: “the same thing may take on different qualities as it is performed in various ways, and those qualities may exist in tension with one another” (Hinchliffe 2015, p.30).

One of the foundations of the engagement with care in STS is the conceptualisation of care as a process or practice of tinkering, which is shared and co-constituted by multiple actors and non-human entities and is oriented towards improvement. Mol (2008, p.18) understands care as an open-ended process, an “interaction in which the action goes back and forth (in an ongoing process)”. By thinking of care as not just something that is, but also something that is done is crucial as it shifts the attention to the ‘ongoingness’ of care, something that is being done in a certain way, in a particular moment, in a given location, and yet continues to evolve. It allows one to attend closely to the intricacies that constitute care. This practice-oriented understanding is encapsulated in the conceptualisation of care as ‘tinkering’ – a “persistent tinkering in a world full of complex ambivalence and shifting tensions” (Mol et al. 2010b, p.14). This points to the modality of a practice, which is continuous, non-linear and situational. Care is thus constituted differently according to the situation and the following quote shows an example of the forms that care may take: “It may involve putting a hand on an arm at just the right moment, or jointly drinking hot chocolate while chatting about nothing in particular. A noisy machine in the corner of the room may give care, and a computer can be good at it, too” (Mol et al. 2010b, p.10). The richness of theorising care in STS literature lies also in the idea that care is not bound to what may traditionally be identified as ‘care settings’, for example within familial relationships or the healthcare context, nor does it pre-empt certain groups of people that are often considered as particularly in need of care. However, a similarity between those studies is that care often draws on qualities such as attentiveness, inventiveness and persistence, and it requires skills, knowledge, and the ability to respond and attune to others enrolled in the care project (Mol 2008, pp.55–56).

This leads to another important point, namely that care is considered to be a shared practice. As a consequence, “[t]he art of care is to figure out how various actors (professionals, medication, machines, the person with a disease and others concerned) might best collaborate in order to improve, or stabilise, a person’s situation” (Mol 2008, p.23). This quote encapsulates two more crucial aspects of the conceptualisation of care. Firstly, thinking of care as a practice which is shared, shifts the attention to multiple actors and actants, and it highlights the importance of the ways in which they collaborate. Care is then a collective effort, whereby patients themselves, among others, contribute as “crucial members of the care team” (Mol 2008,
This does not pre-empt care as a practice facilitated by people in healthcare professions, care workers or close family members. Instead it opens up the concept of care to other people (and things) that are backgrounded in other conceptualisations, constituting a “model of democratisation of expertise” (Mol 2008, p.56). This raises the question of what expertise is required to care or which skills are considered necessary or valuable.

The second aspect that is brought to the forefront by this theory is the orientation of care towards improvement. Originating from a case study in a healthcare context, Mol (2008, p.20) specified ‘good care’ as a “a calm, persistent but forgiving effort to improve the situation of a patient”. This is different from normative values which are often inscribed in care. In Mol’s (2008) book, ‘The logic of care. Health and the problem of patient choice’ she critically analyses the ‘logic of choice’, the approach of allowing patients to make their own decisions with regards to their healthcare. Mol argues that “[w]hen they are patients, people often lack this ability” (Mol 2008, p.6) to make their own choices and a logic of choice may result in inadequate care. Instead, she proposes a ‘logic of care’, in which collaborative, adaptable and perseverant practices work towards the improvement of a situation. The two logics draw on different morals: “While in the logic of choice autonomy and equality are good and oppression is bad, in the logic of care attentiveness and specificity are good and neglect is bad” (Mol 2008, p.74). In a logic of care, “local solutions to specific problems need to be worked out” (Mol et al. 2010a, p.13), which means that care is constituted in practice and under consideration of different norms: “They may involve ‘justice’ but other norms (fairness, kindness, compassion, generosity) may be equally or more, important – and not in a foundational way, but as orientations among others. (…) we do not separate out ethical from other norms (be they professional, technical, economical or practical)” (Mol et al. 2010a, p.13). The body of literature on ‘care in practice’ also advances a sensibility towards the coexistence of different goods around care, which may or may not be conflicting, suggesting that care may lie within practices of “tending the tensions” (Bingham & Lavau 2012). Care is therefore, again, considered to be a form of tinkering which “seeks to improve situations by providing local solutions to the problem of how different goods might coexist in practice” (Lavau & Bingham 2017, p.21). This can mean that competing ‘goods’, such as the logics of choice within care, are being negotiated (Mol 2008), their incompatibilities are being identified (Mol et al. 2011, p.76), or that virtues, such as compassion, which may be associated with ‘good’ care, are being critically and situationally evaluated (see Singleton & Mee 2017). Often there is no clear ‘good’ or ‘bad’, but attending to the subtleties of care as a practice as they happen, helps to better understand the complexities around such values. It may be more useful to think of what makes care ‘good enough’ (Mol et al. 2010a, p.12). In line with this intention of working towards improvement and care that is ‘good enough’, care is considered in terms of “precarious compromises that are always in need of fine tuning” (Piras & Zanutto 2011, p.80).
The understanding of care cultivated in STS thus prompts thinking of medical travel facilitation as a form of care in itself rather than being just a service setting up healthcare. One of the main contributions of this thesis will be to analyse the configuration and collaboration of spatially dispersed care teams, to explicate how attentiveness and specificity play out in smoothing transnational healthcare and to think through the implications this has for improving care. In consultation with care ethics as a second framework, the interplay of different ‘goods’ and ethical values and how they are made to relate through medical travel facilitation (rather than getting into normative debates) will be analysed, especially in view of how this contributes to compromises.

Drawing on these theoretical peculiarities of care, developed by this body of literature, this thesis moves away from looking at healthcare spaces in a medical sense as most of the literature on medical travel does. Instead it explores the practice of medical travel facilitation as a ‘form of care’, rather than seeing it merely as sets of practices that set up care, in the sense of being a means to an end. To date, the contribution of medical travel facilitators to care has predominantly been considered as service paving the way for the ‘real’ care as in care in medical terms. This tends to take away from their contribution to caring itself but working with the concept of care in the STS framework allows to explicate different ways in which medical travel facilitation constitutes forms or aspects of care itself. Moreover, the specificity of transnational healthcare takes care from an often intimate and localised encounters to the transnational setting. This means that the implications of having a spatially dispersed care team and also having temporally, spatially and socially intermittent practices of care can be explored.

As care is occurring in different contexts and it is being facilitated by actors who are more or less connected to other members of the care collective, it challenges the notion of persistence. Aspects of care may be altered by such spatially distributed, multicultural caring arrangements, which go beyond relatively intimate, situated and localised caring encounters, which are more commonly the setting for care, within this literature. All of this opens up room for contributions to the conceptualisation of care within this framework.

Before summarising how this thesis will engage with this conceptual framework, a short excursus on ‘smoothness’. Counteracting ‘roughness’ resulting from and involved in transnational healthcare, smoothness was found to be highly relevant to medical travel facilitation. Inspired by how Annemarie Mol thinks through empirically-derived categories within her work (2002), this thesis attends to and seeks to theorise ‘smoothness’ as it emerged during the research; first as an identified quality of facilitation work and then more broadly in relation to tinkering and care as entwined ways of conceptualising how medical travel facilitation works in the midst of things.

Smoothness as an analytical tool shifts the attention to certain qualities of work rather than the practices as such. It allows to explore smoothness as both a quality of medical travel
facilitation and a goal or outcome. Mol and Heuts’ (2013) study on ‘good’ tomatoes and ‘the economy of qualities’ (Callon et al. 2002) provided a productive starting point for thinking about the qualities of certain work and how they are valued. The latter draws attention to how qualities of products or services on the market come to be following “the controversial process of qualification” (Callon et al. 2002, p.199) – controversial because the quality-relevant characteristics and the valuing of them can both be controversial. This is in line with Heuts and Mol’s (2013, p.125) finding that the registers used to define a quality may contrast one another: “Clashing ‘goods’ may side-line or overrule each other, or become fused into compromise” (Heuts & Mol 2013, p.140). This resonates with the concern of better understanding how care as a compromise is constituted in transnational healthcare through medical travel facilitation and the inherent negotiations of different values, principles and qualities such as smoothness discussed here. It provokes me to think about how smoothness as a quality is valued in the context of medical travel facilitation and how it relates to the concept of tinkering and eventually care. Smoothness might, at first glance, appear to be somewhat of an antithesis to the focus of STS work on patching heterogeneous entities together, attending to frictions and moments in which networks break down and, in particular, to the notion of tinkering as a defining practice of care. Taking the empirically derived category seriously and analysing smoothness with its different modalities as they play out in the practices of medical travel facilitation (Chapter 6 explores smoothness as a disposition, manoeuvre and an outcome) provides an alternative entry point. This offers, I propose, an opportunity to reflect on some of these more established concepts in STS work and ways of working against – or with – smoothness. As outlined before, tinkering is here understood as a persistent effort (Mol et al. 2010b) aiming at improvement (Mol 2008), as “attentive experimentation” (Mol et al. 2010b, p.13) and an ongoing process that requires that we “meticulously explore, test, touch, adapt, adjust, pay attention to details and change them, until a suitable arrangement (material, emotional, relational) is achieved” (Mol et al. 2010a, p.16). This relational practice in which different entities adjust to one another with the purpose to “empirically shape an arrangement” (Winance 2010, p.95) that suits them all is also referred to as ‘empirical tinkering’. Thus, tinkering is not straightforward or smooth, but smoothness can be an outcome. This thesis will explore how tinkering becomes an accomplice to smoothness for its contribution to overcoming different kinds of roughness encountered in transnational healthcare. Tinkering will be analysed empirically as it presents itself in practices of connecting, communicating and coordinating. Taking this empirical-conceptual project further, tinkering and smoothness will be critically discussed as criteria for ‘good care’ in the context of medical travel and some of their limits will be teased out in the given context, also by bringing in a care ethics perspective.
In short, this study draws on and works with different elements of the conceptual and methodological principles of STS, whilst also adding and exploring new aspects. The first empirical chapter (5) about the articulation of spaces of care will attend to the peculiarities of the work of connecting and relating, while the second chapter (6) engages more with the idea of mediating and tinkering and how this relates to care and smoothness as a particular quality of the facilitation work. Analysing how spatially dispersed care teams negotiate different goods and how medical travel facilitation contributes to ‘good enough’ compromise that constitute care is explored in the last empirical chapter (7).

2.2.3 Ethics of care

Although it is reasonable to assume that care is at the centre of medical travel and its facilitation, care as a concept is in fact surprisingly under-examined within this body of literature. This section introduces the ethics of care as a meaningful approach, in combination with STS, to explore the mediations of care within medical travel facilitation – one of the main contributions of this research project. The ethics of care is a normative ethical theory which has evolved from feminist and moral theory and resonates with current concerns in many different disciplines, such as sociology (Gunaratnam 2009), political sciences (Robinson 2013), economics (Himmelweit 2007), international development (Bastia 2015), social policy (Mahon & Robinson 2011; Kofman & Raghuram 2015), women’s studies (Sevenhuijsen & Svab 2003) and also geography (Green & Lawson 2011; Raghuram 2016; McEwan & Goodman 2010; Silk 1998; Popke 2006; Smith 2005).

The ethics of care is a deeply relational approach, that centres on relationships of interdependence and, as a normative theory, suggests that certain ethical values are key to defining ‘good’ care. The four virtues of attentiveness, responsibility, competence and responsiveness, defined by Tronto (1995, p.148), are widely recognised in the ethics of care literature and they correspond with four phases of care: caring about, taking care of, care-giving and care-receiving (Fisher & Tronto 1990; Tronto 1995). This entwinement of values and practices is central to the conceptualisation of care within the concept of care ethics. Care is essentially understood as “both a practice, or cluster of practices, and a value, or cluster of values” (Held 2006, p.4). Raghuram (2016, p.516) explicates their relation saying that “[c]are as ethics is developed through care as practice” in order to have effectual relevance. Care as a practice involves “embodied, physical and emotional work” (Raghuram 2016, p.516) and is “usually driven by its own internal, often implicit, calibration around justice or virtue” (Raghuram 2016, p.516). Based on that, this thesis methodologically starts from practices of medical travel facilitation as a route into the ethical complexities they involve. The four ethical values elaborated by Tronto (1995) provide a platform to critically analyse some of the ethical complexities
involved in medical travel facilitation, such as the questions of competence and responsibility, as well as empathy (van Dijke et al. 2019; Noddings 2010b). Autonomy in care and caring relationships (Noddings 2010d; Moser et al. 2010; Clement 1996), along with patient choice, which has was mentioned in the STS literature, become topics for discussion throughout this thesis.

The understanding of care as a practice, as advocated for conceptually, should resonate accordingly with the methodological approach. However, it remains to some extent unclear as to how care ethics methodologically acknowledges care as a practice. It is therefore suggested to draw upon an STS-approach, to observe how this can inform this study and possibly, go beyond this, to contribute to care ethics on a methodological level. The empirical case and the specific focus on practices of care, supported through the body of STS research, contributes to “rethinking care ethics from and through their empirical practices” (Raghuram 2016, p.525) and subsequently to bridging the gap between the conceptual claims and methodological approaches identified in care ethics and social policy research. Considering interview data, in combination with field notes from job-shadowing, aims to allow a sense of the ethical complexities involved in care practices, through the reflections of different actors upon their practices and their actual doings. This methodological approach will also highlight aspects of care which become relevant for advancing the theorising of care within care ethics.

Ethics of care is also entwined with social policy literature in terms of analysing different types of caring relations and how they are embedded within institutional and spatial arrangements. This model of the care diamond outlines the state, markets, families and households, and the not-for-profit sector, as the four institutions in which care is typically provided (Razavi 2007, p.20). It also indicates different social, economic and political relations within which care is set. The aim is to “emphasize the multiplicity of sites where care is produced and the decisions taken by society to privilege some forms of provision over others” (Razavi & Staab 2008, p.5). This is of interest for care ethics in multiple ways; it raises questions about how qualities of relations change, depending on whether it is provided in familial relations or a setting within which care is commodified and paid for through the market. Whilst the family is often seen as the central realm for ‘good care’, this “naturalised location of care” (Green & Lawson 2011, p.650) has been questioned in care ethics and care has been taken beyond the family (Roseneil & Budgeon 2004). In line with this is the argument that “[p]aid work need not displace a strong sense of responsibility, empathy and even love for those being cared for — much depends on the organizational characteristics, public policies and societal norms that shape such work (Razavi 2007, p.16). The care diamond also raises questions about the responsibilities taken by, or assigned to, those four different domains of care (Tronto 2010; Smith 2005; White & Tronto 2004). However, it is important to recognise that these four domains are “neither clear-cut nor static” (Razavi & Staab 2008, p.5). This thesis will illustrate this in multiple ways;
Chapters will analyse how the tie-ups between a government scheme and private healthcare providers abroad, create alternative spaces of healthcare; Chapter 6 will illustrate how representatives of different institutional care set-ups collaborate in everyday practice, and Chapter 7 will closely explore the implication of mobilising narratives of familial care, as a way of vouching for quality.

As previously mentioned, a common site where care has been configured in social policy and ethics of care has been the nation state but in the course of the transnationalisation of care, a global or transnational political economy of care has come into focus (Mahon & Robinson 2011; Williams 2011). Mahon and Robinson (2011, p.16) describe care ethics as a “lens through which to focus and organise our thinking about the ways in which care is delivered at the local, national, and global levels”. The shifts towards transnational arrangements of care provision reflected in the migration of care workers, global care chains, and the influence of international organisations in matters of care and social policy discourses which go beyond national levels. These changes “raise ethical and policy challenges related to migration, citizenship, and labour as well as basic political and moral concepts like equality, exclusion, and democracy” (Mahon & Robinson 2011, p.14). The ethics of care offers a focus on interdependence to this literature, which does not only apply to individuals, but also to nation states and other institutions. By exploring how Oman and India become entwined, along the axis of healthcare, in the context of medical travel, offers a conceptual way of thinking about interdependencies on a transnational level. This also responds to the critique of care ethics, which argues that it is only viable for the local, and to the question of whether care ethics can “move beyond the interpersonal, the near and familiar, to care for distant others?” (Lawson 2007, p.6). Working both on a level of micro practices that illustrate how initially distant others become enrolled in care collectives, and on a policy level looking at how different care spaces relate, medical travel facilitation engages with these concepts in multiple ways.

Another area in which ethics of care advances our thinking of transnational connections, interdependencies, and institutional care arrangements, is by paying attention to the geo-histories of care and local contingencies. On the one hand, this helps to situate practices and patterns, as they currently unfold today, for example in explaining how Oman and India have become entwined through medical travel. Their interdependence, in terms of geo-historical connections of care, is important for understanding how transnational spaces of care are being articulated in this specific case and how a certain receptivity towards care, is being created over time. On the other hand, attending to the geo-histories of care and how they shape certain understandings and practices of care, contributes to the conceptual project of deconstructing certain assumptions around care. With a spatial sensibility, Raghuram (2016, p.524), in line with Green and Lawson (2011), outlines the importance of taking care as a practice seriously and carefully attending to local contingencies, in order to deconstruct the implicit, but
prevailing locatedness of care ethics in the global North. This is also an area within which a geographical perspective on care ethics can advance the understanding of care configurations and the implications for a transnational setting.

2.3 Conclusion

This chapter introduced some of the main concepts that this research draws upon and engages with and this final section recapitulates the areas in which this thesis will contribute, with reference to how this unfolds across the empirical chapters that follow. One of the conceptual moves is to open up medical travel facilitation to be conceptualised as a form of care, besides the elements that are involved in brokering and to expand upon the view that it is merely an auxiliary service for medical care. In line with this endeavour, the main contribution conceptually developed through the three empirical chapters will be to analyse and discuss how practices of articulating spaces (Chapter 5), generating smoothness (Chapter 6) and negotiating ethical complexities (Chapter 7) become constitutive of care themselves.

The case of medical travel between Oman and India will show how different institutions and actors become entwined, beyond national borders or institutional sectors along different social, economic, political and historical lines, contributing to different forms of providing care. The spatialities of care and how the articulation of certain spaces acts to set up care and how it is in itself a ‘care-ful’ practice are to be explored. The spatiality of transnational healthcare and medical travel thereby challenge the typically more bounded and localised settings, within which care takes place and is researched, and it offers an opportunity to think conceptually about the implications of the transnational for both the practical and ethical dimensions of care.

This is further elaborated in the analysis of how care is made feasible on the ground, given the difficulties of this particular context towards care and care work. Drawing on the conceptual work which looks at care as tinkering, this thesis further elaborates on this concept by relating it to the quality of smoothness, an inductively found category, which will be explored as a disposition, spatio-temporal manoeuvre and outcome of medical travel facilitation. This analytical endeavour contributes to the literature, by not only focusing on relations in itself and the work it takes to build and maintain them, but also by drawing attention to the qualities that these relations hold and generate, and their relevance in terms of feasibility of certain practices.

Engaging with smoothness as a conceptual category, offers a productive route into thinking about the relevance and implications of certain qualities of, and for, care and how different ‘goods’ are being negotiated through facilitation and the different actors involved in it.
Exploring the empirical material will contribute to the thinking of care as a ‘good enough’ compromise. Moreover, the insights from attending to care practices methodologically could be productively be taken on board in the ethics of care.

Besides providing a conceptual underpinning and ground for further theorising different aspects of care brought to the fore in the empirical material, one of the contributions of this thesis lies in bringing the theoretical approaches towards care developed in STS and the ethics of care into conversation. The methodological and conceptual benefits of using the synergies of these approaches for thinking about care generally and for transnational phenomena specifically, as well as some of the cruxes that need further engagement, will be exposed throughout the chapters and discussed within the conclusion.
3 Research design and methodology

This chapter provides an overview of the methodology that guided the fieldwork and data collection of this research by introducing the multi-sited ethnographic research design first and then detailing the different phases and approaches of data collection. This is followed by outlining the approach to data analysis and concluded by a critical appraisal of the researcher’s positionality. More information about the informants who have contributed to this research will be provided in the next chapter (4.2) that is dedicated to giving some more information about the background of the case study and presenting some of the empirical findings that help situate the data presented and discussed in the empirical chapters later on.

3.1 Multi-sited ethnographic research

The research design of this study is driven by the objective that has been outlined before in the form of the set of research questions and underlined by the methodological approaches of the concepts introduced before. The thematic and conceptual concern with practices of care in the context of medical travel facilitation between Oman and India called upon a methodology that would account for the orientation towards practice, transnational spaces and that brings the necessary nuanced sensitivity required for research on care. A multi-sited ethnographical research approach was considered to be most appropriate for following practices of medical travel facilitation between Oman and India and for generating rich qualitative data needed in order to respond to the research questions in this thesis. STS research with its close entwinement of conceptual thinking and methodological practices provided some of the guiding principles for this study. The impetus of tracing associations within this framework and the (un)making of connections (Latour 2005) provides this project also a practical-methodological orientation that directs attention to the articulations and modalities of transnational healthcare networks. Taking different sorts of medical travel facilitators into focus as a way “to follow network builders as they stitch together durable associations through space and time” (Murdoch 1998, p.367) provided a starting point for this endeavour. Using ethnographic methods such as observation, interviewing and job-shadowing offered suitable and versatile tools that generated rich empirical data and allowed to attend to
‘practices’ as one of the main objects of interest in this study. Furthermore the conceptual underpinning of STS provided a methodological “set of sensitivities” (Mol 2010, p.253) that draws attention to the multitude of human and non-human actors, the ways they act and interact, the spaces and relations they construct, or the ways that these practices materialise. The approach thus stipulates attending closely to what is happening by following actions and their traces, getting into the thickness, here, of medical travel facilitation. This is also about acknowledging the complexity and ‘messy world’ (Law 2007) this is likely to present without looking for coherence or consistency. Instead, collecting and patching together different accounts is seen as a valid approach enabling a better understanding of the phenomenon.

In order to get the necessary depth, ethnographic methods such as observations, shadowing and interviewing were found to be most adequate for this project. Cautious of referring to ethnography (Hine 2007, p.665) given the multi-sitedness and time-frame of the research, ethnographic fieldwork is not understood in a strict anthropological sense of a full immersion in a culture and staying in one particular site over an extended period of time. It is rather seen as a toolbox providing methods for data collection and as characterising the type of data generated. It is about being attentive in the field, “watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts – in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry” (Atkinson & Hammersley 2007, p.3). The ‘field’ was explored along the way by identifying and following different sorts of medical travel facilitators that would draw attention to different places, often to corporate hospitals and surrounding premises, to guesthouses, offices, cafes, airports and also conference rooms and exhibition halls. Understanding the field not as a clearly defined premise but as something that is (un)made by the actors themselves is also what “ANT distinctively adds to the conversation about “global” and “multi-sited” ethnographies” (Baiocchi et al. 2013, p.337).

Data collection consisted in conducting interviews, having more informal conversations with different interlocutors, following medical travel facilitators to their work place for job shadowing, taking notes, collecting brochures and copies of different forms, reconstructing emails and text messages with interview partners, asking questions, sensing the atmosphere in different places and moments and trying to capture impressions in words jotted down in a notebook. Moving with the people, literally while shadowing as a form of mobile method to some extent (Buscher & Urry 2009), travelling through different stages and visiting the places of the circuit of medical travel, more and more context-specific practices, mechanisms, underlying rationales and taken-for-granted assumptions could be identified (Atkinson & Hammersley 2007; Kearns 2000). Tapping into mobile methods in terms of shadowing and physically moving around with certain people but also by tracking some virtual mobilities of email and text messages, images and documents (Buscher & Urry 2009, p.106) adds to the research as it “reveals
the intertwining of diverse mobilities” (Buscher & Urry 2009, p.108) and allows to get a sense of the “interspaces” they create.

Following the network builders facilitating medical travel between Oman and India quickly leads to multi-sited transnational research. From the onset, the complex spatiality of transnational healthcare was one of the driving interests of this project and the aim to better understand the connections spun between Oman and India through medical travel facilitation invited multi-sited research in both countries. Marcus’ (1995, pp.106–109) methodological impetus to follow the people, things, or the story, for example, which, as a consequence, leads to research in multiple sites resonates with the theoretical-methodological underpinning outlined earlier. The exploratory character of such research and the openness to “unexpected trajectories” (Marcus 1995, p.96) are important features that align well with the style of STS research. Although “[g]lobal restructuring has transformed many anthropological fields into transnational spaces” (Stoller 1997, p.91) in which certain concepts no longer make sense, whether multi-sited research is necessary may depend on the focus and aspects that one is interested to researching (Tsuda et al. 2014, p.124). If the aim is to “capture the essence of global flows and transborder processes” (Tsuda et al. 2014, p.125) as it is done to some extent in this study, to compare impacts, to track movement and flows and to study connections (Tsuda et al. 2014, pp.125–126), a multi-sited approach is considered to be a sensible approach. Mobility of different groups of people and “the study of connections between places” (Falzon 2011, p.5) as the “grandest themes of late twentieth century and contemporary social science (…) posit frameworks and scales that invite supralocal understanding and therefore methodology”. Multi-sited research is thus an approach to the transnational (Falzon 2011; Marcus 1995) that takes different fieldwork sites into account and is “designed around chains, paths, threads, conjunctions, or juxtapositions of locations” (Marcus 1995, p.105). This study significantly benefitted from research in both a so-called patient sending and a receiving countries and in studying it “from both ends” (Tsuda et al. 2014, p.137). Nevertheless, relationships both between and within sites are important for the study of transnational or trans-local phenomena, (Hannerz 2003, p.206). Fieldwork in Muscat, Delhi and a shorter stay in Kerala allowed me to gain a better understanding of the different places and localised practices of medical travel facilitation as happening on the ground in those different sites and, importantly, the connections and spaces in-between.

So, transnational research not only as research in different locations but also a “study of connections between places” (Falzon 2011, p.5), means moving beyond particular locations and thinking more about what is in-between. This is an area in which migration studies and research on brokerage have been influential in developing a methodology that accounts for the shift ‘from multi-sited to the in-between’ (see Boccagni 2016; and also Lindquist 2017; Lindquist et al. 2012). Taking the ‘here’, ‘there’ and ‘in-between’ into account has important
methodological implications since there is the “need to keep track of three analytical settings simultaneously” (Boccagni 2016, p.6). To some extent this was methodologically realised being present in different sites here and there and at the same time paying extra attention to all kinds of references to the ‘in-between’ space: for example by attending to the circulations of text messages and documents, of medicine, money, word-of-mouth and, of course, also patients and facilitators; also by tracing sequences of practical, logistical and administrative pathways that formalise the in-between space; or by tracing business networks and relations of friendships for example by following up connections between people, places and institutions from one end to the other and interviewing business partners located in either country. Travelling back and forth between research sites (see chapter 3.2.1) and paying attention to the many ways in which those sites were connecting allowed to attend to the particular spatialities but also relations generated through the interactions of medical travel facilitation. Thereby, the methodological challenge for such ethnography, according to Boccagni (2016, p.1) “lies less in staying in more sites than in sensing and understanding the relationships between them and the social practices on which this connectedness relies”. The “multi-relationality” (Boccagni 2016, p.2) encountered throughout the fieldwork on medical travel facilitation between Oman and India will thus become a relevant theme throughout the thesis.

In line with the exploratory approach of qualitative ethnographic research is Grounded Theory as a method for data analysis and “a way of thinking”, which comes with a “set of methods for building theory” (Strauss & Corbin 1998, p.4). It is grounded in the data, rather than being guided by preconceived ideas and concepts. Apart from taking up some of the methodological principles in the process of data analysis, Grounded Theory resonates with some of the underlying conceptual approaches that this thesis engages with, such as the methodological and theoretical focus on practice.

3.2 Data collection, processing and analysis

The research questions and the principles of multi-sited ethnographic fieldwork outlined above together with the specific contexts within which this project was carried out all shaped the realisation of the fieldwork. This section first provides an overview of the different phases and sites of the fieldwork (3.2.1) and then gives some more detail about methods of data collection as adapted in this study (3.2.2), the type of data that was generated, its processing (3.2.3) and the analysis (3.2.4).
3.2.1 Phases of fieldwork and access to the field

Data collection for this thesis consisted of a main fieldwork phase in India and Oman between November 2017 and March 2018 followed by two short visits in Muscat and Delhi to attend international medical travel events, see Figure 1. In preparation for the fieldwork, a short pilot study was conducted during the International Medical Travel Exhibition and Conference held in Muscat, over three days in April 2017. Attending the event allowed an initial understanding of Oman and its entwinement in transnational healthcare, to prepare fieldwork accordingly and to make initial contacts that would later facilitate access to the field. Previous fieldwork in Delhi in the same thematic area allowed me to build on those experiences without a pilot in India.

The main body of fieldwork purposefully involved travelling back and forth between India and Oman, which allowed me to follow the circuit of medical travel between the two countries in both directions. The initial fieldwork in Delhi was facilitated by the familiarity with the field there and the spatial concentration of possible informants and practices to follow since patients, healthcare providers and also medical travel facilitators are physically present at the destination site. Access to the field was gained through internet searches, snowball sampling and being present in places relevant for medical travel and engaging with people there. The combination of these strategies allowed access to different sorts of medical travel facilitators including government officials, hospital employees, medical travel company representatives and also different sorts of facilitators working individually.

A ten day stay in Kerala for a case study as a fellow of the Indo-Swiss research project “National and International Medical Mobility, Networks and Markets” working alongside three colleagues allowed to carry out research in one of the most popular destination regions of Omani medical travellers. Valuable insights into Ayurvedic travel as a particular category of medical travel (see chapter 5.2) could be gained. Different Ayurvedic clinics were visited and interviews with doctors, representatives of medical travel companies and taxi drivers who are essentially facilitating medical travel were conducted.

The second phase of fieldwork took place in Muscat in January 2018. A similar strategy was chosen to find informants in Muscat: participants were obtained by online searches,
connections established during the pilot study, but participants in India sharing the contact of their partners in Oman and interlocutors in Muscat referring other colleagues in the field was also of great help. Contrary to the situation at the medical travel destination site, the actors in the patient country are spatially dispersed and do not need to be physically present in particular places in order to undertake medical travel facilitation. Rather, it often draws on virtual forms of connectivity. Nevertheless, there were different occasions for observations and job shadowing. The team of the Treatment Abroad Committee very kindly allowed me to come into their office and accompany some of the employees. Participating in an informal OPD camp and a Continuous Medical Education event was insightful in many regards as some of the later sections will elaborate on.

Resuming data collection in Delhi in February constituted the third and last phase of the main block of data collection, which was completed in March 2018. With the insights gained in Oman and following up on some of the connections from the Omani side, this third fieldwork phase valuably complemented the previous ones. Attending the Advantage Healthcare India event in Delhi in December 2018 constituted the second case study. The insights gained by observing the proceedings of such an international medical travel event and speaking to the organisers and participant were particularly valuable in terms of understanding and theorising about the spatiality of such events in general and the meaning it has for articulating spaces of transnational healthcare in particular (see chapter 5.3).

All in all, the fieldwork covered a range of sites and situations, summarised in Table 1, that mirror the diverse, stretched and fluid character of the field and the complexity of medical travel and transnational healthcare.

<table>
<thead>
<tr>
<th>Sites:</th>
<th>Situations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- corporate hospitals</td>
<td>- shadowing medical travel facilitators on the job in</td>
</tr>
<tr>
<td>- premises surrounding hospitals such</td>
<td>- job-shadowing medical travel facilitators receiving</td>
</tr>
<tr>
<td>as car parks, pharmacies, guesthouses</td>
<td>- patients at the airport in Delhi</td>
</tr>
<tr>
<td>- office spaces of medical travel</td>
<td>- visit of the Omani health attaché in Delhi</td>
</tr>
<tr>
<td>companies</td>
<td>- continuous Medical Education event held in a hotel</td>
</tr>
<tr>
<td>- office spaces of institutions related to TNHC such as the Treatment Abroad Department in Muscat</td>
<td>- in Muscat organised by an Indian hospital</td>
</tr>
<tr>
<td>- cafes, hotels</td>
<td>- Out-patient department campaign in Muscat</td>
</tr>
<tr>
<td>- event locations</td>
<td>- Advantage Healthcare India Exhibition and Conference in Delhi</td>
</tr>
</tbody>
</table>

Table 1: List of fieldwork sites and situations
3.2.2 Observations, job shadowing and semi-structured interviews

Using the ethnographic methods of observations, in particular job shadowing, became an integral part of following medical travel facilitation on the ground. It involves the “researcher closely following a subject over a period of time to investigate what people actually do in the course of their everyday lives, not what their roles dictate of them” (Quinlan 2008, p.1480). Being physically present in different field sites, observing the environment, happenings, people, things, sounds, etc. revealed much about the studied phenomenon and prompted questions that could be addressed more or less immediately and with reference to concrete moments experienced along the way of shadowing. It was an effective method for gathering data about the “practitioner’s day-to-day realities” (Bartkowiak-Theron & Robyn Sappey 1999, p.8) and learning about the “shadowed person’s understanding of how and why things just happened, according to them and their own frames of reference” (Bartkowiak-Theron & Robyn Sappey 1999, p.8). These are all benefits of this method: “Advantages of shadowing include that it can provide insight into otherwise invisible aspects of people’s work; offer individuals opportunities to explain what they are doing, when they are doing it; allow connections to be observed across dispersed work teams; and yield a holistic understanding of work that may be missed through traditional interviews or observations” (Gill et al. 2014, p.70). Context specific peculiarities, underlying rationales, mechanisms and taken-for-granted assumptions that were not raised in interviews could be captured by this methodological approach (Gill et al. 2014; Kearns 2000).

Shadowing took many forms and involved following different types of facilitators (see description of the participants Chapter 4.2), in a variety of settings (see Table 1). In Delhi it meant mostly that I as the researcher would accompany designated medical travel facilitators on their daily run in one or multiple hospitals while they were catering for their clients, always with consent of the parties involved. Given the nature of this job, shadowing was most often a mobile practice as on-site medical travel facilitation involves frequent changes of location between different areas, rooms and buildings of the hospitals or even different areas in the city while visiting and supporting multiple patients, attending to their needs, accompanying them to consultations, picking up test results and medical reports, buying medicine, meeting them in a café for lunch – and much more. The interlude between Chapter 4 and 5 will provide a direct immersion into this setting and will give a first impression of what medical travel facilitation means in everyday lived realities.

Job-shadowing did not follow a prescribed ‘template’ (Laurier 2010, p.118) but meant being attentive to different sorts of actions and things present in the situations and attempting to capture as many aspects of medical travel facilitation as possible. I did so by taking notes and sometimes even writing down quotes using the shadowed persons original words to capture ‘situated vocabularies’ since “actual words people use can be of considerable analytic
importance” (Atkinson & Hammersley 2007, p.145). Sometimes, notetaking was combined with taking audio recordings, with the permission by the facilitator and the participants. This was mostly used for conversations between the shadowee and me, pre-or debriefing a situation while walking from one site to another, or as a way to take voice memos for myself if it was difficult to take written notes. In other occasions, job-shadowing also covered activities such as handling everyday business in company offices, holding business meetings with partners and having conversations with colleagues.

Besides the more informal conversations during job-shadowing and observations as outlined above, interviews were conducted with different sorts of medical travel facilitators for which the interview guide was adjusted accordingly (see next section 3.2.3 for an overview and chapter 4.2 for more detail on the informants). The method of conducting semi-structured interviews is considered a sensible way to get medical travel facilitators to talk in more depth about their work by asking open questions that cover the main subjects of interest and are guided by the overarching research questions of this study. Developing and working with an interview guide helps to stay focused on those main interests while also letting the interview “unfold in a conversational manner offering participants the chance to explore issues they feel are important” (Longhurst 2010, p.143) and reacting situationally to the interviewees’ statements (Dunn 2000, p.61). The interview guide broadly covered the following three areas of interest: general questions regarding the work of medical travel facilitators (type of facilitation work, typical tasks, experience, background, business model, etc.), networks (network partners, ways to connect, relations with colleagues and clients, maintenance work; things, technologies, infrastructure involved in facilitation etc.) and mediations of care (understandings of care, differences and similarities in the conceptualisation of care, negotiations making transnational healthcare work, difficulties etc.).

There are certain limitations to these methods of data collection and also to their implementation. Almost all interviews were held in English; this is because English is often the common language in the medical travel business and the language that most participants and I as the researcher could speak. This results in a bias to interview partners speaking English apart from a few interviews in Kerala that were conducted with the help of an interpreter speaking the local language of Malayalam. The framing of the research project and the methodological approach also addresses and speaks to certain groups of people who come forward and participate in the project. It is thanks to their openness and willingness to take part and to share their experiences and thoughts that this project could be realised, and I am greatly indebted to them. At the same time, some other potential participants may not consider themselves as addressed or suitable; maybe because their understanding of their work does not match with the framing of the project, maybe because they do not want to expose themselves or think that their approach does not correspond with common understandings of social desirability. It may as well
have other reasons, such as time constraints or mistrust towards the research. Those limitations in the type of facilitators who are represented in the sample should be kept in mind. Apart from that the feedback and conversion rate of potential into actual participants was generally very positive.

### 3.2.3 Data and data processing

The main type of data generated by the methods outlined above were interview transcripts and fieldnotes from job-shadowing and observations. There is an overview of the number of interviews conducted with the different types of participants facilitating medical travel in Table 2. During the main fieldwork, 84 interviews were conducted out of which 63 could be tape-recorded; from the remaining 21 interviews detailed notes were taken that were later integrated into written text. The recorded interviews lasted approximately 45 minutes. The Advantage Healthcare India (AHCI) event provided an opportunity to have 19 more interviews, which were usually shorter given the setting and time available. So, all in all, 103 interviews formed one of the two main data sets of this thesis.

<table>
<thead>
<tr>
<th>Type of medical travel facilitator</th>
<th>Delhi</th>
<th>Kerala</th>
<th>Muscat</th>
<th>AHCI Delhi</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual facilitator</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Medical travel company</td>
<td>15</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>Hospital, internat. patient/marketing department</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Hospital, medical professionals</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Government representative</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>10</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>12</td>
<td>31</td>
<td>19</td>
<td>103</td>
</tr>
</tbody>
</table>

Table 2: Overview of number of interviewees as per site and type of medical travel facilitator

<table>
<thead>
<tr>
<th>Interviews</th>
<th>audio recorded and transcribed fully</th>
<th>notes</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>main fieldwork</td>
<td>58</td>
<td>21</td>
<td>84</td>
</tr>
<tr>
<td>AHCI event</td>
<td>5</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>total</td>
<td>60</td>
<td>38</td>
<td>103</td>
</tr>
</tbody>
</table>

Table 3: Overview data processing

Almost all audio recorded interviews were fully transcribed word-by-word by the researcher using the MAXQDA software, for an overview see Table 3. Five interviews were partially transcribed for time reasons. The recorded interviews were, on average, 41 minutes long; four short interviews were under ten minutes long, and four were over two hours. The notes from the interviews that could not be recorded were edited and then analysed same as the transcripts.
The other main data set consists in data from job-shadowing, which includes written fieldnotes and some audio notes from about 24 days of accompanying different sorts of medical travel facilitators in their work in a variety of settings and observing different situations and events, see Table 1.

<table>
<thead>
<tr>
<th>Job-shadowing &amp; observation</th>
<th>person</th>
<th>fieldwork site</th>
<th>location</th>
<th>No of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Travel Company</td>
<td>employee</td>
<td>in and around hospitals</td>
<td>Delhi</td>
<td>4</td>
</tr>
<tr>
<td>Medical Travel Company</td>
<td>manager</td>
<td>in and around hospitals</td>
<td>Delhi</td>
<td>4</td>
</tr>
<tr>
<td>Medical Travel Company</td>
<td>employees &amp; managers</td>
<td>office</td>
<td>Delhi</td>
<td>3</td>
</tr>
<tr>
<td>Hospital</td>
<td>employee</td>
<td>in and around hospitals</td>
<td>Delhi</td>
<td>2</td>
</tr>
<tr>
<td>Health Attaché Oman</td>
<td>Health attaché</td>
<td>in and around hospitals</td>
<td>Delhi</td>
<td>1</td>
</tr>
<tr>
<td>FRRO</td>
<td>employee</td>
<td>office</td>
<td>Delhi</td>
<td>1</td>
</tr>
<tr>
<td>Hospital</td>
<td>employee</td>
<td>in and around hospitals</td>
<td>Muscat</td>
<td>1</td>
</tr>
<tr>
<td>Medical Travel Company</td>
<td>manager</td>
<td>office</td>
<td>Muscat</td>
<td>1</td>
</tr>
<tr>
<td>Treatment Abroad Committee</td>
<td>employees &amp; managers</td>
<td>office</td>
<td>Muscat</td>
<td>2</td>
</tr>
<tr>
<td>OPD campaign</td>
<td>multiple</td>
<td>hotel</td>
<td>Muscat</td>
<td>1</td>
</tr>
<tr>
<td>CME event</td>
<td>multiple</td>
<td>hotel</td>
<td>Muscat</td>
<td>1</td>
</tr>
<tr>
<td>AHCI event day</td>
<td>multiple</td>
<td>exhibition center</td>
<td>Delhi</td>
<td>3</td>
</tr>
<tr>
<td>Total No of days</td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>

Table 4: Overview of observations and job shadowing during the main fieldwork and Advantage Healthcare India event

As part of the data processing, the data was anonymised and all names in the transcripts and vignettes presented in this thesis are pseudonyms.

Additionally, other data was gathered in the form of documents, such as templates of forms for visa applications, fit-to-fly certificates or hospital admission forms, and also information leaflets and promotional material from hospitals and medical travel companies. Some of them also shared information via email, text messages and images. Some photos were also taken during fieldwork, mainly for illustration purposes to record some impressions from the different fieldwork sites and events.

### 3.2.4 Data coding and analysis

The process of analysing the data was in many ways a logical continuation of the previous steps of the empirical research outlined above. Still guided by the interest in getting a better understanding of medical travel facilitation, the focus on practices and the strategy of following actors and actions in different places and situations continued to guide the data analysis. In order to break the interview transcripts and fieldnotes up into analytical entities as a way of gaining deeper understanding of different practices, sequences, rationales, dependencies etc.
the data was coded and analysed in multiple steps. Methodologically, the process was informed by a Grounded Theory approach in terms of iterating through multiple rounds of coding and analysing the data, the explorative openness within the process and commitment towards attending closely to the data and deriving meaning from it (Strauss & Corbin 1998). The analysis started off with initial coding, a “detailed line-by-line analysis necessary at the beginning of a study to generate initial categories” (Strauss & Corbin 2008, p.57). A number of interview transcripts and fieldnotes from different types of medical travel facilitators and fieldwork sites were chosen to start with to get a sense of the breath of the data and generate a variety of categories to work with. In line with the overall research design, the focus on practices was upheld and the coding labels were verbs rather than nouns which is also a suggested coding strategy in order to capture actions (Charmaz 2013, pp.47–54). Analysing more and more data, the coding structure was developed further, codes were altered, introduced and reorganised in categories or detailed in sub codes, creating a hierarchical structure with the help of axial coding (Flick 2005, pp.265–267; Breuer 2010, pp.84–91). Further developing some central categories and codes through ‘selective coding’, integrating other codes and analysing their relations helped to consolidate some findings “as a set of interrelated concepts, not just a listing of themes” (Strauss & Corbin 2008, p.145). Theorising ‘smoothness’ as it is developed in Chapter 6, tentatively, as novel theme that could be carved out through data analysis illustrates such Grounded Theory-inspired theory building (Strauss & Corbin 2008, pp.143–148). Overall, data analysis resulted in the thesis structure around three main themes of articulating spaces (Chapter 5), mediations of transnational healthcare and creating a quality of smoothness (Chapter 6), and negotiating ethical complexities (Chapter 7).

3.3 Reflections upon the realisation of the research and the researcher’s positionality

This section is to reflect on the research design, pointing to some of the limitations, peculiarities and drawbacks of this study against the backdrop of the realities of doing fieldwork and the positionality of the researcher. This is by no means meant as an exhaustive discussion or move to emphasise the importance of myself as the persona of the researcher but a way to acknowledge the epistemic position of the researcher in the constructivist paradigm and the “reflexive character of social research” (Atkinson & Hammersley 2007, p.14). It is important to be aware of the circumstances under which data is generated, not only in terms of a certain background or lens applied but also with respect to socio-cultural and economic factors, the
political environment and the immediate situations and encounters in which data is collected and the power relations inherent to them. Knowledge as socially produced, in a given situation, under certain circumstances, is situated (Haraway 1988), “local, partial, and embodied” (Kobayashi 2009, p.139). Being part of the situation and the field in which data is being generated, and being actively involved in designing the research, in collecting, analysing and interpreting data as a researcher, it is important to reflect on the implications of the positionalities of the people involved, the web of relations in which they are entangled and how this shapes the data gathered and the knowledge developed in this thesis (Atkinson & Hammersley 2007, p.14).

Doing fieldwork in Delhi, Muscat and places in Kerala, places that are so different from London or the small village in Switzerland where I have been brought up and lived most of my life, made me very much aware of my own positionality and how different factors may influence the way that I perceive the world around me and the ways in which others see me: my physical appearance and other embodied identity categories, my socio-cultural background, certain ways of thinking and speaking etc.. My familiarity with certain things and unfamiliarity with others affect my perception and ability to make sense of the world around me. Positionalities shape encounters and the power relations inherent to them. Imbalances in the relationship with research participants is always a difficult terrain to navigate. Doing international fieldwork adds even more layers to that and “involves being attentive to histories of colonialism, development, globalization and local realities, to avoid exploitative research or perpetuation of relations of domination and control” (Sultana 2007, p.375). Light-skinned, blue-eyed, dressed in a certain style of clothing and not speaking the local language, I was clearly recognisable as a foreigner in Oman and India. It may have worked in my favour in terms of getting access to the field since many of the actors in medical travel seemed to be interested in connecting with foreigners and having an opportunity to showcase what they do in terms of promoting their business. Transparency was crucial, both in building trust with potential participants and in clarifying their expectations and my intentions in connecting with them, the scope of my research and limitations in what I can offer in return. In other situations, my person and background may have been rather irritating, and it was not so clear to understand why I was interested in doing research on medical travel between Oman and India, as a geographer, or why I was interested in certain aspects of the facilitation work and not so much in others. As a student and scholar in geography, the business world and healthcare sector were both relatively new terrain, apart from previous research experience in this thematic area. In some respects, being an outsider to this industry and context was a drawback as it limits my understanding, results in blind spots and may create a barrier between the participants and myself as researcher. However, working across differences in backgrounds, experiences, interests and
sensitivity towards certain aspects can also result in fruitful discussions and create interesting ground for exploration.

With regards to the methodological approach, it is important to mention that job-shadowing creates a particular configuration between the researcher and the participant(s). The method can be quite intrusive and can make the shadowees feel uncomfortable for being under constant observation. However, handing the lead over to them seemed to be a way to acknowledge their expertise and agency and many participants seemed to be appreciative of someone being genuinely interested in their everyday realities and me taking the time to be with them on site and learning from them on the job. Interviewing different groups of people was not only an important strategy to learn about the research object from different point of views but also, as a researcher, to stay attentive to factors affecting my perception, to keep track of them and to regain a fresh eye as far as possible. In any case, it is important to acknowledge that our “assumptions, interactions – and interpretations – affect the social processes constituting each stage of inquiry” (Charmaz 2013, p.132) and to reflect on it also before and after conducting fieldwork.

Some of the limitations of this research have already been pointed out in this chapter and shall be briefly mentioned here as well. The English languages facilitated fieldwork enormously but also constitutes a limitation in that speaking and understanding the local languages would clearly have been beneficial for this kind of research, especially for job shadowing. In terms of sampling, this study did not look for a representative sample in terms of selecting research participants according to some predefined characteristics. There was a sampling strategy in place, but it was important to incorporate learnings directly from the field and to make adaptations so that a broad variety of viewpoints and experiences can be covered. The research design with face-to-face interviews and shadowing create a certain social setting in which not all potential participants are willing to engage and may result in, unintentionally, not reaching some groups of people. Moreover, the framing of the research project and the participants I was looking for, as well as the strategies of reaching out to them, and my knowledge of the field overall, clearly influenced data collection. The success rate of turning potential into actual participants was very high and I am greatly indebted to every individual who participated and contributed to realising this research.
4 Context

This chapter contextualises this research by providing background information about Oman and India, with respect to the healthcare sector and medical travel facilitation. The first section (4.1) gives an overview of the developments of healthcare in Oman and India over the past decades and the geo-historical relation between these two countries, which have laid the foundation for the health mobilities and its facilitation, as they are practiced today. The second section (4.2) introduces the different types of medical travel facilitators who participated in this research. This adds depth to the brief overview within the previous methodology chapter (3) and it provides a more detailed description of those involved in facilitating medical travel, at each of the three fieldwork sites and how these individuals operate. Based on my empirical data, the last section of this chapter (4.3) introduces the basic models through which medical travel facilitation between Oman and India operates at different stages of a patient’s medical travel journey. The purpose of this chapter is thus to provide an overview of medical travel facilitation in which to frame this research whilst also presenting original data about the actual practices in the given context.

4.1 Context of the study sites

In order to have a better understanding of medical travel between Oman and India, it is important to have some background knowledge with regards to how medical travel and the interconnection between those countries developed, prior to exploring the practices of facilitating in more detail. Firstly, this section gives an overview of the period of significant change in Oman over the last fifty years, how this has shaped the healthcare system within the country and how medical travel has become a government supported practice. Secondly, this section provides further information about the relationship between Oman and India, in both historic and current times, which allows a better understanding as to how these countries became connected through health mobilities. Lastly, this section will explore the development of healthcare in India, since the 1980s and how this resulted in an increased privatisation of the healthcare sector and paved the ground for becoming an internationally renowned medical travel destination.
4.1.1 Oman and outbound medical travel

The sultanate of Oman is an Arab country in the South-East of the Arabian Peninsula, strategically located on the Persian Gulf. Oman is a monarchy which was led by Sultan Qaboos bin Said al Said from 1970 until his death in early 2020, when he was succeeded by his cousin, Sultan Haitham bin Tariq Al Said. Oman is described as “a seeming anomaly in the Arab world” (Peterson 2004, p.125) for a number of reasons: Oman’s oil resources are more modest compared to other countries in the region, the country is not part of the Organisation of Petroleum Exporting countries (OPEC) nor the Organisation of Arab Petroleum Exporting Countries (OAPEC) and it “keeps an independent direction and maintains a conciliatory stance within GCC [Gulf Cooperation Council] ranks” (Peterson 2004, p.125). Additionally, Oman has a more diversified economy to other countries in the region, promoting the agricultural, fishery, mining and manufacturing sectors, along with tourism and other service industries (Looney 2009). Oman’s foreign policy is described as “characterized by independence, pragmatism and moderation” (J. Lefebvre 2010, p.99).

A few decades ago, Oman went through a process of immense change that was initiated after Sultan Qaboos succeeded his father in 1970 and affected politics, economy and society of the Sultanate in many ways. Understanding this change, especially with regards to healthcare, is important to situate outbound medical travel from Oman but it also presents certain challenges associated with the literature documenting and commenting on it. One limitation of this literature review here results from consulting only literature in English language. Another difficulty is that much of that literature accounts for the changes in Oman in a very particular way and from a certain viewpoint that needs to be reflected. For example, in a report by the Ministry of Health of Oman (MOH) (2014, p.26), the reign of Sultan Qaboos is described as signalling “the Renaissance or the beginning of a bright new era, that renewed Oman’s historic past and opened a new chapter of development, prosperity and social and economic progress” (MOH Sultanate of Oman 2014, p.26). The statement shows a common narrative of the changes that had happened in Oman from the 1970s onwards, which is oriented on a certain understanding of development and progress. This is emphasised in the quote by the MOH that was itself founded in the course of this change. This discourse of the ‘renaissance’ of Oman and the acclaimed success story of building a healthcare system supposedly “starting from scratch” (Peterson 2004, p.126) is prevalent in much of the policy documents issued by the Ministry of Health of Oman and also some articles commenting on these changes by different social scientists. The changes are repeatedly cast against narratives of the situation prior to the 1970s. For example, in a report on the development of Oman by an American researcher and consultant with background in politics, economy and security affairs, the state of the country at the time when Sultan Qaboos took over is described as following: “The majority of the population lived in a society akin to that of the Middle Ages with no general education, no health services,
poor internal communications and repressive petty restrictions on personal freedom” (Looney 2009, p.4). This statement is very problematic given the racist trope of comparing the state of development with one of the Middle Ages and, with reference to healthcare, the disregard of medical systems in Oman other than Western medicine. Healthcare seems to be equated with Western medicine. Such explicit and implicit racist and colonial tendencies are present in different descriptions of healthcare in Oman. The quote raises the question of what kind(s) of healthcare and what system(s) of medicine are at stake in these accounts – and what is not? This is important because it shapes whether healthcare is or is not considered to be ‘existing’ or ‘adequate’. Moreover, it matters how the relation between Western medicine and indigenous medical traditions are taken into account. Here it is important to note that these medical traditions, here cast against each other, are by no means singular entities themselves although they are often discursively presented as such. They are multiple in practice and evolving and in this process the relation between different medical practices has also been a significant constitutive factor. Traditional medicine, for example, has played a particular role in shaping colonial Western medicine and vice-versa (Jackson 2018; Baronov 2008; Ernst 2007; Arnold 2000). This thesis will revisit this theme of multiplicity in medicine and care but will first take a closer look at some more accounts on healthcare in Oman to analyse what we can learn from them.

Much of the literature on healthcare in Oman that is available in English and accessible online such as the reports by the Ministry of Health of Oman or academic publications by local and Western authors pre-empt a Western understanding of medicine, and where they do so, only acknowledge the coexistence of other forms of medicine marginally and from a certain perspective. The “Health System Profile” of Oman published by the World Health Organization (WHO Regional Health System Observatory 2006, p.21), as another example, describes the “Pre-Renaissance era” as following: “There were only two hospitals (with a total of 12 beds), both in the national capital Muscat, run by the American Mission. (…) the staff had to face great challenges in extending medical care to the people, mostly impoverished citizens, who had nowhere else to turn to for availing of such services. Prior to the arrival of the missionaries, the Omani people had to rely mainly on traditional medicine”. Such descriptions reproduce a colonial Western gaze that conveys superiority, proclaims allopathic medicine and praises the efforts towards their understanding of development, here brought to Oman by the American Mission. Omani people are presented as being at the mercy of, supposedly, inadequate forms of traditional medicine. These accounts prompt us not only to think about the conceptualisation of healthcare but also more generally about how healthcare is done, documented and evaluated.

The development of Western medicine in Oman is relatively well-documented by sources such as policy documents, scientific publications and reports. Most of them draw on certain
measurable indicators that illustrate how Western medicine has improved the health outcomes of the people in Oman in many respects. The Ministry of Health of Oman has adopted a Western understanding of healthcare and medicine. It presents facts and figures about health relevant parameters and population statistics (MOH Sultanate of Oman 2018; MOH Sultanate of Oman 2016) and communicates development plans (MOH Sultanate of Oman 2014; MOH Sultanate of Oman 2011) in which government officials analyse the current situation and set goals for the future that are oriented towards the standards of the WHO. Publications in journals such as Sultan Qaboos University Medical Journal (e.g. Lakhtakia 2012; Al-Hinai et al. 2011; Alshishtawy 2010; Al-Lamki & Lamki 2009) and Oman Medical Journal (e.g. Divakar et al. 2016; Samir & Karim 2011; Alshishtawy 2009) discuss issues related to health and medicine within the local medical community and also review changes in the political and economic organisation of healthcare in Oman. The latter is an area in which American and European social scientists with backgrounds in history, economics, politics, development studies and anthropology contribute (e.g. Peterson 2013; Beaudevin 2013; J. Lefebvre 2010; Cattaneo 2009; Looney 2009). They often presuppose a Western understanding of medicine and the discourse of progress and development that is also present in the publications of the Ministry of Health in Oman and Sultan Qaboos University Medical Journal are reproduced, sometimes in problematic ways as discussed before.

In contrast to the information on the development of Western medicine in Oman, it is more difficult to access information about indigenous medical traditions in Oman – at least as an English-speaking researcher coming from outside. However, there are some sources that discuss such forms of medicine under the notions of ethnomedicine (Divakar et al. 2016) or Complementary and Alternative Medicine (CAM) (Al-Kindi et al. 2011). Articles by researchers and practitioners with a background in Western medicine review traditional forms of medicine rather critically (Divakar et al. 2016; Al Busaidy & Borthwick 2012; Al-Kindi et al. 2011; Hardy et al. 1995) and point out the dangers of different treatment regimens interfering with each other. Some other documentation on traditional forms of medicine, especially of herbal medicine, is provided by researchers with background in botany and ethnopharmacology (e.g. Ghazanfar 2018; Ben-Arye & Samuels 2015; Yesilada 2011; Azaizeh et al. 2010; Weber 2011). There must exist other sources documenting indigenous medical traditions in Arabic that, unfortunately, cannot be acknowledged in this literature review that is limited to sources in English. However, the ways in which such medicine is practiced and documented also determines what sources are available. Divakar et al. (2016, p.245) note that in Oman “the information on traditional ethnomedicine practice is not transferred from generation to generation in written form but is verbally inherited from the elder members of the family”. The medical knowledge thus usually stays with certain designated people in the community and the way in which it is curated and shared makes it remain “unfamiliar to the majority of scientists and the
general population” (Divakar et al. 2016, p.245). This may to some extent explain why there may be fewer written records on this type of medicine, why information is more difficult to access and why there seems to be a certain disconnect between the multiple medical traditions practiced in Oman.

These reflections on the literature on healthcare in Oman indicate that medicine, health and care are multiple, which will be discussed further throughout this thesis. In order to situate outbound medical travel in Oman that is mostly – but not only (see Chapter 5.2) – for allopathic treatment, the following paragraphs focus on the state of the Western medicine in Oman and the efforts of the Ministry of health in building a national healthcare system. It should be kept in mind, however, that the sources documenting healthcare in Oman make certain assumptions and represent particular viewpoints.

When the Ministry of Health of the Sultanate of Oman was established in 1971, the development of a national healthcare system was initiated that provides care free-of-charge care to all citizens of Oman (MOH Sultanate of Oman 2014, p.26). Firstly, a strategy for the development of the healthcare system was devised, which was organised and communicated in five-year plans, starting from 1976. This process was oriented on an allopathic understanding of medicine and Western standards. The guidelines of the World Health Organisation (WHO) signalled the way forward and formed the basis of the country-wide medical referral system, which is structured across three levels: “local health centres, providing primary healthcare; regional hospitals for secondary (that is, more specific) care and tertiary hospitals for advanced care (in the capital area)” (Beaudevin 2013, p.182). Taking particular indicators into account, the development of the healthcare system in Oman was acknowledged by the WHO in the “World Health Report 2000” with top rankings in health system performance (WHO 2000, p.154). The number of hospitals, clinics and in turn, hospital beds, were able to increase and by following a decentralisation policy, such healthcare became more accessible to the population living in the interior of the country, as well as those living in the main cities along the coast (MOH Sultanate of Oman 2014, p.104).

Whilst establishing hospitals and health centres, human resources became a major concern. Sultan Qaboos University was inaugurated as the first, and only, public university in Oman in 1986 and with it, opened the College of Medical and Health Science (Lakhtakia 2012, p.407). This was an important step, as previously aspiring medical professionals had to go abroad for training and Oman was heavily dependent on a foreign workforce within the field of healthcare, as well as other sectors too. Given the rapid development and the lack of medical professionals trained in Oman, it has been a “labor-importing country” (Cattaneo 2009, p.6) within the healthcare sector. The significant number of foreigners living in Oman is in fact an important demographic figure, even to this day. According to national census data (National Centre for Statistics and Information Sultanate of Oman 2020), in 2019 the total population in
Oman was 4.62 Million, with 1.96 Million expatriates accounting for approximately 42% of the population (MOH Sultanate of Oman 2018, p.13). Male labour migrants make up by far the biggest share with 1.61 Million, most of them coming from Bangladesh (623,961), India (616,857), Pakistan (221,538) and Egypt (35,007) (MOH Sultanate of Oman 2018, p.18).

Back in the 1970s, high numbers of workers were needed in order to advance the development of Oman. There has been a high influx of migrants, who have always constituted a considerable share of the population from then onwards. This is illustrated in Figure 2.

In order to reduce the dependency on expatriate workers and provide more job opportunities for Omani people, the so-called ‘Omanisation Policy’ was introduced in 1999 (WHO Regional Health System Observatory 2006, p.22; MOH Sultanate of Oman 2014, p.78). This policy fosters the education and employment of Omani people, in order to increase the local labour force. The health sector was, and continues to be, highly dependent on foreigners, who constituted approximately 40% of health workers (and an even higher percentage among physicians) in the public sector, and over 90% in the private sector in 2003 (Cattaneo 2009, p.6). Health care in Oman continues to be dominated by the public sector; in 2006, it was responsible for 90% of hospitals (WHO Regional Health System Observatory 2006, p.24). According to data from 2012, the government was providing “83.1% of hospitals and about 92.5% of hospital beds” (MOH Sultanate of Oman 2014, p.51). The government is responsible for the biggest share of the Total Health Expenditure at 81.1%; 11.6% is paid by the patients themselves and the remaining 7.3% is met by insurance companies or other sponsors (MOH Sultanate of Oman 2014, p.50).

An important feature of the national healthcare system is the Treatment Aboard Scheme, which was introduced by the Ministry of Health in the early 1970s. As the Ministry of Health recognised the inability to cater for the healthcare needs of the population at the time, they established the National Committee for Treatment Abroad, which allows the organisation of treatment, which is not available in Oman, in a different country, at the expense of the government (Al-Hinai et al. 2011). As there is not a significant amount of publicly available information in English about the workings of the scheme, the empirical data presented in this thesis, in section 4.3 and chapter 6 specifically, offers novel insights into the ways in which the team of the Treatment Abroad Department facilitates medical travel for Omani citizens.
The Treatment Abroad Scheme, intended to be a temporary solution, continues to function today. The numbers of patients sent abroad has supposedly declined from 59 per every 100,000 people in 1977, to only 20 per 100,000 in 2010 (Al-Hinai et al. 2011). However, despite the changes in the healthcare system, it is challenged by the growing population, which has almost tripled over the past 30 years (see Figure 2). This means that there is still a significant number of patients sent abroad for treatment. According to recent figures, provided by the Ministry of Health, there were 600 patients treated abroad through the government scheme in 2017. The list of treatments and investigations, for which patients are sent abroad, has changed over time as more and more facilities and treatments are available in Oman. Figure 3 provides further detail about the range of illness and diseases that were referred to foreign healthcare institutions in 2017. The significant majority of cases were within the medical speciality of Ophthalmology, followed by Brain and Neurological diseases and Oncology.

Figure 3: Number of cases per disease group handled by the Treatment Abroad Department in 2017, own figure (data MOH Sultanate of Oman 2017)

Within tertiary care and certain medical specialities, the healthcare system in Oman is known to be struggling and its infrastructure and training are not yet updated in all areas. In a report by the Ministry of Health, it is stated that “currently tertiary care hospitals are congested and cannot accommodate expansion of the existing subspecialties or the addition of new superspecialties and new services. The congestion seen in tertiary care services and the lack of subspecialties has forced many patients to seek tertiary care outside the country; partly at the cost
of the Government and partly as out-of-pocket expenditure” (MOH Sultanate of Oman 2014, p.112).

As indicated by this report, patients also travel abroad for treatment on their own accord, without the funding and the support from the government. In an article published in the Omani Medical Journal, the question as to why some Omanis “prefer to get medical services abroad in comparatively sub-standard, less qualitative places, rather than from their own country” (Samir & Karim 2011, p.215) was raised and the authors list the following reasons as their findings: “a) long delays, b) fewer competitive private facilities, c) high cost of private medical services and d) the added bells and whistles of medical tourism (...) Moreover, patients may travel to seek medical procedures, such as injections of stem cells, abortion, organ transplantation, infertility treatment, which are illegal or unavailable domestically” (Samir & Karim 2011, p.215).

In addition to these reasons listed above, a lack of trust in local healthcare providers was often mentioned and evident within the data collection for this thesis. This element of mistrust was also outlined by Whittaker (2015, p.489) who interviewed members of nine different families, from Gulf Cooperation Council countries, about their motivations for seeking healthcare abroad. The author concludes: “Many of these patients and their families experience mistrust, frustration and anger at the perceived failure of their governments in their responsibilities to care for citizens” (Whittaker 2015, p.497). Even if treatment is available within a patient’s county of origin, they often seek better quality, timelier and more affordable options abroad. In the “Health Vision 2050” report published by the Ministry of Health of Oman in 2014, the “construction of fresh state-of-the-art tertiary care facilities” or even “world-class tertiary care in hospitals of excellence” (MOH Sultanate of Oman 2014, p.112) is seen as an aim for further development. This should prevent patients from having to travel abroad for treatment and instead “provide care to patients nearer to their homes and within their families” (MOH Sultanate of Oman 2014, p.112).

At present, patients are regularly travelling abroad for treatment, privately or through the government scheme, and India is one of the preferred destinations. A visualisation of the statistics provided by the Treatment Abroad Department for the years 2017 and 2018 can be seen in Figure 4. In 2017, 600 patients were sent abroad through the government scheme; in 2018 the number was 610. The vast majority of cases who could not be treated locally and were therefore sent abroad, through the Treatment Abroad Scheme, were sent to India. The figures show that approximately 90% of the cases were referred to India, in contrast to only 3% of cases referred to Turkey and 2% each to Thailand and Saudi Arabia in 2017. In 2018, this was below 3% for Thailand and below 2% for Turkey. In an article in the Times of Oman titled “Medical Tourism - India becoming preferred choice for Omani people”, Oman is said to significantly contribute to “medical tourism”, with numbers continuing to increase (Raza 2016 published
online). In the article, the Assistant Director of Indian Tourism in Dubai explains that “highly experienced specialised doctors and healthcare professionals, good connectivity with a number of airlines operating between Oman and India, world class healthcare infrastructure and affordable options make India one of the top destinations for medical tourism” (cited in Raza 2016 published online).

There are many reasons why India has become a popular destination for medical travel and why the Treatment Abroad Committee and patients travelling individually frequently seek healthcare there. This thesis will explore some of these connections in further detail in the following chapters. The geo-historical connections between Oman and India appear to have allowed the development of today’s health mobilities, which span across the two countries. The following section therefore gives an overview of the relationship between Oman and India, in order to better understand and situate the findings presented in Chapter 6.

4.1.2 Oman – India relations

One of the arguments presented within this thesis, is that the geo-historical relationship between Oman and India shapes the configuration of transnational healthcare spaces today. Therefore, it is important to explore how the relationship between the countries has evolved, in the past and in more recent times, and how it has laid a foundation for today’s health mobilities. The relationship between Oman and India, separated by the Indian Ocean although geographically close, dates a long way back in history. The two countries are said to “enjoy warm and cordial relations which can be ascribed to historical maritime trade linkages, friendship between Oman’s royal family and India and finally the important role played by the expatriate Indian community in Oman” (Ahamed 2015, p.19). Their relationship rotates around multiple axes, from commerce and trade relationships, to common geopolitical interests, religious ties, cultural affinities, intellectual exchange, individuals’ mobilities for work, leisure and amidst all this, healthcare.
Due to its extensive coastline, the strategic use of waterways for trade and its orientation towards India geopolitically and economically, Oman is said to be “much more of an Indian Ocean state than a Persian Gulf state” (J. Lefebvre 2010, p.106) and the Indian-Arab relations have been of great importance for both regions since ancient times. Since the ancient times, their geographical proximity and strategic location at the junction of Western and Eastern sea routes have resulted in common geo-political and economic interests with regards to securing the waterways and maintaining stability within the region (Ahmad 2011, p.3). The commercial ties established by Indian and Arab merchants resulted not only in the exchange of goods, but also the mobility of people and mutual influence in multiple areas of life with far-reaching consequences. Arab merchants settled down in India and the “regular commercial interactions between Arabs and Indians throughout this period culminated in influencing each other’s language and culture” (Ahmad 2011, p.4), as well as music, cuisine, and religion. Resulting from the Indo-Arab relations and Arab presence, particularly in settlements of the coastal towns in the South of India, the Islamic religion, and with it the Arabic language, spread across India (Ahmad 2011, p.6). The Arabs were drawing upon the “intellectual legacy of India (…) especially in the fields of astronomy, mathematics, medicine, philosophy and wisdom literature” (Ahamed 2015, p.9). From early on, this has positioned India as an authority in healthcare and education. India was renowned, in the Arab world, for its medical expertise and there are narratives whereby Indian doctors have been called upon to cure prominent and important individuals in Oman (Ahamed 2015, p.12). Many Omanis came to India for their studies and Indian institutions are popular in medicine among other disciplines (Ahmad 2011, p.24). Additionally, Sultan Qaboos’ father studied in India, as other members of the royal family did too (Ahmad 2011, p.24). In the present day, Omaniis continue to pursue their studies in India and some Indian institutions have a presence in Oman (Ahmad 2011, p.25).

Mobilities of people were multidirectional and many Indians settled in Oman more or less temporarily, in ancient times, as well as in the present day (Ahmad 2011, p.20). During the oil boom, in the 1970s, there was a high inflow of Indian labour migrants to the Gulf states. Oman had a need in manpower at that time in order to realise the extensive restructuring and modernisation process in the oil industry but also other sectors (Kohli 2014, p.15; Ahmad 2011, p.20). The majority of expatriates in Oman were Indians and they have contributed greatly to the development of the country, as workers within many different sectors, such as “commerce, healthcare, education, horticulture, finance, construction and communication etc” (Ahmad 2011, p.21). Many of these migrants come from states in South India (Kohli 2014, p.119) and they belong to the Muslim community (Zachariah & Rajan 2012, p.27). The high numbers of workers who came from Kerala, where unemployment motivated young men in particular to take on work in the Gulf countries, resulted in a large community of Indians within the region, known as the Kerala-Gulf diaspora (Anjum 2017; Czaika & Varela 2015; Rajan 2004). Unlike
other groups of migrants, “Indian labour immigrants are represented throughout the entire social stratigraphy” (Deffner & Pfaffenbach 2011, p.11). As migrants in the GCC countries are rarely granted citizenship, and most of them have temporary work contracts, they ensure they remain well connected to their home country and community (Kohli 2014, p.134). In particular low-income workers cannot be accompanied by their family and their contracts are often limited to a maximum of two years, with the option to extend this on a rolling basis (Deffner & Pfaffenbach 2011, p.11).

Indian expatriates are also well-represented in the healthcare sector of Oman, as the data in the previous section showed. Given the presence of Indian doctors in Oman, India’s reputation as a health authority and the cultural affinities between the countries that have developed over a significant period of time, this can explain why Omani patients turn to India, with regards to matters concerning their health. In other words, “Indians contributed to healthcare and development of Oman in a widely acknowledged manner. India also helped Oman in the fields of IT, education, and health and thus it is no wonder that the Omani citizens traveled [sic] to India looking for opportunities in medical care and diagnosis” (Aravindhakshan 2010, p.19). The way in which India became a destination for medical travel is reviewed in the next section.

4.1.3 India as a medical travel destination

India is seen as one of the leading medical travel destinations globally and in Asia, in particular (Bhaidkar & Goswami 2017; Lunt & Mannion 2014; Smith 2012; Reddy & Qadeer 2010; Herrick 2007; Connell 2006). For a significant period of time, cost-effectiveness has been one of the most distinctive factors, which has made India stand out from other countries participating in the transnational healthcare market. Following the slogan, “First World treatment at Third World prices” (Singh & Gautam 2012, p.24), treatment costs are often only 20% of the costs that patients would incur in the USA or UK (Reddy & Qadeer 2010, p.70). This feature is a prominent selling point, also in comparison to other medical travel destination: “It [India] arguably has the lowest cost and highest quality of all medical tourism destinations” (Herrick 2007, p.4). Along with the cost advantages, India’s healthcare system has many other strengths which have allowed it to become a renown healthcare destination for international patients. The portfolio of what India has to offer often culminate in lists, such as the following written by Indian researchers with background in health management:

“India is a captivating and appealing destination for people desiring healthcare services for many reasons which include its qualified, trained and experienced health professionals, a large population of hospital and healthcare staff who are proficient in English language, clinical excellence, combination of allopathic and alternative systems of medicine like
Ayurveda, homeopathy, good infrastructure of hospitals, good preoperative counseling facility for the patients and use of diagnostic and clinical equipment which are technologically advanced” (Jain & Ajmera 2018, p.1462)

India is known for its expert treatment across many different medical specialties, such as Cardiology, Orthopaedics, Neurology, Oncology, Ophthalmology, Gynaecology and fertilisation treatments, Bariatrics, organ and stem cell transplants and many more (FICCI 2018; Gupta et al. 2015, p.233). Multi-speciality hospitals conveniently allow access to all of these departments under one roof. Although it does not feature prominently until more recently as medical specialities, India does also have a stronghold in a range of alternative systems of medicine such as Ayurveda, for example. The main hubs for medical travel within India are Delhi National Capital Region (NCR), Bangalore, Chennai, Mumbai, Kolkata and Hyderabad (FICCI 2019; Chaudhary & Agrawal 2014, p.2; Qadeer & Reddy 2013, p.2). Delhi NCR is one of the main centres, with clusters of super-speciality hospitals from corporate chains such as Apollo Hospitals Enterprise, Fortis Healthcare and Max Healthcare. As it is the capital city of India, the flight connections are convenient and frequent and they connect patients to an abundance of destinations (Dawn & Pal 2011b, p.2; Hazarika 2010, p.248; Gupta et al. 2015, p.230).

Medical value travel, as it is known in the industry today, makes an important contribution to the Indian economy and it presents rapid growth rates over the past years. It is difficult to provide exact figures, however, the Indian medical tourism market was said to contribute 3 billion USD in 2015, according to the Confederation of Indian Industries (cited in Jain & Ajmera 2018, p.1462), 6 billion USD in 2018 (Bhaidkar & Goswami 2017, p.86) and it is estimated that it will reach 7-8 billion USD by 2020 (Jain & Ajmera 2018, p.1462).

As highlighted in Figure 5, the majority of people arriving in India with a medical Visa (which includes a patient’s Visa and medical attendant Visa) were from South Asia with 63% in 2019, followed by West Asia with 17% and Africa with 8%. According to the cumulative number of Foreign Tourist Arrivals on medical visa per country for the years from 2014 to 2017, Bangladesh alone accounts for 47% of those
travelers, Afghanistan for 12% followed by Iraq with 7% and Oman with 5% (FICCI 2018, p.19). The total number of Omani arriving on a medical visa in India in 2018 was around 27,500 (Ministry of Tourism Government of India 2019, p.43) which is much higher than the number for the same year presented previously, based on the statistics of the Treatment Abroad Department of Oman, which was only 544 (see Figure 4). One reason for this discrepancy, is that the statistics provided by the Foreign Tourist Arrivals in India include both the patients and their attendants who travel with them. Another explanation for this discrepancy, is that not all patients who travel to India on a medical visa are directed through the Treatment Abroad Scheme; actually, the majority of them travels individually, on their own accord. Along with Bangladesh, Afghanistan, Iraq and the Maldives, Oman is among the top five countries from which patients travel to India for healthcare, as outlined in the most recent report, published by the Federation of Indian Chambers of Commerce and Industry in 2019 (FICCI 2019, p.35).

This knowledge paper reviews many aspects of the medical value travel market in India and it states that medical facilitators are “the major business sourcing channel in this industry” (FICCI 2019, p.6). They describe this affiliated business as “majorly unorganised”, as 80% of the business is managed “by students, translators, tourists, unaccredited facilitators etc” (FICCI 2019, p.22) and only 20% is managed by registered companies. However, these findings lack depth, as the way in which this data was generated is not explained within the report.

The foundation, whereby India became an international healthcare destination, was laid in the 1980s, when political and economic restructuring of the healthcare sector resulted in a profound shift from public to private healthcare. Although for a significant period of time the government in India has been somewhat passive in supporting medical travel compared to other countries, it did foster the private healthcare sector in multiple ways. Facing an economic crisis in the 1980s and with the governmental health expenditure decreasing, the National Health Policy issued in 1983, signalled a policy shift towards liberalisation and privatisation within the healthcare sector (Reddy & Qadeer 2010, p.70; Smith 2012, p.5). The recognition of the hospital sector as an industry, opened it up for investments of public financial institution (Thomas & Krishnan 2010, p.2). Up until this point, the majority of hospitals were government run and the private sector existed only in a few charitable institutions (Murray et al. 2016, p.70), individual doctors, small clinics and nursing homes (Chakravarthi 2013, p.171; Thomas & Krishnan 2010, p.2). However, the new policy, with the “mantra” of “liberalisation, privatisation and globalisation” (Duggal et al. 2012, p.8) opened up new opportunities in the healthcare market (B. Lefebvre 2010, p.3). When the Apollo Group of Hospitals opened their first hospital in Chennai in 1983, it was the first corporate hospital in India and it was seen as “the beginning of a new chapter in the history of healthcare in India: the rise of the corporate hospital alongside the unfolding of liberalisation in the country” (Hodges 2013, p.242).
The government supported the building of corporate hospitals with multiple measures; land to build hospital complexes was made available at concessional rates or a token payment (Duggal et al. 2012, p.21; Thomas & Krishnan 2010, p.2), other subsidies consisted in certain tax exemptions (Bhaidkar & Goswami 2017, p.84). Such “concessions were offered in return for provision of free treatment for the poor as a certain proportion of outpatients and inpatients” (Duggal et al. 2012, p.21). In the case of the Apollo Hospital built in Delhi in 1986, as a joint venture with the government, the deal agreed outlined that “the government provided 15 acres of land and Rs 16 crore [denoting ten million]. In return, the AHG [Apollo Hospital Group] agreed to provide free services to patients occupying at least one third of its 600 beds and to 40 per cent of those seeking outpatient care” (Thomas & Krishnan 2010, p.2). Other hospital groups followed the same incentives; however, they rarely fulfilled their obligation to provide services free of charge or at concessional rates for those from a less wealthy background (Duggal et al. 2012, p.2). Some hospitals have even operated under the Public Charitable Trust Acts to avoid paying taxes (Duggal et al. 2012, p.19). When the New Economic Policy was introduced in 1991, this meant that the regulations regarding foreign direct investments were eased – “a number of foreign investors began to collaborate with Indian health care providers, particularly in corporate hospital groups” (Smith 2012, p.6). The private sector grew rapidly under these neoliberal policies (Sen Gupta 2015, p.4) and “with remarkable swiftness, the Indian corporate sector came of age” (Duggal et al. 2012, p.8).

This development resulted in the domination of the private healthcare sector and thus a reversal of the contribution of private and public institutions (Duggal et al. 2012, p.6). This happened to such an extent that India today has one of the most privatised healthcare systems worldwide (Duggal et al. 2012, p.67). The public expenditure on healthcare, with about 1.2% of the GDP, is extremely low in comparison to “a global average of 6.5 percent, an OECD average of 8.4 percent, a middle-income countries level of 3.0 percent and 2.1 percent for low-income countries as a whole” (Duggal et al. 2012, p.70). The divergence of public and private healthcare has not been without criticism and “[t]he stark differences between private and public health-care centres are seen as an obvious statement of the widening gap between the rich and poor” (Smith 2012, p.6). These inequalities are critically reviewed in the context of medical travel, if local infrastructure and human resources are catering for the needs of international patients, rather than prioritising the needs of the local population (Reddy & Qadeer 2010; Lunt & Carrera 2010; Pennings 2007; Connell 2006).

Nevertheless, in recognition of the growing industry, the government of India has begun to support medical travel to India more actively in more recent years. “Medical and Wellness Tourism” was established as a special division under the Niche Tourism Department and the medical visa was introduced in 2006 (Bhaidkar & Goswami 2017, p.83). The previous application process was described as being lengthy and tedious and it acted as a barrier to patients
choosing India as medical destination. More recent initiatives making the visa application process easier are seen as “an important step by the tourism ministry to bring India at par with competing countries like Thailand, Dubai, Malaysia and Singapore which already offer a Visa upon arrival” (Bhaidkar & Goswami 2017, p.86). An additional way in which the government supported the medical travel industry, is with the National Health Policy of 2002, which “made it easier for the private hospitals to import pioneering cutting-edge technological equipment” (Bhaidkar & Goswami 2017, p.83). The National Accreditation Board for Hospitals (NABH), founded in 2006, acts as an instrument for quality control in the healthcare sector, which also contributes to meeting and communicating certain standards, which are beneficial for the promotion of India as a desirable health and wellness travel destination (Bhaidkar & Goswami 2017, p.84). As recent as 2018, the NABH introduced an accreditation scheme for medical travel companies, which is said to be a novelty in the global healthcare market and an opportunity for India to increase standards and transparency in this associated industry (FICCI 2019, p.23).
4.2 Introducing the informants

Who is facilitating medical travel between Oman and India? This section introduces the informants who contributed the data collected and analysed within this thesis. As an addition to the brief overview presented in the methodology, this section provides more detail about the informants who kindly and generously shared their knowledge and allowed an insight into their work and views on the subject of transnational healthcare. After providing an overview of the sample, background information about the individuals interviewed and shadowed in Delhi (4.2.1), Kerala (4.2.2) and Muscat (4.2.3) will be provided.

One of the conceptual moves of this thesis is to expand the understanding of who is a medical travel facilitator beyond people who are designated medical travel facilitators working for a medical travel company or as an individual freelancer within this business. Other people facilitating medical travel are also considered. Based on their job or work environment, the informants participating in this study can be analytically grouped into:

- individually working facilitators
- facilitators working for medical travel companies
- people working for the international patient or marketing department in hospitals
- medical professionals
- people working for governmental or not-for-profit organisations related to medical travel
- others such as former patients and attendants or other companies related to medical travel

Table 5 demonstrates how many facilitators, within each category, were interviewed within each of the three study sites, during the main phase of the data collection (November 2017 – March 2018). In total, 84 people were interviewed: 41 people in Delhi National Capital Region (NCR), 12 in Kerala and 31 in Muscat. Equal numbers of facilitators working for a medical travel company and facilitators employed by hospitals participated, with fewer numbers of individual facilitators, medical professionals and government representatives. Under the category ‘other’ were former patients and attendants, medical travel related organisations, third party agencies, an insurance company and a visa application centre. Of the 84 participants who were interviewed, 19 were shadowed over the course of one or more days; 12 in Delhi and seven in Muscat.
The majority of participants were male, with the sample consisting of 74 men and 10 women. This seems to provide a relatively accurate representation of the gender split within the field of medical travel facilitation in the research sites, as it does appear to be a more male-dominated profession. This may be due to the features of the role, which include high flexibility, personal contact and long and unpredictable working hours. In many cases, a member of the management team would represent the company or organisation and I assume that women are underrepresented in this hierarchy level. Additionally, it may be related to the cultural or hierarchical structures within the societies where the data was collected.

The data sample was complemented by the Advantage Healthcare India event in December 2018. Besides informal conversations, another 19 short interviews were conducted, mainly with representatives of medical travel companies and international marketing teams from different hospitals, but also with individual facilitators and the event organisers. Given the circumstances by which the data was collected and the length of the interviews, this data set differs to the data collected previously, however it is an important addition as it is specifically focused on the relevance of such events. An overview of the complete sample of research participants is provided in Table 6. Including this sample from AHCI even, a total of 103 people were interviewed.

<table>
<thead>
<tr>
<th>Type of medical travel facilitator</th>
<th>Delhi</th>
<th>Kerala</th>
<th>Muscat</th>
<th>AHCI Delhi</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual facilitator</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Medical travel company</td>
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<td>2</td>
<td>5</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>Hospital, internat. patient/marketing dep.</td>
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<td>3</td>
<td>5</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Hospital, medical professionals</td>
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<td>1</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Government representative</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>8</td>
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<tr>
<td>Other</td>
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<td>0</td>
<td>10</td>
<td>2</td>
<td>15</td>
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<tr>
<td>Total</td>
<td>41</td>
<td>12</td>
<td>31</td>
<td>19</td>
<td>103</td>
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Table 5: Number of interviews with different types of facilitators in each fieldwork site

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<td>103</td>
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Table 6: Number of interviews with different types of facilitators in each fieldwork site
4.2.1 Medical travel facilitators in Delhi

The general impression of the medical travel facilitation business in Delhi, is that there are a good number of registered medical travel companies (15 interviews with representatives of such companies), which are well-known among other companies and well-acquainted with the staff of the international patient or marketing teams (14 interviews) in the prominent corporate hospitals in Delhi NCR. Additionally, there are many facilitators working individually with less formalised set-ups (four interviews); many have a migration background and they have come to Delhi as students. Some of these individuals operate on an occasional business rather than turning it into a full-time job, whereas others put their studies on hold, as they find medical facilitating is both a time-consuming and lucrative job.

The majority of managers in medical travel companies, interviewed in Delhi, had already been involved in the healthcare industry before starting their company. Many have a background in hospital management, marketing, administration and insurance and some have experience in other fields, such as IT, tourism and language studies. The companies have between 10 to 25 employees and some of them hire temporary staff members depending on the tasks and workload. Most interviewees could not give an estimate of the number of patients that their companies handle per month or year on average, explaining it with considerable seasonal fluctuations and different categories of patients, such as sponsored and private patients. However, those interviewees who did give an estimate, the numbers tended to range from around 50 to 80 patients per month on average, or up to 100 patients.

From the group of individually working facilitators, three of the four were students. One was from Syria, one was from Congo and the last was from Afghanistan. All of these individuals became involved in the business after accompanying relatives and friends to Delhi for medical treatment and/or by talking to friends, who were already working within the field. Whilst medical travel companies target multiple source countries, which reflect either the regions with high numbers of patients seeking care abroad, or the personal network of the management, these facilitators tend to connect most often with patients from their home country. Nevertheless, they also try to expand their business by targeting and facilitating patients from other countries.

The hospital staff who were interviewed, who are facilitating international patients during their hospital stay in India, were either in a managerial role or part of the team of the international patients or marketing department. Some of the interviewees had around two years of experience, whereas many others had five to ten years of experience or even more. Many of them studied business administration, marketing or healthcare management; some of the interpreters studied languages or are multilingual due to their migration background. It is noteworthy that some of the facilitators have an Islamic background and they seem to connect particularly well with patients from Muslim countries. It was remarkable, firstly, that the facilitators working
for the hospitals changed jobs frequently and many worked with several of the big corporate hospitals and secondly, that this was the case with many founders of medical travel companies as well, prior to them starting their own company. The transition from facilitating medical travel, as a hospital employee, to working for a medical travel company, seems to be a common career path. Additionally, three nurses working for one of the corporate hospitals, who were looking after international patients, were interviewed. They all agreed that international patients tend to be less demanding, in comparison to domestic patients and despite the language barriers, they enjoy interacting with them.

The remaining category is comprised of government representatives, as well as three individuals who facilitate medical travel, who do not belong to the groups discussed above. It was possible to interview a representative of the Ministry of Tourism in India, which was important, as health and wellness travel falls under the Niche Tourism Department. Furthermore, it was specifically insightful shadowing and speaking to the health attaché of Oman for a day, during his hospital visit in Delhi. I also interviewed the manager of a company, who is organising events to promote medical travel to India, in collaboration with the Ministry of Commerce and Industry. This individual had over thirty years of experience in healthcare marketing. Furthermore, a representative from the Federation of Indian Chambers of Commerce and Industry (FICCI) and the founder of the Medical Tourism Development Association were interviewed.

4.2.2 Medical travel facilitators in Kerala

Medical travel facilitation in Kerala appears to be to some extent structurally different, in comparison to Delhi NCR, as highlighted by the interviewees there and their accounts. Most striking was the dual role of taxi drivers, who are also actively involved in medical travel facilitation and are known for it. Many of them are well-networked with individuals in the Gulf Cooperation countries (GCC), either because they have friends living there or because they themselves lived abroad for some time. These individuals have acquired valuable language skills and cultural competence. For two of the four taxi drivers interviewed, medical travel facilitation was more of a side-business; the two others, however, were actively involved in the job, acquiring new clients through their network and purposefully tying up with healthcare providers, similar to other individual facilitators. These facilitators whose main focus was the medical travel facilitation business brought large numbers of patients to the hospitals. For some facilitators, they were bringing in around 15 patients per month, whereas for others it was 50 to 60 patients. For one of the facilitators, it was as many as 150 to 200 patients per month and he had to rely on support from friends, in order to handle such a high number of clients.
It was more of a challenge, in the limited time available during the stay in Kerala, to find and communicate with facilitators who were working for a registered medical travel company. One of the two interviewees started his company with two partners only a year ago and they are all fully qualified doctors. Apart from supporting international patients, side-businesses involved hospital auditing roles, whereby the company would help the hospitals achieve accreditation and develop IT solutions for the healthcare sector. The manager of the second company with a background in management studies had a bit more than one year of experience in the field and was keen to promote both ayurvedic and allopathic treatments to foreign patients. The profiles of the three facilitators working for the hospitals’ international patient or marketing departments were similar to the ones interviewed in Delhi.

4.2.3 Medical travel facilitators in Muscat

Whilst conducting the fieldwork in Muscat, there did not appear to be as many registered medical travel companies, as in Delhi NCR. Through an Internet search and a discussion with other informants, it became apparent that there were only a few known registered companies and five of them are represented in this study. Out of the managers who were interviewed from these companies, three were Omani and two were Indian. One of the Omani facilitators had around thirty years of experience, as he had been working for the Treatment Abroad Team, under the Ministry of Health from the early beginning before moving to a tourism company, with medical travel as a specialty field, after many years of experience had been obtained. The others had a range of experience between one to twelve years. The number of patients fluctuated on a seasonal basis; whilst completing this fieldwork, the number was rather low due to the economic crisis. The estimates given were around 20 to 30 patients per month.

Two of the individually operating facilitators had longstanding experience, one with twelve years in the field and the other with sixteen. Both facilitators started by accompanying a friend, who was seeking treatment in India. They were helping with language translation and providing moral support and they eagerly learnt about the healthcare providers abroad, connecting with doctors and drivers there. Soon, due to word-of-mouth, they were asked for help by numerous others. These facilitators were gradually building a network in India and making a name for themselves in Oman. It was difficult to get a sense of how many of these types of individual medical travel facilitators were operating in Muscat. Those working in the field stated that there were not many Omanis, but there was an increasing number of Indian agents entering the field of medical travel facilitation.

The Health Minister of Oman and the head of the Treatment Abroad Committee both gave valuable insights into the government’s approach towards medical travel facilitation, outlining the general principles and connections with India, but also sharing details about the internal
organisation, their work practices and protocols. Three members of the Treatment Abroad Department team could be interviewed and shadowed, which allowed insights into the ways in which they operate, their daily duties, the documents they circulate, people they interact with etc. A representative of the Oman Medical Association was also interviewed, representing the viewpoint of medical professionals, who are also concerned with the development of the healthcare sector in Oman and transnationally.

Additionally, within in the category of ‘other’, medical travel facilitators were representatives of an insurance company, a third-party agency and the Indian Visa application center. Furthermore, six former patients and attendants shared their thoughts and experiences with medical travel.

4.3 Overview: stages and modes of medical travel facilitation between Oman and India

This chapter is gradually moving towards empirically grounded information and this last part is based on the data collected during fieldwork. It assembles the material in a way in which it is designed to offer a schematic overview of medical travel facilitation. This has the purposes to give a clearer understanding of what medical travel facilitation may comprise of in practice.

To do so, the sections are organised chronologically, and they follow the typical stages of medical travel facilitation between Oman and India. Before that, Figure 5 gives an overview on the main actors – conceptualised in a simplified manner as people, institutions or authorities at this point of analysis – and their relative place in the transnational configuration.

The chart in Figure 6 shows four common – but simplified – models of medical travel facilitation as they were found to be practiced in the context of Oman and India representing some of the main actors from both private or public domains, but it does not provide details about varying funding schemes, the operational set-up through which the facilitation work is carried out nor the scope in which the patients’ treatment abroad is being facilitated.

Figure 6: Overview of typical constellations of main actors involved in medical travel facilitation between Oman and India (own figure)
The first pathway shows medical travel facilitated by the Treatment Abroad Scheme in the Sultante of Oman. Within this pathway, the organisation of the travelling process, the access to the treatment and also the funding is taken care of by the state; all other pathways are privately organised. The second and third pathway involve designated medical travel facilitators, who are either based in India or Oman, connecting an Omani patient to a hospital in India. The patient may pay for the treatment out of their own pocket or the payment may be covered by an insurance company. In some cases, the patient may also pay a service fee to the facilitator. The common business model of the facilitating agent, a company or individual facilitator, however, foresees reimbursement for their work through the healthcare provider in India in terms of a referral fee payment. The fourth mode involves both, a facilitator based in Oman and one based in India, who collaborate in the facilitation process. The conditions for their collaboration and the way they split the income varies.

What might look like a fairly straightforward process, evolves in reality along a more intricate plot: more people may be involved in the facilitation process such as family members, former patients who give advice and recommendations, the patient’s doctors, facilitators working for companies or an individual base, facilitators provided by the hospitals and more. The patient may try multiple ways, both simultaneously or one after the other, after encountering a dead-end or if they are not satisfied with the proceedings. The actual complexities of medical travel facilitation are thus further explored in the empirical chapters with different analytical lenses. Nevertheless, some aspects of medical travel facilitation seem to be relatively consistent, such as the need to invest in some sort of medical travel infrastructure, practices of pre-travel counselling and assistance, providing on-site support to the medical traveller at the destination site and some (mostly limited) follow-up activities. These are reviewed in the following four chronologically ordered sections.

### 4.3.1 Establishing the set-up for medical travel facilitation

To facilitate medical travel from Oman to India successfully, some sort of set-up or mobility infrastructure needs to be in place, which consists of a network of contacts which have already been established and certain processes and protocols that are in place and provide some level of standardisation. People working as facilitators need to be informed about patients’ needs and the circumstances in their home countries, they need to have knowledge about the medical travel market and healthcare industry, within which they operate, and they may need to have the language skills to communicate adequately within the transnational setting, with patients from a number of different countries, in order to gain their trust. There are multiple ways to gain such knowledge and build the required set-up. Some actors engage in medical travel facilitation on an occasional basis to help friends and family; they bring the necessary knowledge.
base from being an insider within that community and they can operate without investing in a specific set-up, to facilitate medical travel. Some others facilitate medical travel on a freelance basis, without having a professional set-up, whereas some others work for a company that is officially registered as a medical travel company with the government in Oman or India. Those companies often invest specifically in business development and they have a proper set-up which allows them to handle higher numbers of patients, in a professional way.

A separate division within the field of medical travel facilitation is coordinated and sponsored through the government’s Treatment Abroad Scheme, in Oman. This scheme, under the Ministry of Health of Oman, sends Omani patients abroad for medical investigations or treatments, which are not available or accessible in a timely manner, in Oman. A committee and team within that department coordinate such government-sponsored medical travel. In order to do so, they have contracts with different healthcare institutions abroad and chapter 5.1 will explore, in more depth, how these connections become established and how they subsequently entwine different spaces. Before signing a Memorandum of Understanding, specifying the relation between the hospital and the Ministry of Health in Oman, the Treatment Abroad committee sends a team abroad to evaluate the hospitals: they ask for the hospital statistics, the doctors’ profiles, the number of cases they have had in different specialties, they check the facilities and discuss with the hospital representatives which services and packages they have to offer. The head of the Treatment Abroad committee explains:

Mainly we are concerned about few things. Of course, if we go from the hospitals, the doctor’s reputation, their CV’s. Then the accessibility of that premises of that hospital as well as the easy travel from the airport to the hospital. And good hotels and accommodation near to the hospitals. And then also, ehm, good frequent flights from Muscat to that area. So, this we take into consideration. The convenience also of the patient. The reliability of the doctors and the hospital, that means we don’t want our patients going there only for doing nothing. (I.24)

Another factor to take into consideration is the specialty of the hospital. Furthermore, there are some more specific requests, given by the transnational healthcare set-up, such as the availability of translators and particular types of food for patients from different backgrounds. After auditing a hospital, the committee decides whether the institution meets their criteria and whether they want to include the hospital on their list. This list is said to be continuously reviewed and adapted, according to the feedback of the patients and the health attachés and the success rates of the treatment.

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1 Number referring to the interviewee
Similarly, medical travel facilitation, which is handled privately, also draws on connections between hospitals, doctors and facilitators, who are actively and purposefully being established or have been established earlier on in a different context. Through their previous work experience in the healthcare industry, that the majority of founders of medical travel companies in India possess, they have acquired knowledge about relevant processes, the internal organisation of hospitals and the struggles of international patients. The process of making contact with potential clients and establishing connections in the patient-sending country is usually more challenging for these individuals. One way to promote their services is via the Internet, through their webpage and advertisements. Another way is to participate in international industry events, such as medical travel exhibitions and conferences (see Chapter 5.3). These events create a platform to connect with other actors within the field, to establish business-to-business relationships, tie-ups with healthcare providers and on some occasions, to reach out to prospective clients. Alternatively, medical travel facilitators may have to do their own research online and contact potential partners in the patient-sending country directly. Having a local partner, who can establish trust with patients and refer them to these services abroad, is a vital resource for medical travel facilitators who are based at the destination site. Some facilitators may already have an extensive network in the patient-sending country, as a result of earlier labour migration. The Kerala-Gulf diaspora, in particular, plays out in medical travel facilitation to Kerala, the southern state which is also well-known for Ayurveda treatments and wellness tourism (see Chapter 5.2).

Other medical travel facilitators based in Oman, who do not have this connection to India, pursue similar strategies in building an operational set-up abroad, as the solely India-based facilitators; they attend international events to connect with healthcare providers in India and with other medical travel companies, or they may contact potential business partners directly, discussing possible cooperation, during a short visit. Sourcing clients is easier for these facilitators, as they are physically present and they are living locally, meaning they are familiar with the patient’s situation. They can draw on their personal networks and their connections with the individual doctors who refer patients and they can promote medical travel on their website or as an additional line, to their travel or tourism business.

As previously mentioned, medical travel facilitation has become a common ‘side-job’ for some international students who are attending school or university in India and who have learnt about the work of medical travel through first-hand experience, either by receiving treatment themselves or assisting friends or family, who have heard about the availability of effective and affordable medical treatment in India. Those students or other facilitators with a migrant background, have the advantage of speaking and understanding multiple languages, being well-connected to the patient-sending country, and familiar with the context in India.
4.3.2 Pre-travel facilitation

The scope of pre-travel facilitation varies, however there are some preparatory steps which are typically followed in medical travel facilitation, with a certain level of standardisation. The process typically begins with the patients and their family being provided with a diagnosis, by their local doctor. Then if the medical intervention required is not available, accessible, or affordable in an appropriate timeframe, they have to start looking elsewhere for treatment and may consider going abroad, consulting a friend or family member, or even the doctor, who may suggest a place or a hospital to travel to or they can recommend a medical travel facilitator. Alternatively, patients may come across advertisements of medical travel companies online and send an enquiry. If the treating doctor in Oman sees no valid option to treat the patient within the country, they can make a recommendation to send the patient abroad, through the government-sponsored Treatment Abroad scheme.

Once the first contact between a patient and a facilitator is established, the process of exchanging information starts. Facilitators will provide information regarding the different steps of medical travel and the benefits of their assistance. They ask the patients to share their medical records and any particular requirements, wishes or apprehensions about their treatment abroad.

If the facilitation is directed by the Omani Treatment Abroad Scheme, these tasks are undertaken by a team of around 14 people (at the time of data collection in early 2018). For them, the process starts with the recommendation from a local doctor to the committee, to request that their patient to be sent abroad. This referral letter is accompanied by the medical reports that provide the details of the patient’s medical history and these reports are sent to the Treatment Abroad Department for approval. The different files and forms of the cases are collected and presented at the weekly meeting of the Treatment Abroad committee, which consists of the chairman and four doctors. At the time of data collection, in January 2018, they would discuss around thirty to fifty cases in one meeting. They then decide whether treatment abroad should be approved or not, or the case is declared as ‘pending’, if the committee asks for more investigations, before reviewing the case again.

If the decision is made to direct the patient abroad, either based on the Treatment Abroad Committee’s decision or based on the patient’s decision after the first interactions with a private facilitator, the facilitator then looks for possible healthcare provider in India. The Treatment Abroad Committee in Oman is associated with the appointed health attaché, who is based in the Omani Embassy in Mumbai. The health attaché and his team are aware of all Omani citizens, traveling to India for medical reasons, under the government scheme and their role is to report back to the Treatment Abroad department about the hospitals and the patients, to coordinate and resolve issues on site in India, whilst also processing the bills and pay-backs. The team will also assist patients travelling through other organisations, such as the Royal Oman Police or NGO’s and patients travelling individually, paying out-of-pocket. With regard
to the government-sponsored patients, the health attaché and his team take over the coordination work in India. Once the Treatment Abroad coordinator in Oman sends the medical reports of the patients, which have been approved by the committee, the health attaché in Mumbai sends these reports to different hospitals, which are included in the Treatment Abroad Scheme, to request an opinion, a treatment plan and cost estimate. This is then referred back to the team in Oman, for the committee to make a decision on the options and suggestions provided, in their next meeting.

Similarly, individual medical travel facilitators, or facilitators working for medical travel companies, contact the healthcare providers that they are affiliated with, they share the medical information of their client and they ask for a quote for treatment. The responses are then usually compiled in a spreadsheet by the facilitator, which allows the patient to compare their different options and the costs, more easily. The ethical implications involved in choosing and advising on healthcare providers and more will be critically analysed in Chapter 7, and the ways in which medical travel facilitators act to generate smoothness is investigated in Chapter 6.

Once the decision is made and the patient wants to proceed with their treatment abroad, the facilitators attend to other pre-travel arrangements, such as the visa application process and coordinating with the hospital about the patient’s appointments. To obtain a medical visa, a visa invitation letter needs to be requested from the healthcare provider in India, which is then sent, along with the patient’s and attendant’s application and passport, to the Indian Embassy in Oman. Then travel and accommodation need to be organised. In some cases, the patient and attendant may stay in the hospital; in other cases, they need to be booked into a nearby hotel or guesthouse. The coordination of the journey and the patient and attendant’s stay abroad is all taken over by the Treatment Abroad Committee and often also by medical travel companies. The facilitators should also check with the patient and treating doctor whether there are any special medical requirements during the journey, such as a nurse or doctor accompanying the patient, or the need for equipment such as a stretcher, wheelchair, oxygen or medicine, for example. These pre-travel facilitation tasks may be split between facilitators, present in both Oman and India, who are better situated to coordinate certain aspects of the process, due to their location.

Such pre-travel facilitation by the Treatment Abroad Scheme typically takes around two weeks. If there is an urgent case, it can all be done within two to three days – or even within a few hours, if there is a serious health-related emergency. For privately organised medical travel, the timeframe mostly depends on the patient and the duration for processing the medical visa; medical travel facilitators can usually make those pre-travel arrangements within only a few hours or days’ notice, and the patient is able to travel.
4.3.3 On-site support

On-site medical travel facilitation, understood as the support that patients receive during their time abroad at the medical travel destination site, varies considerably, depending on who is taking the lead, where the facilitator is based geographically, to what extent the process is formalised and what has been set-up (or not) in the pre-travel stage. In some cases, there is a protocol in place and a patient coordinator is assigned, who provides all sorts of support in- and outside the hospital, to ensure that the patients feel comfortable throughout their stay. In other cases, medical travel facilitation starts at the airport, upon the patient’s arrival, with some taxi drivers functioning as ad-hoc medical travel facilitators. The following sections trace along some typical practices of on-site medical travel facilitation, as well as also introducing some alternative forms.

On-site medical travel facilitation commonly starts with receiving the patient from the airport. This is typically taken over by an Indian-based facilitator, in the role of a ‘patient/ case manager’, who works for a hospital, a medical travel company, or individually, as a freelance facilitator. It is important that the patients and attendants are met immediately upon arrival, to ensure that they are safely directed to the right place and not ‘snatched away’ by dubious touts, waiting in the reception area of the airport, which is unfortunately a possibility. Chapter 6 will follow one of the facilitators to the airport, to scrutinise the strategies with which an experienced facilitator smoothens the arrival of an international patient in Delhi.

The next step, before or after settling the patients in the hospital or guesthouse, is to accompany them to the chosen healthcare institution, to take care of the registration process and guide them through the different steps such as: admission to the hospital or registration as OPD patient, consultations with the doctors, moving to the different departments where the investigations are done, collecting and discussing the results, deciding on the definite treatment plan, preparing for the treatment, going in for the treatment, recovering and accessing follow-up care, having final appointments with the doctor(s), completing the discharge process and accessing their prescribed medicines or other medical products to take back home. Throughout the time when the patient is in hospital, medical travel facilitators may – or may not – perform a myriad of practices to inform and assist the patients and also their attendants, to guide them physically through the often maze-like hospital space and to make sure the transitions between the steps run smoothly. Facilitators who are employed by the hospital and who are part of the international patient’s department are often also language interpreters and they are assigned to patients from a certain geography.

Medical travel facilitation is often extended beyond the realm of the hospital, if a freelance facilitator, or a facilitator working for a medical travel company, is in charge. Again, language translation is an important duty and it may be required to handle matters, ranging from an appointment at the Embassy or the Foreign Regional Registration Office (FRRO), to speaking
to a taxi driver or buying fruit at the market. Many medical travel facilitators are eager to provide a satisfying overall experience, for both the patient and their attendants, so they visit them regularly, to ensure they feel comfortable and they are entertained throughout the stay in India. Sometimes this includes organising some trips to nearby tourist attractions, but ‘leisure tourism’ aspects are often very limited. Some facilitators handle multiple patients, and their attendants, at the same time, and the practicalities of running in between the different parties, rooms, hospitals, the airport and other locations too, make the phone an essential device in everyday on-site facilitation (for communication and facilitation pre- and post-travel anyways).

Another mode of medical travel facilitation presents itself when the facilitators are based in Oman. There are different options to organise on-site support for the patients. One option is for the facilitator to travel abroad with their patients, to support them throughout the process. Alternatively, the Oman-based facilitator may collaborate with a partner, who is based at the destination site, so the patient can be handed over for their time spent abroad. Another option is for the facilitator to coordinate the entire process with the healthcare provider and designated hospital staff members, who will look after the international patients. However, there will not be one-to-one support and the patient and attendant are on their own when outside of the hospital.

In the case of the Treatment Abroad Scheme, on-site facilitation is mainly provided by the hospital staff. However, some tasks are also looked after by the health attaché and his team (Chapter 5.1). If the situation does not go as smoothly as planned, the health attaché is the patients’ first point of contact. Even if there are no pressing matters, the team checks on the patients and their progress with their treatment plan. They provide the patients with the allowance for local transport and their stay abroad, which is paid in cash. On some occasions, the health attaché travels around India to check on Omani patients who are currently undergoing treatment in different hospitals.

However, there are also less formalised modes of on-site medical travel facilitation. An example of more ad-hoc facilitation, which provides insight into how multiple mobilities and geo-histories become entwined, was found in Kerala and is explored, in detail, in Chapter 5.2. The context differs from Delhi, as this southern state is particularly well-known for its Ayurveda treatment methods and wellness tourism, and the Kerala-Gulf diaspora considerably shapes the relation between the patient-sending country and the receiving region. It was discovered that migrants who have returned to their home country, who work as taxi drivers, had found themselves involved in the field of medical travel facilitation, solicited or unsolicited, when picking up people at the airport in Kochi. The scope of what medical travel facilitation involves, in these types of cases, tends to be more varied. In some cases, facilitation only involves recommending a hospital or clinic; in other cases, the taxi driver accompanies his or
her client to the hospital, to translate and support them throughout the treatment, by bringing them food, negotiating matters with the hospital if necessary, and by buying them medicine. This level of business, as well as undertaking the role of a taxi driver, brings additional income, as they are often rewarded by their clients, who give them generous tips or gifts. Some individuals also receive referral fees from the hospitals and clinics, to which they bring business and commission, from the hotels or shops they recommend.

### 4.3.4 Post-travel assistance

Follow-up medical travel facilitation differs according to the patients’ condition and the facilitators understanding of their responsibilities, after the patient returns to their country. If the patients require follow-up checks with their local doctor, the facilitator may send the updated reports to the doctor in India, to check if their recovery is going according to plan, or if any further action is required. On some occasions, the facilitators organise video-calls, so that patients and doctors can interact directly, despite the distance. Post-travel facilitation may also involve sending medicine or prescriptions to the returned patients. Depending on whether the patients’ treatment is paid for by the government scheme, an insurance company, an NGO or out-of-pocket, there are sometimes some financial claims which need to be processed, if the patient has already left the country.

If there is further treatment abroad required, the process starts anew and even in cases where no further treatment is needed, medical travel facilitators often keep in touch with ‘their’ patients despite the distance. Sometimes this is for personal reasons, if patients and facilitators develop friendships or have found other common ground, but it is also an important channel for future business, as the former patients are likely to return at some point or refer family members or friends, in the future.

### 4.4 Conclusion

This chapter has explored how the basis for medical travel between Oman and India has been laid in the configuration of the national healthcare spaces of each state and the longstanding relation that spins around multiple axis, such as foreign affairs, trade, education, labour migration and healthcare, and builds connectivity between those two countries. Oman’s national healthcare system is relatively new and to compensate for the shortcomings, the Treatment Abroad Scheme constitutes a particular way of exercising its responsibility towards Oman’s citizens, by utilising foreign resources. India’s private healthcare sector is thereby conditioned
to receive foreign patients, which has been made possible by the initiatives of entrepreneurs in the healthcare domain and subsidies from the government. These circumstances and the complex entwinement of different institutions and health-related mobilities provide an interesting case for analysing how transnational spaces of healthcare are being articulated. Focusing mainly on the initial stage of developing the necessary connections to facilitate medical travel, the first of the three empirical chapters (Chapter 5) analyses how different types of medical travel facilitators, introduced in this chapter, act to articulate spaces of healthcare. This will take us to three different settings: 1) the practices with which the Treatment Abroad Committee of Oman establishes connections and reviews its cases, 2) the more ad-hoc practice of taxi drivers in Kerala, who articulate transnational healthcare spaces that entwine multiple medical systems, drawing on their connections and experiences in the Gulf countries, and 3) the international event that promotes India as a healthcare destination, by connecting spaces and creating new ones, which are aimed at facilitating medical travel.

The articulation of such transnational healthcare spaces across national borders, as well as across different governmental and institutional authorities, locations and cultures, creates friction. As outlined in the overview of the different stages of medical travel facilitation, a significant amount of work is necessary to hold transnational connections together and processes in flow. The way in which this is done specifically, on the ground of everyday facilitation businesses, is analysed in Chapter 6, which explicitly explores ‘smoothness’ as a relevant quality of and for medical travel facilitation.

Articulating spaces of transnational healthcare and working towards smoothness in the facilitation process requires constant decision-making and adapting to changes across the process. These involve negotiating a myriad of ethical complexities, resulting from the number of different actors, interests and also values of care involved in the mediation of medical travel. What is the ethic of care that makes transnational healthcare made ‘good enough’? This question is at the centre of Chapter 7, which takes a close look at the ethical implications of assisting a patient with the decision-making processes, and at the ways in which ethical dilemmas in the patient-facilitator relationship are handled in everyday realities.

Prior to exploring the empirical subtleties and theoretical intricacies of the chapters outlined above, an interlude will provide you with a sense of the everyday realities of medical travel facilitation, by taking a close look at on-site facilitation in Delhi.
Interlude: Starting in the middle
with on-site medical travel facilitation

Being right there, in the middle of where so many of the threads of medical travel run together, shadowing a team of freelance medical travel facilitators over multiple days in a corporate hospital in Delhi National Capital Region (NCR), generated some of the most vivid insights into medical travel facilitation. Starting with some more personal accounts of the practices carried out at the destination site resulting from job-shadowing provides a direct route into the facilitation work and stages some of the core themes that are analysed in the following three empirical chapters.

First thing to say about those day of shadowing is that they were long days with an overflow of impressions and insights that was mesmerising but hard to keep up with. Most shadowing was done on the ground of a hospital, a bounded space, demarcated by walls of concrete and glass. These purpose-built buildings with common features that help one to navigate and yet are confusing and maze-like, staged an unfathomable number of happenings ranging from being (seemingly) neglectable to lifesaving. There was a steady coming and going; people and things, material, machinery, in constantly changing constellations, running all-over. And so, the shadowed facilitators and I, constantly moving, were blending in. In an attempt to capture our trajectory, I recorded my movement using a running tracker as an experiment. The Figure 7 shows two-dimensional movements, projected on to the map, which unfortunately neglects the vertical movement across the different floors. Before relocating to another place, we covered just over 13km over an eight-hour period inside hospital: running up and down between the basement and top floor, often using the staircase that is for the hospital staff as we did not have the time to wait for the lift, turning left and right in the maze of corridors and rooms: patients rooms, doctors’ offices, consultation rooms, nurse stations, the pharmacy, admission counter, billing counter, cafeteria, Intensive Care Unit. Although the recorded pattern tells a story about back-and forth movement in physical space, it does not tell how it relates to other places and spaces,
Interlude: Starting in the middle with on-site medical travel facilitation

the qualities it holds and effects it generates, nor what actually happened in those moments. So, here is more on that:

Nasim², the head of a team of facilitators, was keen to provide me with a ‘true’ impression of what it means to be a medical travel facilitator and he was happy to have me follow him around on the job. He has longstanding experience in this job, working as a freelancer with three or four colleagues. We met in one of the hospitals where most of his patients got treatment; that day his team catered for about 40 people that were on site. For bringing a good amount of business and the frequent contact, Nasim is on good terms with the hospital staff and manager. This allows the team to move around freely and confidently.

*I meet Nasim in ‘his’ main hospital, in the morning just around the time when the Outpatient Department opens. Cars and autorickshaws queue in the driveway leading up to the hospital entrance. It is an impressive building with glass façade, situated a bit removed from the busy road. The floor is freshly polished in the entrance hall, flowers bouquets and posters with the hospital’s logo flank the reception. We meet in the cafeteria that serves beverages and snacks I am familiar with, prepared by well-known coffee and sandwich chains; but then there is also a booth called ‘Kabul Palace’, another one selling Masala Chai and a selection of Indian snacks and dishes and a stand selling fresh sugar-cane juice. (FN³, 4.12.2017)*

This place, located somewhere in Delhi NCR, that patients travel hundreds of miles to come to receive treatment, has at the same time a universal character following the set-up, aesthetics and organisation of hospitals that look familiar to me and yet it provides a unique combination of experts, socio-technical infrastructure and other entities generating, hopefully, the desired healthcare outcomes. That the hospital accommodates medical travellers becomes visible in the design and arrangement of the facilities specifically dedicated to foreign patients: There is an international patient lounge, a team from the international business development, translators who speak the patient’s language and run them through the processes, leaflets and forms translated in multiple languages. These facilities and services aim to make the medical travellers and their attendants feel more comfortable in the hospital environment. The cafeteria caters for different tastes and dietitians are used to tweak the menus for foreign patients. The set-up of the hospital is reconfigured by transnational healthcare whilst also delivering and up-holding the specificities of that place and the institution such as the expertise and experience of the doctors, state-of-the-art technologies and cost and time effective methods of handling patients – and the warmth of a cup of chai.

² All names mentioned in fieldnotes or quotes are pseudonyms
³ ‘FN’ referring to field notes
Nasim opts for coffee. He was up until 6am to collect patients at the international airport. The first appointments with the doctors have already started and while he is on the phone, we walk over to one of the consultation rooms on the ground floor.

The consultation was in progress when we enter the room, passing a line with chairs where others wait for their appointment. The doctor explains the medication regime that the patient needs to follow after discharge and hands over the prescription to Nasim who translates into Arabic and speaks with the patient and the two attendants. A CT scan is scheduled for the afternoon to check the outcome of the treatment. The attendants look concerned and Nasim asks the doctor when the patient will be discharged. They have a return-flight booked for the following day. The doctor says it depends on the result of the scan. Nasim asks the attendants to send him the booking details and calls his colleague in the patient’s country to delegate the task of checking options to change the return flight. Also, Nasim has just received some medical images via WhatsApp from a patient in Bagdad and asks the doctor to have a look. He is too busy right now but promises to have a look over them later, if he forwards the images to him. Nasim does so right now, he thanks the doctor and indicates to the patient and attendants that the consultation is over. (FN, 4.12.2017)

Documents and paperwork related to the practicalities before, after or during the medical journey are handled by medical travel facilitators on a regular basis, whilst they carry out their daily duties: meeting with patients, translating, alleviating their concerns, explaining, arranging investigations, accompanying the patients to the different appointments and guiding them through the different places. On their phone medical travel facilitators receive enquiries of potential clients; medical reports and images with requests for a medical opinion or prescriptions for medicine; they receive messages, photos and updates from their team members and hospital staff; questions and blessings from returned patients; complaints from current clients etc. Solely through their phone, they are connecting with patients in their home-countries, staff at the airport or embassies, taxi drivers, guesthouse managers and colleagues. They gather relevant information from sources in different places and sort out issues by talking to the respective parties over distance. They circulate relevant documents such as passport-copies, medical reports, visa invitation letters or fit-to-fly certificates but also medicine and other medical supplies.

In the OPD waiting area Nasim hands over the prescription to his colleague and tells him to get the medicine from the pharmacy outside the hospital as it is cheaper. He also asks him to get some other tablets for another patient who already returned and lives close to the patient we had just seen. (FN, 4.12.2017)
Over the day, the paths of Nasim and his team cross many times in and around the hospital. The encounters were the combined result of coincidence, going with the same workflow and clever orchestration using the phone to coordinate their trajectories and a whistling sound to call each other when nearby. The encounters were smartly used for updates, assigning duties, handing over documents. They know where to get things such as medicine for the best rates and channel supplies to patients in their home country via other patients. Health mobilities thus not only include humans but different sorts of material and digital circuits as well and they are multi-directional. Even among the different sorts of facilitators and hospital staff working in the hospital that day, phone calls and text messages are exchanged at second intervals to coordinate and fine-tune the happenings of the day.

We take the elevator to the 6th floor; Nasim doesn’t have to queue, he is well-known here and the security man lets him through. Something seems to be going on around the nursing desk and I learn from Nasim that one of the nurses called him earlier because there is an inspection going on today; foreign delegates visiting the hospital. He is constantly on the phone, it is like he is participating in multiple parallel worlds, and it is hard to keep up with all that is happening on his phone. The nurse guides Nasim to the delegates that are already in the room of his patient. He checks on her state and asks if she feels comfortable. He tells the delegates that his patients are all satisfied with the service and treatment in this hospital. Then he gets another phone call. (FN, 4.12.2017)

The hospital showcases not only the state-of-the-art technology and infrastructure by inviting foreign delegates who audit the hospital to visit but also provide first-hand testimonials from patients currently undergoing treatment. They rely upon the positive testimonials of international patients which spread across the patients’ communities encouraging medical travel, strengthening existing ties and thus reproducing transnational spaces of healthcare.

On the phone is a patient who cannot obtain his medicine because he had lost the prescription. Nasim explains that he will send a digital copy of the doctor’s prescription shortly. Whilst he attempts to find the photo he had taken on his phone, we take the stairs to the ground floor. There he picks up the test results of another one of his patients; he knows the patient number by heart. (FN, 4.12.2017)

Being on call is crucial for deescalating any difficulties and keep everything running smoothly. Nasim is equipped with three phones and multiple power banks that will get him through the day. His work heavily relies on these devices, but he relies on his own abilities of remembering the details about the different cases he and his team are handling simultaneously. Switching from one to another and quickly deciding what to do next.
In the waiting area we meet Nasim’s team and some more patients who have just arrived and were escorted from the airport to the hospital. Nasim takes their passports and visa documents, hands them over to one of his colleagues to complete the registration and gives him some cash to do that. He tells another colleague to take the patients luggage and store it in the international patients’ lounge while he moves on to pick up another patient in the cafeteria for her consultation. (FN, 4.12.2017)

And so the day went on until the Outpatient Department closed and Nasim’s admitted patients were settled. While Nasim returned home around 9pm to have dinner before collecting the next batch of patients at the airport, his team extended their service beyond the medical site by assisting patients and attendants with their shopping, organising food and joining them for a while in their guesthouses to make sure they are all comfortable.

Departing from these episodes, three main areas of interest crystallised: One area of interest is about space. These episodes cut across space in different ways: there is a physical, bounded space of the hospital where medical travel facilitation is practiced that day, the configuration of people and things right there. At the same time, this space is constantly related and reconfigured through people, things, practices in other places, simultaneously or happening at different moments in time. While Nasim is walking along a corridor in that hospital in Delhi to meet a patient on-site, he receives an image on his phone that was taken two weeks ago by a doctor in a different country, and just runs into a foreign delegation auditing the hospital, maybe of representatives of the Ministry of Health of a patient sending country. Bounded and networked spaces, public and private actors, geohistorical and biographical linkages come to be entwined, in the long durée and fleeting moments. So, what are the multiple ways in which medical travel facilitation contributes to relate spaces that makes transnational healthcare possible?

The second area of interest is the smoothness that practices of medical travel facilitation generate. Nasim and his team come across like masters of coordination, attentively handling multiple patients simultaneously, looking after their physical and emotional needs while streamlining their treatment abroad trajectories and keeping all the necessary things circulating. But while such smoothness seems to come about en passent, it involves a lot of work that is carried out in certain ways. The question is how is ‘smoothness’ as a quality constituted, and what mediations are necessary to generate such smoothness that makes transnational healthcare feasible?

Thirdly, the interest lies in what shapes these practices of medical travel facilitation and how to negotiate different pulls in a way that achieves ‘good’ care in transnational healthcare. It is about those moments when facilitators like Nasim need to decide what to prioritise, what
process to follow personally and what other to delegate, in what moments their work is about handling cases to keep it efficient and when to just sit with a person for a chit-chat, how to keep their business profitable and when to put the health of an individual above all. It is about the ethical complexities involved in medical travel and how they can be negotiated in ways that make transnational healthcare ‘good enough’.
5 Articulating transnational healthcare: relating spaces and spatialities

Spatiality is the specificity that makes transnational healthcare (TNHC) special. This in terms of not adhering to the nation state as spatial entity within which healthcare is commonly conceptualised but instead forming other spatialities that are particular in the ways that they span across national borders. This chapter is concerned with the spaces and spatialities of TNHC and how they emerge from diverse practices of facilitation. The research question analysed in this chapter is the following:

*How do practices of medical travel facilitation act to relate/ articulate different kinds of spaces and spatialities involved in transnational healthcare?*

The focus is on the ways in which medical travel facilitation acts to connect different sorts of spaces such as regional and network spaces and on the spatialities that result, understood as “diverse ongoing connections and networks that bind different parts of the world together and that are constituted through (and in fact constitute) particular sites and places” (Featherstone et al. 2007, pp.383–384). This is relevant, because the articulation of healthcare spaces is seen as crucial for the possibility of care. The coupling of certain spaces is in some ways a condition for the provision of healthcare, for making it possible to connect over distance and render the co-presence of patients and medical professionals who are otherwise in different locations. These spatialities, however, take different forms and this chapter will analyse how they are formed through formal and informal practices and variegated mobilities. By focusing on one of the three fieldwork sites (Muscat, Delhi and different locations in Kerala), the following three sections analyse the articulations of these spaces and spatialities, and how they create the possibilities for healthcare to be mediated between and across Oman and India. The first section looks at the relation between (allegedly) national and transnational spaces, as they are being articulated by the Treatment Abroad Scheme in Oman and different sorts of mobilities. This shows how geo-historical connections, and mobilities for education and work in

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4 To ‘articulate’ means ‘giving shape or expression to something’ (Merriam-Webster 2020) and also “to make connections and to join” (Law & Mol 2008, p.142). In the latter meaning, “the work of articulation” then is “to build connections that lead towards a set of new configurations and possibilities” (Clarke 2015, p.281).
healthcare and other sectors, translate into connections that establish healthcare spaces. Moreover, it is analysed how these spaces are being monitored through stretching health authorities beyond national territory and international schemes and perpetuated through normalising the practice of treatment abroad and circulation of word-of-mouth. The second section looks at how health and place become entwined in the example of Ayurveda travel to Kerala and how the Kerala-Gulf diaspora is involved in coupling spaces of labour migration, healthcare and medicine. In contrary to the previous section, these connections are not narrated through the state, but instead through biographical accounts of individuals and more informal practices of medical travel facilitation. The third section takes international events, such as the ‘Advantage Healthcare India’ exhibition and conference, as a route into analysing the networked, eventualised and topological spatialities that are formed by folding transnational connections into the event spaces. The spatial compression and the intensification of existing and new connections form some kind of miniature composition of a certain transnational healthcare market. The intensified momentary space-time constellation holds transformative power of making transnational healthcare possible beyond the event.

Throughout these three examples, I explore how spaces with different topological forms are interrelated, by attending to connections (networked, statutory, informal, biographical, geohistorical, eventualised) and spatial operations (such as stretching, stitching together, folding, or translating). In light of that, it is not just spatialities, but also different temporalities that come to the fore, ranging from the long durée to momentary events, and contemporary everyday practices and from continuousness to temporariness. Articulating those spaces and spatialities of transnational healthcare along this spatial and temporal axis is suggested to be an important practice for creating the possibility of care.

5.1 Oman: articulating national and transnational spaces of healthcare

Looking at healthcare in Oman and its Treatment Abroad Scheme, this first section analyses how transnational spaces are being established, safeguarded and perpetuated along specific kinds of connections that are networked, geohistorical and statutory. It shows how national and transnational spaces of healthcare are being co-constituted and thereby how different topological forms become related. This is illustrated in the first section by the ways in which medical travel gets entwined with other sorts of mobilities such as labour migration or short-term student mobilities that articulate transnational spaces of healthcare. The second section looks at practices and mechanisms of monitoring and safeguarding such transnational spaces
through the persona of the health attaché of Oman, non-profit organisations and (inter-)national accreditation schemes. The third section explores how treatment abroad is being normalised through sustained circulations of people and word-of-mouth testimonials and how this acts to perpetuate the articulation of TNHC spaces.

5.1.1 Establishing TNHC spaces: Treatment Abroad Scheme and related mobilities

Before looking at how spaces of TNHC are established in more recent times, it is important to know that Oman has a long history of medical travel and that transnational spaces between Oman and India predate – and also preform – those targeted practices of medical travel facilitation analysed later on. The government of Oman began taking responsibility for the healthcare of its citizens when Sultan Qaboos came into power in 1970 and initiated the development of a healthcare infrastructure (MOH Sultanate of Oman 2014, p.102). Given that national healthcare was non-existent for so long, Oman has a long history of medical travel and although it is not documented officially by the government, the Omani Health Minister said it is “as long as you can imagine”. In an interview talking about medical travel to India he explained:

I think it has usually been there. We don’t have record, but we know that in 1970s during the whole transformation we call it, like when things start to run differently, so then officially the government started to send patients. Earlier, patients went individually on their own and paid for their own expenses from their own pockets. So, we know nothing. But again saying, you know, it is as long as you can imagine. (I.22)

The interviewee then related this self-administered treatment abroad back to the longstanding historical connection between Oman and India and argued that two-sided mobilities through trade relations and labour migration had built connections that paved the way for medical travel. The relationship between Oman and India illuminated in Chapter 4.1.2 shows that the geohistorical connections are multiple. Since ancient times there were trade relations and Omani merchants travelled to different regions in India (Risso 1986, pp.3–4). In an article on Oman’s foreign policy, Lefebvre (2010, p.105) says that earlier and still today, “[g]eography, history and economics are thus working together to lead Omanis to look outward, not inward”, meaning to South Asia and particularly India, rather than to other states on the Arabic Peninsula. The royal family of Oman has had particular bonds with India; Sultan Qaboos bin Said spent some years in India for education and so did his father Sultan Said bin Taimur who even ruled Oman, whilst being situated in India for some time (Ahmad 2011, p.24). Moreover,
“Indian migration to the Gulf has a long history” (Rajan 2004, p.499), with a major inflow around the oil boom in the early 1970s. Still today, there are many Indian people in Oman. According to the newest population statistics from 2019 (MOH Sultanate of Oman 2018, p.13;18), out of the 1.96 Million expatriates (total population is 4.62 Million) 1.6 Million are male with 616,857 Indians and 623,857 Bangladeshi being the most significant contributors. Indians are very present in different sectors in Oman:

You know, people see the Indian people, they are available in the army, they are in the police, they are in contractors, they are builders, they are around. So, they give you information, so they say, why don’t you go to India, I tell you that place and this place. But officially the government sends patients since 1970, 1971. (I.22)

The frequent contact between Indian and Omani people and personal recommendations to visit hospitals in India translate into transnational spaces of healthcare. This is presented as a natural consequence of these connections by the interviewee.

Healthcare as a connecting link is not a new concept either. When the national healthcare system in Oman was developed in the 1970s, the government had to reach beyond the national borders in order to provide adequate healthcare services for the citizens of Oman. The government followed a two-pronged approach; firstly, by developing a healthcare system in Oman, which meant “building the country’s health infrastructure almost from scratch” (MOH Sultanate of Oman 2014, p.78) and in order to do so attracting personnel from abroad; and secondly, by formalising treatment abroad. At the time, Oman was significantly lacking in its infrastructure, expertise and trained personnel to provide adequate healthcare services. To address the issue of limited manpower in both short- and long-term, Oman followed two strategies: “the rapid demand for healthcare provision meant healthcare workers had to be hired from abroad while simultaneously increasing the number of locals educated in the health field” (Ennis & Walton-Roberts 2018, p.174). De facto, both of these strategies meant reaching beyond national borders to hire health workers and access expertise. This is because the training of Omani doctors in medical and health sciences, which started only in 1986 at the newly established Sultan Qaboos University, involved training in other countries (MOH Sultanate of Oman 2014, p.127).

Part of the “workforce development scenario” was an “active collaboration with universities and overseas specialty boards” (Ghosh 2009, p.1). This meant that the Ministry of Health “sponsor[s] Omani candidates in various specialties under OMSB [Oman Medical Specialty Board] or for overseas education/training” (Ghosh 2009, p.7) and Sultan Qaboos University “benefits from short and long term transnational faculty that enriches curricular content and educational delivery” (Lakhtakia 2012, p.408). Sending medical students abroad, especially
Articulating transnational healthcare: relating spaces and spatialities

for postgraduate training, still remains part of the efforts directed at developing human resources for the national healthcare sector (MOH Sultanate of Oman 2014, p.125). Transnational spaces of education in medical science thus become entwined with national spaces of healthcare. The Health Minister explains:

Because the doctors were coming to be trained all over the place. Now it is almost like a set-up, all of them are trained in Sultan Qaboos University, they graduated from the medical college here and then we send them only to certain places. At one time it was Canada, and Britain mostly, for training, postgraduate, something like two years. So, they graduate from here and then they do the training there where they are sent. (I.22)

Mobilities of medical professionals for training and work play an important role in articulating transnational spaces of medicine, whilst also strengthening national healthcare systems (Raghuram 2009; Raghuram 2008). What Raghuram (2009, p.31) elaborates on the case of the UK’s National Health Service and medical labour market applies thus to some extent also to the situation in Oman in that national healthcare has “deep and continuing international roots” making it transnational from the outset in terms of labour force (not to mention the geo-history of allopathic medicine). Despite the efforts to train Omans in the medical field and the Omanization policy introduced in 1988, which aims at increasing the level of Omani employees in comparison to foreigners in multiple sectors, the health sector was, and still is, reliant on expatriate workers. In 2003, foreigners constituted around 40% of health workers (67% among physicians) in the public sector and there were 95% of foreigners in the private sector, “mostly from India, Egypt, Pakistan, Philippines, Sudan, and Iraq” (Cattaneo 2009, p.6).

In parallel to the efforts of building up the healthcare in Oman, the Ministry of Health introduced the Treatment Abroad Scheme in 1970 turning medical travel into a formalised statutory practice. Facilitating and sponsoring treatment abroad is a way of taking responsibility for the well-being of Omani citizens, even if this means that the actual healthcare service occurs outside the national territory. The government takes over the funding and organisation of treatment that cannot be provided in Oman, due to lack of expertise, equipment or failure to address the issue in a timely manner and outsources the investigation or actual delivery of medical procedures to different healthcare providers abroad. This set-up is different from the often-assumed spatial and administrative congruence of funding, provision and delivery of healthcare services or the “frequent geographical conflation of nation state and welfare state in analysis of welfare” (Raghuram 2008, p.183) and such implicitly reproduced political and analytical norms (Clarke 2005, p.408). It is about “[i]ncorporating services outside the country into a national health system” (Kangas 2012, p.356) while “governments bear the main responsibility for providing medical care for their citizenry”. Connections with healthcare
providers abroad were facilitated by the previously mentioned educational mobilities of Omani doctors and in this way networked spaces of medicine were translating into medical travel. The Health Minister of Oman looks back at how the Treatment Abroad Scheme started:

This [1970/1971] is the time when the government started to provide service for the patients. The patients picked up and then we have got a committee that would say, okay, this patient needs to be sent abroad for treatment. Let’s go to India or sometimes to the UK, Germany, ehm and America, sometimes to France. It depends on the doctors and their training, when they come back, because they contact with other doctors there. (I.22)

The Treatment Abroad Committee is now well-networked with healthcare providers abroad in countries such as America, Australia, Germany, France, Austria, Turkey, Thailand and India and the GCC countries. These affiliations often result from educational mobilities, as mentioned by the interviewee. After their return, Omani doctors facilitate tie-ups with the foreign institutions where they did their training and so the patient mobilities come to follow the trajectories of medical student mobilities. It is important to note that the Treatment Abroad Committee connects with individual healthcare providers and treatment aboard is not organised through bilateral agreements with other countries, although medical travel is often presented as mobility from one country to another. Although the healthcare system of Oman integrates “services outside the country” (Kangas 2012, p.356), it is not necessarily a model of “inter-linked-nation states” but of foreign healthcare providers linked to Oman’s national healthcare system. Although anchored within the nation for being regulated and funded by the government, those healthcare spaces span across national borders and directly connect with certain actors and places and not with other states as such.

The connection with India, however, is less a matter of educational mobilities but linked more to overall migration and geo-historical relations. The presence of Indian workers in Oman mentioned before, and the high number of them working in the healthcare sector especially, is shaping the spatial pattern of medical travel in multiple ways. One is that Indian doctors affiliated with the Treatment Abroad Department foster connections with Indian hospitals:

And of course, at the time because India, as I told you the Indian doctors are almost more than 50%, they will recommend Indian hospitals. But again, the committee now is concentrating on India, Thailand, and very rarely we send to European countries. (I.22)

Over the last years, the Ministry of Health confirms that they direct the majority of their patients to India. According to the statistics of the Treatment Abroad Department out of 610 patients sent abroad in 2017, 544 patients were treated in Indian hospitals, which is approximately 90% and in 2018, it was 93%, with 567 patients out of 610 sent to India (MOH
Sultanate of Oman 2018; MOH Sultanate of Oman 2017). India is also said to be the preferred destinations for Omanis who travel abroad individually and pay for treatment out of pocket. In 2018, there were 27,501 Foreign Tourist Arrivals from Oman on a medical visa in India (including both patients and attendants visa). Although these numbers cannot be directly compared as they also count the attendants of the patients, they indicate that the number of individually travelling patients is much higher than those routed through the government scheme. Furthermore, people travelling from Oman on a medical visa contribute substantially to the number of Foreign Tourist Arrivals on medical visa, being amongst the top five countries from which patients travel to India for healthcare (FICCI 2019, p.35).

Apart from the ease in establishing tie-ups with Indian healthcare providers, India stands out for many reasons that explain why Oman – the state and individual patients – turn towards India where their healthcare is concerned. Geographical closeness becomes a relevant factor in transnational healthcare. As it is ill bodies that need to be moved from one place to another, transport must be quick and efficient and short, direct flights are critical. One of the employees of the Treatment Abroad Department explains:

> Going to some European country or US, you have to keep in mind the distance. To India it is takes two to four hours to reach, maximum, so it is easy for the patients. But to go to the other countries like Turkey is five hours, it is very difficult for the patient. Plus, maybe he has to take transit. (I.29)

Closeness is also an advantage in terms of cultural similarities. India is described by another employee as “near, not the same but at least near our traditions, near our food, it is mostly the same” (I.24). Even communication does not seem to be too much of a challenge, according to the interviewee:

> The language, yes, sometimes it becomes a barrier, but I think between Oman and India not that much. Many Indians can speak or understand Arabic and many Omani can speak English or Hindi. (I.24)

In reverse, she says that the cultural distance to the lifestyle in countries such as those in Europe or America, for example, makes patients and their attendants feel less comfortable during their stay abroad. Additionally, from the point of view of the Treatment Abroad Committee, sending patients to these countries makes less sense as it is more expensive and the organisation of the treatment abroad is more challenging, as there are fewer doctors and hospitals, longer waiting times, lengthy processes and appointments have to be booked far in advance. India, highly privatised, in turn, “is cheaper than other countries, and there are many and many hospitals and doctors there” (I.24) who are said to be even more experienced and routinised and appointments are available at short notice.
A more recent trend, initiated by the Ministry of Health in Oman, is to bring specific doctors to Oman to carry out a specialised surgery or procedure, rather than sending the patients abroad one by one. This brings multiple benefits as one of the employees working for the Treatment Abroad Department explains:

First of all, the patient will be around his family. So, he will get the security and support of his family. Second, we are preventing the travel for him for long hours. And the third, it is also cheaper if you are paying for the doctor to come here than when you are sending five patients there. And on the other hand, the doctors in Oman they will learn. They can get the skills or training from the treating doctors that are coming from outside. And in the future maybe they will not need the doctors to come from outside, they can do it themselves. (I.29)

This option prevents patients from the hassle of travel and being exposed to an unfamiliar environment in their vulnerable state and instead, they can be cared for by their families. If the facilities are available, it can be more economical for the Ministry of Health to pay for specialists to come to Oman to perform their task, rather than sending multiple patients and their attendants abroad. Furthermore, doctors in Oman can make use of the specialists’ visits as a training opportunity. This reversed mobility pattern of having medical professionals travelling instead of patients complements the array of mobilities that produce the transnational healthcare space that spans across Oman and India and the synergies that are exploited.

This section allows the first insight into the specific spatialities of transnational healthcare created through connections that are networked, statutory and geo-historically rooted, which also gives it its specific temporality. The evolution of multiple transnational connections that span Oman and India in the long durée shows that different mechanisms are at work in facilitating medical travel with some being more closely tied to the nation than others. Tracing the entwinement of medical travel with other sorts of mobilities contributes to an “integrated agenda that addresses these diverse expressions of care transnationalization and how they ‘touch down’ in a range of sectoral, social and country contexts” (Yeates 2012, p.1109).

One of the findings of this first section is that, what is allegedly considered as Oman’s ‘national’ healthcare regime, is transnational in multiple ways. This not just due to the fact that national welfare and healthcare schemes are tied to places and institutions abroad, where direct healthcare provision happens, but also because healthcare in Oman is provided by foreign trained Omani doctors and a substantial number of expatriates, working in the healthcare sector. What is seen as ‘national healthcare’ is established through transnational mobilities for education and work in the medical field. Acknowledging that what is considered as ‘national’
is in fact already ‘transnational’ and rooted in international mobilities, we then have to “move beyond health care provision as simply theorised within autonomous states” (Raghuram 2009, p.31). The example in this section also shows that transnational links established through student mobilities and labour migration can translate into patient mobilities, both in the form of statutorily regulated treatment abroad and individual patient trajectories. So, when those different spaces of education, medicine and healthcare come to overlap and connect, different authorities and mechanisms come to intervene. Medical spaces, for example, have their own workings and are shaped by mobilities of individuals for training and in pursuit of their careers with an orientation on the spatialities of medicine (see also Raghuram 2009; Raghuram 2008). Healthcare spaces articulated through the mobilities of patients travelling abroad for treatment, that pre-dated the Treatment Abroad Scheme or that is/was not routed through this official channel but organised individually and funded privately only loosely connect to the nation as spatial frame or relevant authority, as the government is not involved in funding nor regulating these mobilities apart from common international travel regulations.

In other instances, however, the government of Oman is more actively involved in shaping transnational healthcare spaces, as illustrated by the Treatment Abroad Scheme and also the sponsoring of training of Omani doctors abroad. Actively establishing connections with healthcare providers abroad and developing standardised processes, the Treatment Abroad Scheme can be seen as some sort of mobility infrastructure that facilitates patient mobility (Hartmann 2019; Xiang & Lindquist 2014) and thus creates the possibility for care. The way in which this is established in everyday practice is further explored in the next chapter (6). Through these schemes, medical spaces that touch down in India and elsewhere for direct provision of services, networked and transnational in nature, are folded into Oman’s national welfare space through the provision of funding and regulations. Despite – or rather because – of the integration of services provided abroad into the national welfare regime, the government takes responsibility for the provision of healthcare (see also Kangas 2012, p.356). However, it is not through direct provision but rather through funding and regulating of it (Kofman & Raghuram 2015, p.90).

Another finding that will be further developed in the next section is that geo-historical connections between Oman and India also facilitate the formation of TNHC spaces between these countries. The longstanding relationship between the two countries with regards to healthcare, but also more generally the connections through trade, common interests in foreign policy, labour migration and cultural affinities seems to create a certain receptivity towards healthcare provided in India or by Indian health professionals. Considering the geo-historical configurations that shape the organisation and conceptualisations of care (Raghuram 2016) is thus important to understand the particular spatialities of transnational healthcare.
5.1.2 Monitoring and safeguarding TNHC: stretching authorities beyond national borders

The previous section illustrated how national and transnational spaces of healthcare have become established along geo-historical relations, labour and student mobility and targeted efforts of the Treatment Abroad Scheme in Oman. This next section focuses on two practices or mechanisms that contribute to monitoring and safeguarding TNHC, firstly by looking at how Oman extends control over treatment abroad beyond its borders through the persona of the health attaché, and secondly, by looking at international accreditation schemes and non-profit organisations.

The aspiration of global health diplomacy is to have nations “joining together in the diplomatic fora to tackle public health problems” (Brown et al. 2018, p.2). Health attachés, considered to be “focal points” (Brown et al. 2018, p.2), are meant to “represent the views of their governments and forge partnerships with other governments, multilateral institutions, private sector companies, non-governmental organizations, academia, and the public” (Brown et al. 2018, p.2). Oman has an appointed health attaché in Mumbai, who represents the interests of the Ministry of Health on a diplomatic level and advocates for Omani patients seeking treatment in India, whether they are sent by the Treatment Abroad Scheme or travelling individually. The health attaché is in close contact with the Treatment Abroad Department in Muscat; they discuss treatment options for their patients, confer about how to move forward if there are complications or changes to the treatment plan of some of the patients who are already in India, and exchange feedback about the associations with different healthcare providers. If any of the patients travelling individually face any problems, the health attaché is their official point of contact, which means that the state comes into play and medical and national spaces become entwined.

On a practical level, the health attaché of Oman regularly visits Omani patients who are currently treated in India. Since they are in different hospitals all over the country, visiting them in person requires a significant amount of travelling on his part. The health attaché appointed during the time of data collection considers these personal visits as an important part of his job for multiple reasons. One of the immediate benefits of his visits is to “change their [the patient’s and attendant’s] mood and to make them feel like there is someone checking on them and ensuring that they get what they need” (I.78). He explains that it makes a difference to the patients if they know that although they are sent abroad for treatment, they are not completely left to their own devices. Knowing an official point of contact, someone who is familiar with the circumstances in Oman and India and the set-up of transnational healthcare can be on-site, at least temporarily, gives them reassurance.
On a political level, the state quasi reaches beyond the national territory through the persona of the health attaché and takes a monitoring role. Through the health attaché, the authority of public healthcare is extended beyond Oman and into the sector of private healthcare in India for the purpose of monitoring and safeguarding healthcare and – if patients are routed through the government scheme – Oman’s welfare in this transnational space. In the words of the health attaché: “it is important to show presence in the hospitals, so they see I am following my patients and ensure that they are treated well.” (FN 14). Being present on site, is considered an important signal to the international marketing teams and a way of securing some influence and control in this transnational sphere. Unheralded visits to the hospitals allow not only to check in on the Omani patients, but also to assess the performance of the healthcare providers and especially the staff that are taking care of international patients on a day-to-day business. The health attaché explains that sometimes he purposefully does not announce his visits to see how things are in the hospitals on a normal day and to check if the team of facilitators in the hospital are on top of their duties. In this situation, the health attaché is in a more powerful position, given his influence in advising the Treatment Abroad Committee in the process of empanelling hospitals. International patients constitute big business for corporate hospitals and therefore they try to impress the health attaché positively, improve their services and they are proactive in making the experience of patients more comfortable and the job of the officials facilitating medical travel easier. Being present on-site occasionally is part of a monitoring practice and a way of extending the state’s sphere of influence beyond national borders and safeguarding transnational spaces of healthcare. Even if temporally sporadic and spatially limited, the effect of such monitoring is meant to continue even in the absence of the health attaché. Additional to funding and a regulating function, Oman’s national healthcare provision extends across other spaces, bounded and networked, in the form of monitoring. Whilst these practices are closely tied to the persona of the health attaché and his or her practices on the ground, there are other efforts that attempt to safeguard these spaces through international or transnational regulations. Industry associations based in Oman and India have clear visions of how to improve medical travel and its facilitation. The Oman Medical Association was established in 2001; it provides a forum for medical professionals in Oman to discuss issues and advancements in their industry and is the connecting link between practitioners and the Ministry of Health. To safeguard healthcare transnationally, the president of the Oman Medical Association envisions policy interventions on different levels that prevent malpractice and protect different stakeholders:

Our advice actually was to have some sort of a policy between all countries and one association related to medical tourism. We do have one in India and Turkey and US, but we don’t have one in Oman, that protect all the people who provide the medical treatment, and agencies and patients as
well. (…) We need to have some meeting with all those countries, and we should have a policy that clearly mentions who can do it, who is recognised to see the patient there and who should be accredited and licensed by the country as well. (I.23)

The concerns and visions of the Medical Tourism Development Alliance founded in Delhi in 2014 are very similar. The president conveys his two main requests:

So, there are two things: 1) to give a quality care to the patients. And 2) the persons who are giving the quality they should be recognised, and they should have a voice and convey their problems to the Ministries as well. (I.55)

On the one hand, the president stresses the importance of creating a safe environment for the patients, for example by defining certain parameters of ethical conduct and training for medical travel facilitators and by providing patients with some sort of helpline in case they face any difficulties. On the other hand, he emphasizes the importance of acknowledging those facilitators who are following those parameters, for example by involving them in discussions with the relevant ministries and providing some sort of licenses or accreditation.

National and international accreditation schemes are other means targeted at quality control and safeguarding certain values, ethics and actants in transnational spaces of healthcare. The ones most commonly mentioned in the context of this research are the National Accreditation Board for Hospitals and Healthcare Providers (NABH) in India and the Joint Commission International (JCI), a not-for-profit organisation based in the United States, which audits and accredits healthcare providers in different countries around the world. Such internationally recognised accreditation schemes are considered to be “one of the influential mechanisms for assessing the performance of healthcare organizations (HCOs) and improving the quality and safety of healthcare services” (Jaafaripooyan et al. 2011, p.645). One of the interviewees who is managing the international patient department of a multispecialty hospital in Delhi NCR explains:

Obviously, if you are buying something, you want to know this thing is quality approved. Quality always plays a role. Now, we as a hospital, we are a NABH and JCI accredited hospital. We have JCI accreditations also. So, patients who are coming from a far country, from a different country, obviously the accreditation is a parameter; they see the credentials, how well established is a hospital, what accreditations do they have, if they have accreditation or not. And for me all kind of empanelling with the embassies and all these accreditations play a very big role. (I.48)
Rao (2012, p.23) argues that “[t]he demand for accreditation is spurred by emerging new markets, like medical tourism, and the insistence by health insurance companies and third-party administrators for the purpose of reimbursement”. Ganguli and Ebrahim (2019, p.109) observe a considerable increase of JCI-accredited programs: “For instance, in India and Thailand, these programs during 2016 to mid-2018 alone have raised amounts which are 30% more than the entire number of accredited programs before this period” and argue that “JCI accreditation has become a part of marketing strategy though it positively influences customers' perception about quality and safety”. The actual effect of such accreditation schemes on these parameters, is, however, debated (Todd 2012, p.40; Grepperud 2015; Roy et al. 2018).

Recently, the NABH has introduced an auditing and accreditation scheme for ‘business auxiliary units’ in India such as medical travel companies based on the suggestions of some stakeholders (FICCI 2019, p.23). This has been implemented and is considered to contribute to the quality control of the market by forcing companies interested in the accreditation to reach certain standards. In return, they can provide international patients with an official certificate that helps them with evaluating the company. One of the supporters of this newly introduced scheme says:

We are very proud that this kind of accreditation has started in India only. It is not available in other countries for business intermediaries and we are also very proud that we are one of the first recipients of such accreditation. (…) Now there are one or two benefits out of this: One, this gives us a lot of credibility; second because this kind of accreditation cannot be achieved unless your processes are very strong, it keeps us pushing to ensure that we have our processes and protocols in place. (I.47)

Whereas this interviewee, the manager of a medical travel company in Delhi NCR, is convinced that the accreditation scheme pushes the companies to improve themselves and increases their credibility, other stakeholders in the market are more critical. They challenge the validity of such accreditations and its ability to succeed. Two interviewees, both managers of medical travel companies, express harsh criticism around the NABH accreditation for medical travel companies. In a conversation with both of them about the accreditation scheme they say:

B: That’s a failure. That’s a complete failure.
A: It’s a scam.
B: That’s a non-starter failure. We haven’t even applied for it. We follow processes. All the processes that are mentioned in the requirement of that accreditations. (…)
A: Being in it [the industry] for almost 10-11 years that’s when these [other
individuals or companies initiating accreditation] actually came up. And they are the guys that came into medical travel that want to make themselves up. And they could not. Then they realise okay we need to do something else (…) So they are the ones who are the most unsuccessful guys actually, sitting on the accreditation board. Pretending, this is all.

(I.62, I.63)

Instead of being a legitimate way of evaluating companies and increasing quality control, these two interviewees dismiss this accreditation scheme as an invention created by a few individuals wanting to give themselves an advantage. They do not consider the accreditation scheme to be a genuine instrument for quality assurance in the facilitation business.

This section showed different attempts at monitoring and safeguarding healthcare through certain articulations of spaces, within which the state, economic actors, and not-for-profit organisations take different roles. One way of relating national authority in healthcare to transnational practices of direct healthcare provision is by stretching this authority beyond the national borders by appointing a health attaché who represents the interest of Omani patients abroad on a diplomatic level (Brown et al. 2018), checks in on them through personal visits and ensures that the different actors involved in facilitating and delivering treatment abroad are doing their job properly and intervenes, if necessary. The health attaché thus takes a typical broker role, representing different parties and mediating between them; not as a neutral intermediary but a mediator who takes an active role (Latour 2005). On a diplomatic level and as an individual, the health attaché is in a powerful position in terms of making and unmaking connections. Such monitoring as performed by Oman’s representative is thus another way in which the state is providing healthcare, additional to other forms such as funding, regulating or direct provision (Kofman & Raghuram 2015, p.90). National and international accreditation schemes provide another mechanism to develop and control standards that are intended to make medical travel safer for providing a more or less reliable means for quality control. Not-for-profit organisations such as the Oman Medical Association or the Medical Tourism Development Alliance in India often have the country in which they are based as a reference frame, but their efforts are targeting transnational practices.
5.1.3 Perpetuating TNHC spaces: normalising treatment abroad

One thing that was striking about fieldwork in Oman was how normal treatment abroad seemed to be. This last section starts with a more personal fieldwork account as an illustration of how treatment abroad is being articulated as a normal practice in every-day encounters in Oman, which arguably contributes to continuously reproduce and perpetuate spaces of trans-national healthcare through practices of word-of-mouth and regular travel. An example of how present treatment abroad is in ordinary life and how readily existing associations are activated, in order to facilitate medical travel, is outlined in the following fieldnotes excerpts:

> It is a mild January morning in Muscat, and I am in a taxi on the way to a hospital in Al Khuwayr area. The taxi driver asks me what I am doing here in Oman and I tell him about my research. I am not sure how much English he understands but it is enough to communicate, and he definitely picked up ‘medical’ and ‘India’ as he instantly grabs a big envelope and a letter and hands both over to me in the back seat. I ask what it is and if I can have a look. In broken English, the taxi driver tells me that this is his cousin’s medical report from a hospital in Kerala. He himself has also been to Kerala about eight months ago for a health check-up. He travelled with his parents and grandparents and they all had check-ups. (FN 18.1.2018)

Just as this envelope with medical reports was right at hand in the taxi, so were the many stories about treatment in India shared in everyday encounters during fieldwork. Taxi drivers – a business run by Omanis only following the Omanisation policy – were talkative and they would quickly share their experiences and stories about treatment abroad without hesitation when I mentioned this research topic. These common word-of-mouth conversations made treatment abroad sound like a ‘normal’ thing to do. The taxi driver here in this fieldwork excerpt explained that a man in India, who knew Arabic from his previous work experience in Saudi Arabia, helped them with everything in Kerala: “speaking to the doctors, translation, medicine and all”.

> He continues saying that everyone goes to India for any problem; because India is very good, the hospitals and doctors are very good, but the costs are less. I want to know how he got to know his helper in India, and he says his cousin knew him. He went to India before and in the hospital this man came and asked how he was and if he needed any help. That’s how they got to know him. (FN 18.1.2018)

After speaking briefly on the phone to the taxi driver’s wife, who shared her father’s experience of treatment in India, the taxi driver calls his cousins and hands his phone over to me again.
The cousin tells me that many people travel to India: “It is very common, they have very good doctors there, they have good certificate. Most families in Oman go there, it is the number one place to go for medical things. The doctors are very, very good. And you can find translators there to help with the language”. He can connect me with someone who can help me with everything, he says. He is called Rashid and he “knows the good places to go” he reassures me. He is a family member and the taxi driver’s cousin shares his phone number: “Tell him that I gave you the contact, he will help you”. (FN 18.1.2018)

Within only a few minutes, three people had shared their experience of medical travel to India and they were happy to pass on the contacts of other people, who would be able to provide further accounts or even practical assistance. A similar scenario unfolded when speaking to other taxi drivers, shop assistants, staff in cafes or hotels. The frequency and consistency with which I came across treatment abroad outside of planned research activities reinforced the impression that it is a common practice among Omani families. An Omani interviewee, who works as medical travel facilitator for many years as a side-job, mentions buying medicine in India and buying stationary – and candies – in the same sentence, pretty much:

Yes, I buy medicine from there [India], everything; if I am ill, I take Indian medicine. And this is for you, I bring it from India (gives me a candy). Also, for children, for school, I buy books, pencil all things for school, I buy in Calicut. (I.16)

Treatment abroad seems to be so normalised that, to an extent, not going abroad for treatment is almost seen as ‘abnormal’. A doctor practicing in a private hospital in Muscat reports that he advises patients to go to the government hospital where they can have the investigations and treatment for free, “but unfortunately many people prefer to go abroad for various social reason” (I.18). He points to the weaknesses of healthcare in Oman such as limited numbers of health centres and long waiting times, and in some cases, the options in Oman are not as advanced as in other places and people do not trust the doctors because of stories they have heard from patients who have had bad experiences with the treatments in Oman circulate. The doctor understands that people are worried about losing a beloved friend or family member due to poor local treatment options and therefore they are willing to seek alternative treatment elsewhere:

So, they want to take the patient abroad if there is a chance that he or she gets a little better, they think ‘let’s try’. They are very anxious; they want to know if there is something more advanced available. For example, they try alternative medicine like Ayurveda for post stroke or post cardiac treatment. (I.18)
Hence, he talks about the social pressure to exhaust all possibilities and do everything within one’s power to save a friend or family member and this does not stop at national borders. Additionally, treatment options are sought abroad, even if the chances for successful treatment or a cure are minimal. The benefits of accessing treatment abroad and the hopes tied to that seem to outweigh any difficulties or uncertainties. In line with the doctor stating that many patients actually prefer treatment abroad, another interviewee, the manager of a Muscat-based medical travel company, says that Omanis are even enthusiastic about it:

They are enthusiastic to go. Going abroad, people are enthusiastic and there is a new ray of hope that comes to them. A fresh thought, new hope. They feel like now they are getting something extra, something not available here and I am getting the benefit of that, there is new hope generated. (...) Maybe generally one feels going abroad and having treatment in isolated places is a botheration or a problem normally, but it's the other way, people are enthusiastic to go because they believe their problem will be solved. They have a new hope, that's what I said. (I.34)

Apart from stressing that medical travel is seen positively by many in Oman, this quote shows how closely medical travel can be tied to hope from the side of the patients and their families. This contributes to the receptivity of treatment abroad and possibly the relative success of medical travel facilitation. However, medical travel facilitators enter critical ethical terrain by mediating these hopes and the promises made by foreign healthcare providers.

This last section showed how spaces of transnational healthcare are maintained and reproduced through repeating articulations of medical travel, as an established, commonly occurring, and ‘normal’ practice in the form of word-of-mouth that is shared in everyday situations – and the practice in itself. I suggest that the relevance of word-of-mouth, acknowledged in medical travel literature for mobilising patients to certain places for treatment (Hartmann 2019; Yeoh et al. 2013) thus reaches beyond the individual level by creating a certain atmosphere of receptivity among the wider community. Medical travel is being normalised through the frequent and long-established practice, also approved by the government. It has become an integral part of national welfare and healthcare and it is an entrusted recommendation, which circulates within social networks through word-of-mouth and practical support. The mobilities of people for healthcare, and also the unfettered circulation of testimonials and stories about those experiences, constitute a continuous actualisation of the relations between patients in Oman, healthcare providers in India and other facilitating entities in-between (connections established and maintained through practices analysed in the first two sub-chapters). These factors bind places together, so that transnational spaces of healthcare are perpetuated.
5.1.4 Conclusion

Focusing on healthcare in Oman and its Treatment Abroad Scheme, this first sub-chapter looked at how TNHC spaces are being established, monitored, safeguarded and perpetuated through different schemes, institutions, actors and practices that facilitate medical travel. It showed how Oman’s national healthcare is constituted by multiple short- and long-term cross-border mobilities and is therefore already part of a transnational configuration of healthcare. This also applies to what is commonly known as ‘Indian healthcare’, which will be further explored in the next section. The way in which the migration of health workers and the temporary movement of patients become entwined, provides an example of the nexus between different modes of cross-border health services. However, it is not only health-related mobilities, but also geo-historical connections that have formed networks over a long period of time, which translate into healthcare spaces and result in a certain receptivity towards treatment in India. A specific focus on the history and particularities of certain connections, as well as the configuration of healthcare in certain places is important for understanding the mechanisms that facilitate medical travel. This will be taken further in the next section, not through the lens of the state but through biographical connections of individuals and specially to the diversity of medical systems, which also contributes to the discussion of ‘national’ and ‘transnational’ healthcare.

Besides from the multiple networks that establish TNHC spaces, another contribution of this section lies in the recognition of how different practices act to monitor, safeguard and maintain healthcare transnationally and the different authorities involved in doing so. Appointing a health attaché as a diplomatic representative of Oman in India, who acts as an official local contact person who is present at the medical travel destination site, is an example of how health and cross-border mobilities of patients are safeguarded on a practical and political level. Through the health attaché the sphere of influence of Oman can be stretched beyond the national borders, which means that different spaces and authorities overlap and come to be folded into one another. Accreditation schemes with national or international reach constitute another means to monitor and control practices, services in direct healthcare provision and auxiliary services.

Long-established and approved practice of medical travel in Oman, through the government and social networks as entrusted authorities, and the unfettered circulation of testimonials and advice was found to contribute to the normalisation of treatment abroad. Through the practice itself and the common narrative of it, transnational spaces of healthcare are continuously re-articulated and reproduced.

Such networked, (geo)historically anchored and statutorily regulated connections articulate spaces that constitute the possibility for care to be provided transnationally, also through practices such as funding, regulating, monitoring and normalising treatment abroad. As indicated
above, the next section looks in more detail at the entwinement of migrant and patient mobilities drawing on the Kerala-Gulf diaspora, and it follows informal practices of medical travel facilitation, along these biographical connections. Known as a destination for Ayurvedic travel, this case study also offers insight into the multiplicity of medical systems and how they are differently used in the articulation of healthcare spaces, through economic actors and governmental bodies.
5.2 Kerala: inherited spaces and (in-)formal articulations of healthcare spaces

The next take on analysing how practices of medical travel facilitation act to articulate spaces of transnational healthcare draws mainly on the data from the fieldwork in Kerala. The ‘Kerala case’ attends to a double specificity: firstly, for introducing Ayurveda, an alternate system of medicine of India, and secondly, for introducing the Kerala-Gulf diaspora, both of which are relevant factors in the articulation of transnational spaces of healthcare. These specificities highlight the unique spatialities which are specific to Kerala, whilst also showing how varying models of medical travel facilitation act to articulate spaces of transnational healthcare differently.

The first section looks at targeted efforts of different Indian authorities, in articulating India in general and Kerala specifically, as destination for different types of medical travel. Such targeted measures contrast with the individual contributions of taxi-drivers and agents with migration backgrounds, who find themselves acting as medical travel facilitators and contributing to articulating TNHC spaces, on a more ad-hoc basis using their entrepreneurial skills. The second section thus explores the potential that the Kerala-Gulf diaspora holds, for articulating TNHC spaces, along biographical and informal connections.

5.2.1 India and Ayurveda travel: promoting India’s medical heritage

The previous chapter showed that, despite the delay in taking control of developing healthcare in Oman, transnational spaces of healthcare were articulated by the government from the onset. On the contrary, it was mainly private sector actors, such as corporate hospitals, that promoted India as a medical travel destination – or rather their brand name and as an effect of it, India as a country – when medical travel started approximately forty years ago. The government of India subsidised the private healthcare sector in multiple ways since the 1980s, as outlined in chapter 4.1.3 (Sengupta & Nundy 2005; Murray et al. 2016). However, it has not been since the last few years that the Indian government became involved more actively in promoting the country as a medical travel destination. Medical travel was then considered under the Niche Tourism Department, under the term: “Medical and Wellness Tourism”. One of the representatives of that division reflects on the promotion of so-called “medical and wellness tourism” from the government’s perspective:
We didn’t have a promotion for medical tourism. This has come to focus only in the last maybe ten years or so. Before medical tourism was not something that was focused on and the market was not that big. The medical tourism in India really took place after it started booming, after you had these big corporate hospitals like x, y, z [hospital names anonymised]. In fact, x hospital is, I would say, the game changer. Because it was set up with the specific focus on high end and overseas visitors. (I.52)

Referring to patients as “visitors” already mirrors the positioning of the industry. Its framing as a niche form of “tourism” and thus the affiliation with the Ministry of Tourism, rather than the Ministry of Health and Family Welfare, is considered to be “ironic,” by one of the interviewees with longstanding experience in the Indian healthcare industry:

> The Ministry of Health and Family Welfare is involved in domestic health. Medical value travel doesn’t come under the Ministry of Health. It comes under the Ministry of Tourism only. That is the irony of that [laughs]. Okay. So, Ministry of Health and Family Welfare they take care of domestic healthcare. Anything to do with foreign patients, with projecting the image of India aboard this body [points on a hand-drawn illustration], the Ministry of Tourism, and this body, Ministry of Commerce, is in the line. (I.64)

It is thus different departments and confederations concerned with the economic potential of medical and wellness tourism, that are in charge of promoting and facilitating medical travel to India. Involved in this project are the Ministry of Commerce and Industry, with its two divisions, the Service Export Promotion Council and the Niche Tourism Department. Moreover, industry organisations including the Federation of Indian Chambers of Commerce and Industry (FICCI) and the Confederation of Indian Industry (CII) are concerned with promoting and facilitating medical travel to India. This involves activities, such as organising and participating in international exhibitions and conferences, developing campaigns and creating forums to discuss current issues and visions for the future of this industry.

Medical and Wellness Tourism considered under the umbrella term of Niche Tourism, reflects the ambiguity in categorising and differentiating between different types of services. This is a known dilemma, reflected in the multiple terms used, such as medical, health, wellness or therapeutic tourism/ travel and the scholarly critique of the association with tourism, leisure and pleasure that often contradicts the patients actual lived experience (Kangas 2012; Sobo 2009; Ormond & Sothern 2012). In response to the question of how to define and differentiate between medical and wellness tourism, the representative of the Niche Tourism Department says:
Well, see, wellness is a holistic approach and what elsewhere we call the alternate systems of medicine. So, medical tourism as we look at it is the treatment, the therapeutic part. You know, you have a specific problem, so you have a specific solution for that, and which basically is looked after through the means of modern Western medicine. That is what we say medical tourism. And wellness is holistic medicine through our traditional systems of medicine like Ayurveda of course. And then also, we have smaller other streams like Unani, and these are ehm Unani is an ancient Arab medicine, and Siddha is from the South of India. It’s again a natural medicine. And of course, homeopathy is big in India, especially for the domestic consumers. So that’s the broad differentiation between the medical and wellness. (I.52)

In this conceptualisation, ‘medical’ relates to so-called Western medicine or allopathic medicine, whereas ‘wellness’ relates to alternate systems of medicine. This categorisation is not uncontested: “concerns are raised that globalisation and resulting standardisation have reduced Ayurveda from a system and overriding philosophy, to itemised commodities to be traded on the global market” (Bisht et al. 2012, p.10). This relates the “commodified version of Ayurveda, which has been developed in the West as part of ‘wellness and spa culture’” (Islam 2012, p.220) to “new age orientalism”. This points to the power dynamics involved in negotiating and emplacing different conceptualisations of care, a field in which Raghuram (2016; 2012) made important contributions, from an care ethics perspective. In her paper, “Locating care ethics beyond the Global North” (Raghuram 2016), she discusses the implications of implicitly locating care in the global North and calls for research that attends to local variations and how these come to relate. Assumptions or perceptions of ‘Indian healthcare’ or ‘state of the art medicine’ in the context of medical travel refers to allopathy or what is called Western medicine or biomedicine as the internationally recognised ‘norm’. A closer look then clearly highlights that what is seen as ‘Indian medicine’ in Oman or promoted by Indian stakeholders, is already transnational, as it is based on the Western medical system, it is assessed by international standards, its driven by foreign investments and is provided by doctors, who received training abroad and who work with equipment that is distributed across the global market. The hegemony of Western medicine must be understood in the context of India’s colonial past (Bala 2012a), as well as its prevalence globally, calls upon more sensitivity to the history of medicine, or histories of medicine given variegated systems and traditions, and the power relations that have shaped it (Anderson 1998; Bala 2012b).

However, there seems to have been a shift in the 'Indian' medical travel market, since Indian systems of medicine specifically, are becoming more prominent in the promotion of India as a medical travel destination. The coexistence of allopathic and alternative strands of medicine
seem to be increasingly more acknowledged by industry players, as a particular strength and selling point and ‘alternate medicine and wellness’ are seen as a growing sub-sector of medical value travel (FICCI 2018, p.41). The multiplicity of medical systems in India and its entwinement with different political and economic authorities is reflected in the establishment of an association called the National Medical and Wellness Tourism Board. It was formed in 2016 initiated by the Niche Tourism Department, in order to bring different bodies and stakeholders together:

It has members from different stake holding ministries like the Foreign Ministry, the Health Ministry, and for alternate systems we still have the AYUSH Ministry. It’s an acronym for Ayurveda, Yoga, Unani, Siddha and Homeopathy. So that’s a separate Ministry. So, we have representatives from them, we have representatives from the major hospitals, also leading practitioners of these systems (...). And we have members of the hotel association, from the tour operator association. So, it’s a board from all the stakeholders and then if there are any issues, come up to the board to discuss and try to find a solution. (I.52)

The affiliation with the Ministry of AYUSH, which comes under the Ministry of Health and Family Welfare and represents Indian systems of medicine, brings the aforementioned multiplicity of different healthcare systems into the focus. The prominence of alternative practices of healthcare such as Ayurveda, Yoga, Unani, Siddha and Homeopathy, a specificity of healthcare in India, has become an important differentiator, that makes India stand out from other medical travel destinations.

Ayurveda travel to Kerala, a state in the South of India, provides a prominent example of articulating healthcare spaces, that are tied to a certain place and simultaneously projected globally. Kerala, said to be “synonymous to Ayurveda” (Padmasani & Remya 2015, p.223), is “considered to be the home of traditional ayurvedic system” (Harilal 2009, p.46). It is the specificities of Kerala that are mobilised as origin of the development of the medical system, for example in statements like this: “Owing to the great variations in climate and soil condition and good rainfall (nowhere less than 120 cms. Annually), Kerala had a rich and varied flora and fauna and this has definitely played a major role in the development of the medical system in Kerala” (Variar et al. 1985, p.54). Since the 1990s, the Kerala Tourism Development Corporation has been working on branding and developing the region, as a hub for wellness tourism and alternative medicine internationally (FICCI 2014, 57), together with healthcare providers (Raj & Krishna 2010, p.82). Kerala is even called the “pioneer state in marketing health tourism in India” (Ram Raj & Krishna 2010, p.82) and Ayurveda “has become a huge selling point for Kerala Tourism Industry” (Padmasani & Remya 2015, p.222). The Kerala Tourism
Development Cooperation seems to make use of the heritage of the traditional medical system by projecting the local specificity in healthcare successfully, onto the global healthcare market: “Today popularity of Kerala Ayurvedic treatment has gained such a momentum that tourist from across the world come to Kerala only for Ayurveda” (Padmasani & Remya 2015, pp.222–223). Indeed, the interviewees in Kottakkal, where the famous Arya Vaidya Sala, a charitable heritage healthcare center for traditional Ayurveda, is located, state that they have visitors from many different regions, including the Gulf countries, Germany, the United Kingdom, Switzerland and Canada.

However, it is not only the importance of Kerala as a place for Ayurveda that mobilises patients, but also particular connections that facilitate these health mobilities. The majority of patients are said to come from Saudi Arabia and other states of the Gulf Cooperation Council such as United Arab Emirates, Oman, Qatar, Bahrain, and Kuwait. As a response to the question when and how these patients from the Gulf countries, and Oman in particular, started coming to India for Ayurveda treatments, one of the medical travel facilitators in Kerala says:

    Ages ago; even before the Ministry could start, people have been traveling. Why? Because there were a lot of South Indians working in the country. So, it was those people who were working for the family, people working for the companies they always recommended to the people that they come here, and they would arrange everything for them. (I.41)

Thus, there is another mechanism at work here connecting Oman, among other Gulf countries, to India: Labour migration is considerably shaping medical travel from Oman to India and it creates a connectivity that shapes spaces of transnational healthcare in ways that differ from the targeted efforts of the Indian authorities, introduced in this section, and the mobilities (migration of health workers and educational mobilities) analysed in the previous section.

5.2.2 Kerala-Gulf diaspora: translating existing potential

Kerala, considered as the cradle of Ayurveda and one of the most progressive states in India (Kasezawa 2004, p.89) is also known for emigration to the Gulf countries, resulting in the Kerala-Gulf diaspora. The lack of employment has been “a structural problem in Kerala for more than 30 years” (Percot 2006, p.43) and it has resulted in a large number of workers emigrating from the region (Kasezawa 2004, p.89). Many Keralites found employment in the Gulf Cooperation Council (GCC) countries, which were in need of foreign workforce from the oil boom in the 1970s onwards (Anjum 2017, p.83). Drawing on figures from the United Nations Global Migration Database, Garha and Domingo (2019, p.148) illustrate the phenomenon of the Kerala-Gulf diaspora with the following statistics: “Malayalis was the second
largest ethno-linguistic group with 1.7 million individuals settled in 44 countries around the world. They were emigrated from Kerala, a state in southern India. 85% of them settled in the Gulf countries, where the main destinations were the United Arab Emirates (43.7%), Saudi Arabia (15.7%), Qatar (9.9%), Oman (8.2%) and Kuwait (7.6%)”. Although there have been different trends of immigration and emigration in the past decades, Indian people make the largest share of foreign nationals in the Gulf region: “Indian migrants dominate the largest group of foreign workers in every Gulf country. While Indian expatriates currently constitute almost 50% of all foreign workers in the private sector in Oman” (Anjum 2017, p.83).

This prevalent pattern of migration from Kerala to Oman establishes a networked space of transnational labour migration that is maintained through the myriad biographical ties that span those places, which eventually translate into spaces of transnational healthcare. This is because the connections that individual migrants hold with friends and family back home, set different kinds of mobilities into motion: On the one hand, Indian people, who are currently living in the Gulf region “function as ambassadors for Kerala” (Cherukara & Manalel 2008, p.374) and their accounts of allopathic and alternative treatment options are a powerful mechanism, encouraging patients in the Gulf region to travel to the places they recommend. On the other hand, fieldwork in Kerala showed, that returned migrants are particularly well positioned to engage in some sort of medical travel facilitation that is often informal. This is an excerpt of a conversation of myself as the interviewer (I) with a man who started to facilitate medical travel on an individual basis (F) and a representative of the international patient department of the private hospitals in Kochi (H) to which he brings most patients:

I: You said you have an agent working in Oman. How did you get to know him?

F: It’s my neighbour. He’s working there and he’s a Keralite. I was also working there and also seven years in Qatar. I’ve spent also seven years in Qatar, in a hospital in Qatar, seven years. They are also my friends, the doctors and all staff. They will help me.

I: So, you have worked in a hospital in Qatar, in what role?

F: I was PRO, public relations officer.

I: And you learned Arabic there?

F: Yes.

I: And now you are based here [in Kochi], and you have a company?

F: No, I’m working individualised.

H: Intuition, intuition. Through the connections he gets the patients.
I: So, how does that work? Do you get their number and you contact them?

F: Yes, yes. And the patients also give my number.

H: They are also his friends. And either give his number to the patients or they give the patient’s number to him. Both way it happens.

F: It’s a chain-system.

I: Do you communicate through phone calls or WhatsApp or email or what medium do you use?

F: Ehmm that’s too much in WhatsApp. (…)

I: Can you give an estimate of how many patients you bring to this hospital?

H: 150-200 patients they [the interviewee and another individual facilitator working with the hospital from the beginning] bring per month.

I: And these all come through your friends in Qatar and Oman?

F: Yes, yes.

I: Do you know how they get in touch with the patients?

F: They also have so many friends, so many Malayali people. Malayali people are working there with the Arabic, know so many supports in Arabic. They will help. My friend is working there, they will give my number. (I.12, I.7)

Returning migrants such as the interviewee are in a favourable position to facilitate medical travel. During the time abroad they have acquired Arabic language skills and are familiar with the culture and the way things work in the patient sending and receiving context. They often sustain extensive links with relatives and colleagues, often other Keralites, who are still abroad, former employers and other Arabs they met during their time abroad. The interviewee and another facilitator who used to work in Saudi Arabia report that upon their return to Kerala, friends in the GCC countries contacted them, asking for their help in arranging treatment for their friends/patients there. This is how both interviewees entered the business of medical travel facilitation; they came to it without knowing much about medical travel nor actively considering working in this field. Nevertheless, “gradually it became a profession” (I.13), one of the interviewees says.

Despite their informal status of working individually without affiliation with a registered company, those facilitators seem to be particularly valued for their ability to bring in business from foreign patients to the local hospitals. One of the agents even describes his job as working in
“patient supply” (I.13). A patient coordinator employed by a corporate hospital in Kochi states that such “agents play a huge part in convincing patients” (I.10) to seek treatment at a specific institution, often by using their ability to bridge the communication gap with their language skills. An interviewee working in the business development of a large corporate hospital in Kochi argues:

Word-of-mouth is advertising for them, because as individuals, ehm, if it’s a company, okay, they can do the advertising but for the individual it’s like this. But I would say they are the ones that bring more patients. More than the registered companies. This word-of-mouth is much sharper than the normal advertising. (I.7)

The mechanism of having friends and former patients, who pass on their facilitator’s phone number and recommend the service is called a “a chain system” (I.12) by one of the facilitators. It is considered to work well, along informal but entrusted and powerful connections. Similar to the example presented earlier of testimonials shared in Oman, word-of-mouth seems to travel particularly well in the transnational personal networks, that these individually working facilitators in Kerala cultivate to draw in international patients. One of the international patient coordinators in Kochi says:

When it comes to Gulf countries, word-of-mouth is the biggest strategy. If they know that there is good care awaiting them, they will tell their friends and relatives to come. (I.10)

The efficiency with which word-of-mouth travels is specific to the Gulf countries, he argues, and differs from mechanism that initiate medical travel in Western countries. A slightly different model of medical travel facilitation was encountered during a short fieldwork stay in Kottakkal: returned migrants, who now work as taxi drivers embody the role of a medical travel facilitator on an ad-hoc basis, when picking up people at the airport in Kochi. Whilst in some cases this is solicited, there are also situations whereby this behaviour is unsolicited. Some inbound travellers come specifically for treatment, whereas others, who visit for business or tourism purposes, come to learn about the Kerala’s wellness and healthcare facilities through word-of-mouth, for example during their taxi ride from the airport. Taxi drivers thus play an important role when it comes to articulating the region, as a medical travel destination, and to guiding people to different clinics and hospitals for medical treatment, whether this is ayurvedic or allopathic. They are known among other drivers, hospital and hotel staff for providing this additional service of facilitating medical treatments to their clients. One of the interviewees explains: “I am not only a taxi driver; I am a helper too” (I.3). Despite not identifying as a ‘medical travel facilitator’ specifically, these individuals participate in many practices that facilitate medical travel, such as advising and guiding foreign people –
and also Indian travelers – in finding and accessing treatment during their stay in Kerala, arranging transport and accommodation, helping with language translation, assisting with shopping and organising leisure activities. The engagement of these individuals in medical travel facilitation varies, whilst some individuals only help upon request, others are looking for clients more actively. Some invest in building a network with individual doctors and healthcare institutions in their area and they try to connect with patients before they even arrive in India.

One interviewee (I.6), who is known by his taxi driver colleagues to be more “deeply in it”, involved in the medical travel facilitation, receives many queries from individuals, who explicitly ask for his advice and support in accessing medical treatment and he engages in typical pre-travel facilitation activities, which includes obtaining medical reports, asking local doctors for their opinion and a preliminary treatment plan and then, when the patient agrees, making travel arrangements. After their clients return, these taxi-drivers/medical travel facilitators hope for positive word-of-mouth reviews, which will perpetuate their business through their clients’ network. This is said to work well, however, some are making efforts more actively, trying to stay in touch with returned clients, mainly through WhatsApp. Aside from this, there is also another “business trick” (I.12).

This ‘business trick’ or practice, cultivated by individual medical travel facilitators/taxi drivers, which reinforces transnational ties, is sending medicine abroad to the patients who have returned to their countries. Medicine is sent via a courier, often a tourist, patient or friend who is travelling to the respective country and who can bring the medicine along with them. This can be difficult with Ayurvedic medicine, two of the interviewees mention, as it often comes in liquid form. One of the medical travel facilitators in Kochi (I.12) states that he is sending medicine to his former patients “too much”, meaning two to three times a week. Despite the work involved in arranging the medicine and transport logistics, it is also an important way to keep in touch, nurture the relationship with the former patients and enhance word-of-mouth promotion. He says it is a way to “catch the patients” and explains: “They will be very happy if I send the medicine that is not available there. They will help, they will give my number to other patients”. The circulation of pharmaceuticals (see for example Quet et al. 2018) is thus not only another expression of therapeutic or health mobilities going back and forth between certain places but it is also a strategy to maintain transnational healthcare spaces.

The translation of spaces of labour migration into spaces of healthcare, as constituted by the spatiality of the Kerala-Gulf diaspora and its temporal evolution – from the long durée of diasporic networks to ad-hoc and short-term instances of informal medical travel facilitation in the taxi driver example– illustrate that articulations of transnational spaces of healthcare have their own geo-histories and temporalities. In this chapter, they are not narrated through the state, but through individual biographic ties and the articulations of those networks happen
more informally and without the strategic moves displayed by typical authorities, such as the government or private healthcare sector stakeholders. Instead, the ‘taxi-driver’ model of medical travel facilitation found in Kerala showed that the articulation of transnational healthcare spaces may also happen more informally and organically. Individual entrepreneurial opportunities result from phenomena, that are not per-se related or intended to constitute transnational spaces of healthcare, such as labour migration and diasporic communities, and yet they hold this potential to translate into health mobilities. It is then the ability of individuals to recognise and actualise the existing potential, by using ties that span different places more or less frequently and establishing new connections ad-hoc with their specific skills and knowledge, to hold places together and facilitate mobilities. All these individual efforts of medical travel facilitation dispersed between different actors act as ‘clamps’, holding specific places, such as a town in Kerala and a town in Oman together, as a way of articulating transnational spaces.

5.2.3 Conclusion

The analysis of the data from Kerala shows that the inherited connections, that are not per se related to healthcare but established through labour migration from Kerala to the Gulf countries, and the heritage of traditional medical systems, are now being utilised to facilitate and promote medical travel. The Kerala-Gulf diaspora equips particular kinds of actors with the necessary skills and network connections which can be turned into a successful model of, often, ad-hoc medical travel facilitation. The sum of such individual actualisations of this biographic potential and the occurrence of multiple such trajectories of labour migration, translating into medical travel facilitation, seems to gain transformative momentum, turning into a transnational web that allows multi-directional mobilities of workers and patients and the numerous other entities that are involved (e.g. information, reports, testimonials, money, medicine, phone numbers etc.). Contrary to the mobilities of health professionals and medical students that are related to healthcare, these networks translate into patient mobilities are independent from those medical spaces. The diasporic linkages and back-and-forth mobility of labour migrants provide valuable skills and an inherited mobility infrastructure that is used by entrepreneurial individuals to facilitate medical travel. Although mostly routed by informal channels, the connectivity established between the regions through diasporic linkages seems to create a certain receptivity of Omani patients towards healthcare in India.

Apart from these organically evolving entrepreneurial practices of medical travel facilitation, performed by individuals with a migration background, this section also showed how transnational spaces of healthcare are being articulated through a combination of targeted efforts from governmental bodies and economic actors. The framing of medical travel in India, as a form of tourism or a wellness product by associating it with the Ministry of Tourism, ascribes it to
a particular kind of spaces in which it is formally integrated. Due to the assignment to the authorities of the tourism department and the strong influence of economic actors of the private healthcare industry, this ties medical travel to certain market mechanisms. The promotion of Kerala as a renowned destination for Ayurveda shows that relating it to certain medical spaces is seen as holding a particular marketing potential. Ayurveda, as a medical system closely associated with Kerala, as its place of origin, and India more generally, explicates a specific nexus between medical spaces and geographical places, which points to certain implicit geographies of healthcare. The prevalence of allopathic medicine globally, raises questions about colonial heritage in medical spaces and its normative implications. The designation of certain medical systems as a norm is mirrored, for example, in the formulation of internationally accepted standards and the fact that it does not need to be specified. To some extent, this is being reproduced in the medical travel literature in which the medical implicitly refers to allopathic medicine without specifically attending to its history or the multiplicity of medical systems.

After this geo-historical perspective, the next section looks at current and future-oriented happenings by exploring, in more detail, the targeted efforts of different organisations, companies and governmental bodies in presenting India as a healthcare destination to the world, by hosting an international medical travel exhibition and conference. This illustrates how targeted and eventualised forms of connections contribute to the articulation of transnational healthcare spaces and in themselves are productive of certain topological formations in the event space and beyond.
5.3 Delhi: spaces of international events on medical travel

We call stakeholders from different countries to come to India, connect them with the hospitals out here in India, show them what we are. Seeing in believing, you know. It’s within this idea. (Mr C., event organiser)

“Seeing is believing” is the mantra of Mr C., the individual behind one of the main international events, promoting India as a medical travel destination to the world. International events such as exhibitions and conferences provide platforms to see, showcase and experience products and services, to interact in person, and in turn, allow people to believe in what they see. The event that the company of Mr C. organised, in collaboration with other bodies in the form of a public-private partnership, was “Advantage Healthcare India 2018 – International Summit on Medical Value Travel”, a three-day exhibition and conference, that is said to be the biggest of its kind in India and most likely, the whole of Asia. The organisers present their figures with pride; in 2018, there were 171 exhibitors and 705 foreign hosted buyers, from 73 countries. Over 12,543 business-to-business meetings were arranged, more than 45 speakers took part in the conference and more than 6000 visitors were counted. These figures illustrate the significance of the industry and the reach of the event, whilst also reassuring of its quality, by highlighting how many people want to be involved and have trust in Indian healthcare.

Events such as “[t]rade shows, exhibitions, fairs, conventions, congresses and conferences” (Player-Koro et al. 2018, p.685) provide “arenas in which networks are constructed, business cards are exchanged, reputations are advanced, deals are struck, news is shared, accomplishments are recognized, standards are set, and dominant designs are selected” (Lampel & Meyer 2005, p.1026). Events are held in different industries and fields, such as tourism (Oromendia et al. 2015), education (Player-Koro et al. 2018), technology (Garud 2008), sports (Glynn 2008), literature (Anand & Jones 2008) and many more. They offer “settings in which people from diverse organisations and with diverse purposes assemble periodically, or on a one-time basis, to announce new products, develop industry standards, construct social networks, recognise accomplishments, share and interpret information, and transact business” (Lampel & Meyer 2005, p.1026). The literature of “Event Studies” (Player-Koro et al. 2018, p.685) is mostly interested in the benefits that such events provide to the industry. This section offers a novel perspective by shifting attention to the spaces and spatialitites of such events. Despite space being implicitly present in many studies through vocabulary with spatial references like ‘platforms’ (Li 2014; Power & Jansson 2010; Bathelt 2017), ‘arenas’ (Cook & Ward 2012),
or “clusters” (Li 2014; Maskell et al. 2004; Bathelt & Schuldt 2008), for example, the attention put on spaces and spatialities is relatively limited. The first section analyses how established and tentative healthcare networks are activated and assembled in the run-up to the event. The second section sets out to explore the spatiality, articulated through the entwinement of these networks at the International Summit event, to allow a better understanding of the spaces that may emerge during the event or in the aftermath, through the relational intensification.

5.3.1 Reaching out and drawing in: getting actors from far and near involved

Advantage Healthcare India (AHCI) started out in 2015 as the biggest industry event in India, promoting India as a medical value travel destination and it has taken place annually ever since then. The event is organised by a number of bodies: the Government of India represented in the Ministry of Commerce and the Service Export Promotion Council (SEPC), the Federation of Indian Chambers of Commerce and Industry (FICCI) and a consultancy company as official sales partner. The idea is to join hands to promote India as a healthcare destination with more unison. Therefore, efforts were made in empaneling both key industry players and policy makers, to jointly present India to the outside world. Organising and hosting this event has the advantage of showcasing the facilities, mainly of the hospitals, but also of the related sectors, such as travel, tourism and hospitality. After all: “seeing is believing” (I.85).

Defining the reach of an event like AHCI is an important part in the planning phase. The organising committee decided upon five geographical regions: Africa, Eurasia, Middle East, ASEAN (Association of Southeast Asian Nations) countries and SARC (South Asian Association of for Regional Cooperation). Thereafter, they select around 75 countries from where to invite hosted delegates. Through this selection, the committee draws an imaginary map of their target markets, some of which are already developed and others which require development, reaching out to actors who are, in a relational understanding, relatively close and others who are further away. Depending on these criteria, the event organisers follow different strategies to reach out to the range of geographies, either by activating existing network connections or identifying new stakeholders, which are potentially relevant for creating business or the advancement of the industry. Mr C. explains the types of people they connect with and what these individuals are trying to access, when tapping into new markets. By doing so, he also gives a version of a definition of the role of medical travel facilitators, reflecting upon criteria which are relevant for the event organisers, such as status, influence, economic power or access to certain other groups of people:

So, CEO of the top hospitals, then the CEO of medical insurance companies of that country. Then there is the president and secretaries of the
medical association over there; senior officials of a Health Ministry of that country, the medical facilitating companies, top medical facilitating companies’ CEO is invited of that country. Then the dean of the medical college of that country. And in some countries, there are travel companies, good top travel companies, so we invite the CEO’s of the top travel companies also. So, these are the stakeholders which we invite from the countries. (I.85)

The above list shows that the event organisers have a relatively clear vision about which stakeholders they want to reach out to and include in the event: people who hold a stake within transnational healthcare and people “with significant agency and purpose” (Amin 2002, p.390). Such enrolment creates a topological space that is, at this stage, mainly defined in relation to the team organising the event, as a central node in the network. This space, topological in relational terms, happens to be transnational with stakeholders being dispersed across those 75 different countries, some associated with government bodies, and others not. This outward-looking approach is complemented with an inward-looking strategy. The event is also promoted to the local industry players, suggesting that they invest in the opportunities provided. As sponsors and partners, these stakeholders can also recommend delegates they would be interested in meeting:

We [the event organisers] send communications to the industry that are the hospitals in India that you recommend, you tell us which other delegates can be useful to you in sending patients to India. If you want to invite them to India give us a list. So, the hospitals send us a list of guests that can be their potential customers or the potential customers for the healthcare industry of India. (I.85)

Mr C. has a lengthy history of working in the healthcare sector in India and he is extremely well-networked. He can contact relevant actors in this field easily, for example, through a WhatsApp group that he created:

I have a WhatsApp group with close to 200 people of the hospital industry pan India. So, I show you that. This is all stalwarts of ehm this is the WhatsApp group [shows phone] and I am the admin of this, see this, there are 190 participants. So, this is all top shots of the hospitals that are in my group. (I.85)

The personal relations of one significant individual, like Mr C., can considerably shape the configuration of the actors involved, given the extensiveness of his personal network and, as a cause and effect, his popularity in the field. These individuals, in India and abroad are nodes,
opening up a network space and this space seems to reflect the positions of those influential individuals. These last two quotes say something about the people who are considered relevant (CEO’s, senior officials, deans, stalwarts, top companies) and the use of a certain communication media and style (WhatsApp groups). On the other hand, it points towards the absence of others, such as other types of facilitators who are considered to be less influential, who would not fit the group and those who use different means of communication, for example. The spaces articulated prior to the actual event are selective and as their network-character suggests, presences and absences are constituted simultaneously – and also strategically.

5.3.2 Folding spaces in: claiming space, intensifying relations, changing constellations

In the immanence of the event, proximate and more distant spaces of healthcare start folding in: stakeholders of the Indian medical travel industry, mainly major hospital chains and medical travel companies, but also ministry officials and representatives from different organisations and related businesses, attend the event venue to claim their space, quite literally, by setting-up their stalls. The knowledge, expertise and experiences travel with them and the locations where they usually practice healthcare, materialise in posters that decorate the walls of their exhibition booths, the slideshows on display and the brochures and bags that were designed for the exhibition visitors. For the time of the event, being present at the exhibition is about increasing one’s status within the market. One of the participants, the director of a well-established medical travel company, calls the event a ‘branding exercise’ (I.88). His company also participated in the previous years and he always buys the same stall. He raises an interesting point:

We have been here in the previous years. We do not expect any money from the event. But if we are not here it would be a sign that something is wrong; people would wonder why and if there is something wrong with the company. (I.88)

The director was not the only participant following this logic. Showing presence at the event by having an exhibition booth, taking part in the conference sessions and being available in person seems to be important for these businessmen, to claim their space and sustain in the market. Additionally, by not participating in the event, this may also be seen as a statement, which can be interpreted by local exhibitors and foreign delegates as a sign that the company may not be doing well or may not be on good terms with the event organisers or other actors in this field. This interviewee also outlines his concern, with regards to positioning himself clearly in relation to others. Participating in the event seems to be less about pursuing the
company’s monetary interest, but more about performing and upholding a relational configuration.

The physical presence and the enacting of relations has two consequences for the spatiality of the event. Firstly, the exhibition hall becomes a miniature world with a folded, altered and compressed geography representing a filtered version of the network of local stakeholders of the event organisers. Walking around the exhibition is like an efficient, but selective journey which allows one to be exposed to all of the different actors within the market, whose presence materialises on site. Additionally, the event allows the connectedness of the different actors to unfold, which could not be achieved by visiting them individually in the places where they are usually based. This leads to the second consequence for the spatiality. Seeing people interact with each other, the way they speak and sit, how they introduce each other and make connections, gives insight into the qualities of their relations. These are not fixed, and the folding and pleating of spaces into the event space provokes new constellations and changes in the relations. The relational quality of the assemblage on display, through live enactment of the relations and constellations between the different stakeholders, allows for a topological understanding that can only be gained by participating in the event. This is potentiated with the arrival of foreign delegates, who have a more fluid presence at the exhibition. The delegates do not have a fixed exhibition stall, instead they are wandering around, which adds another layer of complexity to the spatiality created during the event.

Such enacting of relational constellations was a valued aspect of the event, which was enjoyed by attendees, whilst also being a strategic move. Many participants celebrated their connectedness and appreciated the AHCI exhibition and conference, for initiating a reunion of colleagues working in the same field and providing a sense of community. Interviewees spoke about the joy of meeting friends and colleagues, as frequently as they mentioned the business opportunities created by the event. Friendship and business are presented as mutually influential. One of the participants says:

We come here to attend these kinds of events because we can meet our old colleagues in the same industry and also meet our same partners who are there, and we can have an update on the changes that are happening in the industry. (...) And secondly it helps us to maintain our old partners for a longer duration. (...) We also make our efforts in planning and designing this stall and planning this nicely. We travel all the way; we spend three four days here. It is just a reunion, kind of a reunion we do here for our staff and everybody. That’s the best part of why we are here. (I.93)

Many interviewees assign value to meeting colleagues regularly who they know from similar events or those they used to work with. One of the participants says: “We keep meeting them
[representatives of ‘the big hospitals’ at such events] and everyone knows me very well; it is a small industry; people are very familiar to each other” (I.97) and many others convey the same perception. Observing the interactions and the way in which people talk to each other and sit together, shows that many of them know each other well and they feel comfortable being informal and joking around with each other.

The more apparent and frequently discussed reason behind participating in such international business events, is for the networking potential and the opportunities to identify and connect with new business partners (Rogers 2008; Schuldt & Bathelt 2011; Maskell et al. 2004; Player-Koro et al. 2018; Li 2014). The manager of the international patient department of a hospital in the South of India said: “We are here because we want to raise awareness about our hospitals and extend the network. (…) it is about increasing the patient income and identifying business partners” (I.98). Providing the opportunity to meet such potential partners face-to-face and discuss common interests is an integral part of international events, such as the AHCI exhibition and conference, and it is valuable for the participants. The representative of the marketing department of another hospital says: “Our objective is to meet people from various countries and having a direct contact with them. (…) This means we have a better understanding. (…) Many high-profile people are here that you do not get everywhere [at other events]” (I.95). The participants value this specific event particularly for having high-profile delegates and the importance of meeting people face-to-face was stressed many times. Meeting face-to-face allows a better understanding of who the other stakeholders are and what their requirements involve (e.g. in terms of specialty treatments, doctors, facilities they are looking for). For the many Indian exhibitors, it was particularly important to identify potential partners that are based in patient source countries. One of the participants says: “Local partners are our ears and eyes in the region”. The interviewee explains that for being immersed in the local context, these partners often have a better sense of shifts and trends in the industry, can provide a deeper understanding of what is actually happening in a given situation and connect with gatekeepers more easily. International exhibition and conferences seem to provide a shortcut to overcome this difficulty of finding trustworthy partners, as they provide a platform for meeting face-to-face.

The opportunity to interact and network face-to-face is considered to be important for establishing and maintaining good business relationships and it is one of the main benefits provided by such international events. Although most interviewees agreed on this, they struggled to put into words what it is specifically, that makes it so valuable to meet in person. It may relate back to the principle that the event organiser introduced at the beginning: “seeing is believing”. Not only seeing the healthcare facilities and the places, but also seeing and interacting with people who are (potential) partners or competitors, makes a significant difference, or in the words of the event organiser: “nothing can beat personal relations” (I.85). He is convinced:
See, it [face-to-face meetings] is always better. Seeing is believing. It is always. So definitely, this kind of b2b meetings on a common platform it is really meaningful instead of what you call ehm communication through email or online media and all that. Though it helps. But you know, it emphasises your relations which you have built up online or on email and all that when two persons meet each other. (I.85)

Some argue that personal relationships are particularly important when it comes to healthcare, which has much to do with relationship building and requires “a lot of human touch” (I.91). Others relate the importance of meeting in person to a particular mentality or culture. Drawing on self-attributed stereotyping, one of the Indian interviewees argues: “We need to meet face-to-face because it’s India, we do not believe unless we meet face-to-face. This is our mentality.” (I.97). Building trust and confidence through personal meetings and interaction allow a ‘better sense’ of who the other person is, by reading body language, the way they speak, learning more about the person, their knowledge and skills and the requirements. It helps to identify who would and who would not be the right partner: “We know who they are and vice versa. So, we get to know if we are dealing with the right person. (…) Based on their knowledge and skill level you get to know who they are and what kind of work they do” (I.98). This is more difficult to evaluate over a distance and one of the interviewees who works for the international marketing department of an Indian hospital explains:

We talk, small minor issues get resolves, all this are the benefits of face-to-face meetings (…) Via phone or email there is a limitation; 20-30% one understands but the moment they meet face-to-face a lot of things you come to know about each other (I.87).

It seems that physical distance acts to conceal certain things that are more easily identifiable or revealed in personal encounters. Furthermore, the event is considered to provide a “safe environment” (I.101) for networking in an otherwise unorganised market, as only registered companies can participate as exhibitors. This relates back to the previous subchapter, analysing how the event organisers chose who to invite to participate in the event. The personal network, interests and also positionality of some influential actors considerably shapes the space that is created through an event, such as AHCI. On the one hand, this can have positive consequences, such as the perception of creating a safe space, for example by inviting a certain type of medical travel facilitators, and not others, either through structural requirements (such as being a registered company) or by carefully selecting and deselecting participants. On the other hand, such filtering produces a bias that leads to blind spots and unused potential.
5.3.3 Conclusion

The previous two sections traced articulations of healthcare spaces, mainly along geo-historical relations and mobility patterns, that act to relate and shape spaces of regional and network topology. This subchapter approaches space and spatiality differently. On the one hand, the Advantage Healthcare India (AHCI) exhibition and conference, allows the tracing of the spatial operation of folding and shows how such events allow the production of network spaces, which create the possibilities for transnational healthcare. On the other hand, it is suggested that the event itself generates its own kind of spatiality, which is further theorised in the second part of this conclusion.

The first contribution of the AHCI example is to show that the folding in of spaces for the happening of the event is produced by and productive of a certain spatio-temporal configuration of relations. The configuration consists of a selection of the relations (not all of them), with some actors being more powerful in assembling their distant and closer, actual and potential partners, than others. Due to the fact that the event organisers draw upon their existing network and project their understanding of relevant stakeholders, the spatially and temporally compressed configuration of actors at the event, is like a partial reproduction, a filtered version, of already existing relations that centre around the network of some influential individuals. Reaching out to invite delegates abroad, as well as the local actors, the first move, is followed by the second move which consists in folding the spaces into the location of the event. The event itself constitutes a moment of compression of spatial relations, which are being assembled and concentrate, in a particular physical space for a particular amount of time. This results in its own kind of spatiality, which is conditioned by temporary presence and intensifications of relations. This spatiality is fragile in nature given its limited temporality, whilst also being powerful, given the compression and number of relations assembled together.

The spatiality created through these events, as in a temporary intensification of connectivity through the presence and compression of relations, may be best captured as a momentary flaring up that then relatively abruptly collapses, to some extent. After the event, the level of connectivity flattens but the relations in the form of transformed networks continue to simmer on a low flame, until the next event. This allegory brings to mind the topology of fire and the conceptualisation of fire space, developed by Law and Mol (2001). Other than in a topology of region, network, or fluidity, they suggest that “in a topology of fire constancy is produced in abrupt and discontinuous movements” (Law & Mol 2001, p.615). The event, as an eventualised, abrupt movement of spaces folding in and out, articulates a certain space that lights up for a moment, through the sudden co-presence of people and intensification of relations in a given place. The intensity of this event has some transformative power to alter relational configurations among the participants, and thereby to (re)articulate spaces of transnational healthcare in the course of the event and beyond.
When the event is over, the intensity of the connectivity collapses to some extent and spaces are transformed (with ties newly established, undone, intensified etc), folding out again. The connectivity levels off, until the associations are intensified again during the next event, unless the spark has been ignited and some actors transform the energy into new or strengthened business activity that starts right from the event.

The frequency of similar events indicates that these spatial operations of forming connections, gather people together and draw them in for the purpose of facilitating interactions and business development. This means that such highly networked, eventualised spaces are formed repeatedly and they flare up again, so to say. The actors’ attention is again drawn to the centre, to the event, summoning the energy to “shoot out new beams” (Bachelard 1964 in Law & Mol 2001), that eventually boost or at least perpetuate transnational healthcare.

5.4 Conclusion: making transnational healthcare possible

This chapter looked at three examples, that illustrate how different sets of practices, which involve varying actors and actants, facilitate medical travel by articulating transnational spaces of healthcare and thereby creating the possibilities for care to be mediated between Oman and India. Each section has started with one of the three fieldwork sites – Muscat, Kerala, Delhi – but, as the empirical material shows, the networks initiated from there are linked along multiple axis and span between and across these places, enrolling spaces, people, things and practices, which contributes to the complexity of transnational healthcare. This reinforces the importance of carefully attending to what is encapsulated by the notion of ‘transnational healthcare’ – the peculiarities of spatiality and of healthcare.

The analysis of the empirical material in this chapter has allowed an in-depth understanding of how closely national and transnational spaces are entwined and it raises the question of what to think of notions such as ‘national’ healthcare, given that it is constituted by multiple transnational mobilities. Both healthcare in Oman and in India – besides medical travel – are transnational for being constituted by cross-border mobilities of people, things, money, ideas etc., and for being shaped by international policies, healthcare standards and accreditation schemes. This raises the question of which medical systems are given a space in transnational configurations of healthcare. The prevalence of allopathy, ‘Western’ or ‘modern’ medicine, in medical travel globally, shows an implicit geography and normativity in transnational healthcare. Ayurveda travel to Kerala is thus an interesting narrative complementing the mainstream version of the global marketisation of allopathic healthcare. These reflections call upon more sensitivity towards the multiplicity in healthcare, its spatiality – and also temporality,
which is explored in the following discussion of the research question that is at the centre of this chapter: *How do practices of medical travel facilitation act to relate/ articulate different kinds of spaces and spatialities involved in transnational healthcare?*

One way in which practices of medical travel facilitation act to relate and articulate different kinds of spaces and spatialities, is by establishing a certain *infrastructure* that links particular institutions, actors and places, by setting up formal connections and channelling patient mobilities as shown by the Treatment Abroad Scheme, under the Ministry of Health in Oman. The Treatment Abroad Department is in an intermediary position, both between Omani patients and the government and national welfare, and between patients in Oman and foreign healthcare providers, commissioned to broker cross-border patient mobility. Provided with statutory regulations and funding by the Ministry of Health of Oman, having tie-ups with hospitals abroad, appointed health attachés and protocols in place that standardise internal processes, the Treatment Abroad Scheme and the team behind it acts to articulate transnational spaces of healthcare by taking an active role in building and engaging with a mobility infrastructure constituted by “systematically interlinked technologies, institutions, and actors that facilitate and condition mobility” (Xiang & Lindquist 2014, p.122). The notion of the infrastructure shifts the focus away from the mobility of individuals, towards the ways in which different actors and actants become associated with networks that facilitate mobilities “within specific infrastructural frames” (Lin et al. 2017, p.169) rather than in an ad-hoc manner. Multiple and partly interlinked networks operate in medical travel facilitation between Oman and India, as all three sections of this chapter have evidenced. The potential of an infrastructure perspective in terms in that it “emphasises operational processes” (Xiang & Lindquist 2014, p.133) and allows “surfacing invisible work” (Star 1999, p.385) will be taken up in the next chapter, in order to analyse, in more depth, how some networks and mobility infrastructures work in every day realities of medical travel facilitation. This becomes a key point, as it is relevant for understanding how medical travel is turned from a possibility into a feasible option.

Another way in which practices of medical travel facilitation act to articulate transnational healthcare spaces is by coupling spaces of medicine, education, and migration to healthcare and thus translating existing mobilities into patient mobilities. The overlay of geographic and social spaces, the multiple connections and the multi-directional mobilities are an “essential definitional element of transnationalisation” (Yeates 2012, p.1113). Given that there are “only a few studies showing the nexus between patients and health workers travelling abroad” (Bell et al. 2015, p.288), the entwinement of temporary health professionals migration and cross-border patient movement, two prominent modes of trade in health services (Woodward 2005), in the case of Oman and India, is an important contribution to the literature. This for explaining
certain patterns and prompting us to think about the complex ways in which the actualisation and coupling of existing relations come to shape current mobilities and especially the receptivity to certain forms of healthcare provision. There is scope for further research on the dynamics and interconnections between mobilities of patient and health professionals, to better understand particular geographic linkages and the spatialities of care more generally. This is important, also for its political and ethical implications in terms of regulating and directing certain mobilities and the possibilities and inequalities that may result for different groups of people.

Similarly, drawing on already existing connections, the situation found in Kerala showed how entrepreneurial individuals enact diasporic links and skills from their work experience in the Gulf countries, to relate spaces of migration to spaces of healthcare. This connectivity between the two countries points to the particular geo-historical relationship, that has evolved over hundreds of years and connections through healthcare in the more recent past. Working through the data, exemplifying the networking practices of taxi-driver/facilitators in Kerala, the normalisation of treatment abroad and also the orientation towards India in healthcare matters found in Muscat, lead to three additional interrelated findings.

The first is the importance of understanding transnational healthcare as spatio-temporal configurations. The articulations of the spaces that make transnational healthcare possible show different temporal stretches and temporalities, ranging from long durée to recent events and from continuous to intermitted temporalities. The ancient relationships between Oman and India define the long durée in which connectivity was created between those countries; the high number of Indian migrants working in Oman over the past decades, indicate a mid-range duration in which existing linkages are actualised and strengthened continuously. There is a comparatively short timespan during which medical travel is facilitated in real-time or the temporariness of transnational healthcare spaces as they are constituted by international events such as AHCI. As time is considered to be a crucial dimension of smooth medical travel facilitation, temporal aspects, relevant for making transnational healthcare feasible, will be explored further in the next chapter.

The second finding is the relevance of particular geo-histories for the conceptualisation and organisation of care, nationally and transnationally, and the receptivity towards it. Treatment abroad has been an integral part of healthcare for multiple generations of Omani patients and it is widely approved in society and formalised by the government scheme. Being accustomed to healthcare being provided by Indian professionals, in Oman or India, has led to a certain receptivity of Omani patients towards ‘Indian’ healthcare. It is suggested that this receptivity, continuously actualised until today, facilitates the articulation and reproduction of these specific healthcare spaces and contributes to the relative success of medical travel facilitation, as carried out by individual people and companies, as people are already attuned to the concept.
These “different geo-histories of care are crucial to how people come to understand care” (Raghuram 2016, p.15), and as this example shows, the geo-histories relate to their receptivity to certain forms and spatialities of care.

Attending to the spatiality as the specificity of transnational healthcare, through the three cases presented within this chapter, showed how different topological formations of space (Law & Mol 2001; Murdoch 1998; Murdoch 2006b), such as regions, networks and the exploration into fire space, came to be related and articulated through spatial operations, such as stretching, folding, coupling, translating. It points out that spaces are relational and they are in the process of being formed by practices which establish connections, maintain ties and order associations (Latour 2005; Murdoch 2006b; Murdoch 2006a; Jones 2009; Amin 2002). Articulations of different spatialities through funding, regulating, monitoring, safeguarding, normalising and initiating medical travel form arrangements that create the possibility for transnational healthcare: If “spaces are arranged so that certain types of action can be conducted” (Murdoch 1998, p.361), here spaces are arranged so that certain forms of care can be mediated transnationally. Articulating transnational spaces in those specific ways, creates the possibility for care. However, the fact that these spaces are articulated, joined together across different nations, cultures, healthcare systems, systems of medicine and conceptualisations of care, means that they exhibit certain frictions and unevenness. In order to establish transnational healthcare, this potential for care needs to be translated repeatedly into action and the roughness, a by-product of spaces being articulated, needs to be managed. How medical travel facilitation deals with this roughness in everyday practices, in order to actualise the potential for care and making TNHC feasible, is the crux of the next chapter.
Mediating transnational healthcare: creating a quality of smoothness

The previous chapter analysed how practices of medical travel facilitation relate and articulate spaces that make transnational healthcare (TNHC) possible. However, this alone does not yet make TNHC feasible and medical travel a practicable and reasonable option for patients. One of the specificities of TNHC, as explored in the previous chapter, is that it is mediated across physical distance and consequently across different nations, cultures, healthcare systems, systems of medicine and conceptualisations of care. This results in different sorts of ‘frictions’ or ‘roughness’ that needs to be considered, managed, and overcome, compared to healthcare that can be accessed by the patient locally. Time constraint, another peculiarity of TNHC, results partly from the transnational setting with options for copresence between the patients and healthcare providers being very limited, and partly from the matter of healthcare, given the urgency of healthcare matters. Moreover, there may be financial constraints for utilising services beyond national funding schemes and additional costs for travel and accommodation abroad. Lastly, there are logistical constraints of moving ill bodies in space given their particular needs, which requires careful planning and execution.

The question is, how can the roughness of TNHC spaces and the implicated difficulties be navigated on a daily basis? How can these constraints be managed? How can medical travel be transformed from a possible into a practicable and recommendable practice? What does it take for TNHC to run smooth enough to make medical travel feasible? What stood out in the data and came out as major theme in medical travel facilitation was ‘smoothness’; smoothness as some sort of quality to work towards, as an outcome of dealing with frictions and complexities of TNHC, and as a manoeuvre or way of doing something. Led by those questions and findings, this chapter centres around the following research question:

*How do practices of medical travel facilitation act to create a quality of smoothness in order to mediate healthcare transnationally?*

To answer this question, this chapter draws on vignettes to delve into the detail of everyday practice of medical travel facilitation following the methodological and conceptual principles and sensitivities of studying practices developed in STS research. Vignettes, “generative rather than purely descriptive” (Singleton & Mee 2017, p.133), can bringing out complexities of practices that would remain invisible without attending to them closely with a sensibility to
the associations of heterogeneous actants and the effects they generate. Three sets of facilitation practices – connecting, communicating, and coordinating – sit at the centre of analysis. They resonate with different types of brokerage such as ‘matchmaking’, ‘transfer’ and ‘coordination’ brokerage (Spiro et al. 2013, p.131). More importantly, these three sets of practices were identified in the empirical material as being particularly relevant for dealing with major fractions and frictions of transnational healthcare and for generating smoothness. Conceptually, this chapter takes the focus on practices of medical travel facilitation as the making of connections and relations one step further, by exploring not only the work involved in making connections but also the qualities of and resulting from that work – here the quality of smoothness as it is created through the mediation of relations by medical travel facilitation. This is a particular area of interest because such qualities allow a deeper understanding of the specificities of transnational care as well as the relation between care and medical travel facilitation, which, I am suggesting, goes beyond ‘just’ setting up medical care.

6.1 Connecting

The physical distance between patients and healthcare providers is one of the specificities and also difficulties of transnational healthcare (TNHC). Building, maintaining and managing connections is essential for making TNHC feasible and a central practice of medical travel facilitation. Connecting previously unconnected parties and facilitating their relation can be framed as a typical ‘matchmaking brokerage’ (Spiro et al. 2013, p.131) and a service provided by brokers who “manage structural holes” (Obstfeld et al. 2014, p.137), or in the given context here, by medical travel facilitators. They are described as “intermediaries who connect patients to medical providers in a different country” (Dalstrom 2013, p.25) and “crucial connectors between foreign patients and host countries” (Wagle 2013, p.28). Although different sets of practices are discussed in the literature (see for example Bochaton 2015; Ormond et al. 2014; Dalstrom 2013; Crooks et al. 2011), connecting features prominently as one of their key practices and contributions in TNHC markets. It is that “simply serving as a middleman who puts the patient in contact with medical professionals abroad and makes travel arrangements” (Snyder et al. 2011, p.533) is presented in the literature as the most basic service that a medical travel facilitator can provide.

This section takes a close look at this basic, yet fundamental practice of connecting, suggesting that for TNHC to be feasible, it is not enough that patients and healthcare provider are connected but that it matters how medical travel facilitation acts to connect and eventually creates smoothness. Three aspects of connecting and the ways in which they act to generate
6.1.1 Forging connections and providing continuous hand-overs

This section looks at ways in which practices of medical travel facilitation act to build connections between patients and healthcare providers by actively mediating them in the situation and providing hand-overs that facilitate future connections. In order to better understand these practices and highlight how they act to generate smoothness, we follow Rashid, a freelance facilitator, who is mediating an informal consultation of Omani patients, with an Indian doctor in Muscat.

The vignette starts in a hotel in Muscat, where Rashid is co-organising and hosting a meeting between Omani patients and representatives of an Indian hospital. Rashid is an Omani businessman in his forties, who started to facilitate medical travel on a freelance basis after accompanying one of his friends who travelled to Thailand for medical treatment about twenty years ago. As mentioned in the previous chapter, Rashid’s contact was passed on by the cousin of a taxi-driver, who I met by chance during fieldwork. The connection spun from there and after exchanging a few messages we met a few days later for an interview. Rashid told me that he runs a group chat on WhatsApp, which allows him to share information about treatment abroad with a community of over fifty Omani people (more on medias of communication in Chapter 6.2.1). Rashid would announce his upcoming trips to India, to give the group members the opportunity to join him and use his service, whilst also promoting events related to treatment abroad held in Oman. One of the upcoming events was a Continuous Medical Education (CME) conference, held in Muscat, which was hosted by an Indian hospital where Rashid has connections. Though the event was for medical professionals only with his proactive attitude Rashid suggested generating synergies and, along with the marketing team, he arranged an opportunity for patients and their families to meet with one of the Indian doctors prior to the conference in the informal setting of a hotel lobby. I had the opportunity to accompany Rashid that day.

*Rashid calls the doctor as soon as we arrive at the hotel and we meet him in the dining room. There is time to exchange a few words before moving to the lobby, where we are joined by the marketing team, moments before the first ‘visitors’ arrive. One of them is Mr S, with his wife and daughter and a few other female relatives. Mr S already has plans to take his family to Kochi for treatment, but when Rashid mentioned on the WhatsApp chat that there is an option to speak to*
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Giving potential medical travellers the opportunity to directly connect with a doctor, to discuss their individual cases, is an important move for business development, from the hospital’s point of view but also for a designated facilitator if they are involved in mediating this encounter. Unlike in other settings that draw on the principle that the parties involved interact only through the broker and do not connect directly (Spiro et al. 2013, p.132), here interaction between patients and healthcare providers are actively initiated by the medical travel facilitators. It does not make the facilitator redundant since the need for further mediation of the relation secures the brokers role.

In order to acquire new clients, facilitators and healthcare providers at the medical travel destination site often connect first with facilitators in the patient’s country. This form of business development in which the network comprises, sometimes multiple, middlemen and extends into the patient sending countries was found to be a common strategy to mobilise patients and direct them towards healthcare providers in India since they have a “channel-based trust” (Hartmann 2019, p.79). Building such channels that facilitate and streamline mobility, resonates with an infrastructure perspective that has already been touched upon in the context of articulating TNHC spaces in the previous chapter and that is also defined in migration studies as “the systematically interlinked technologies, institutions, and actors that facilitate and condition mobility” (Xiang & Lindquist 2014, p.124). However, understanding facilitators as mobility brokers that not only establish these channels but who are also “dealing with various components of infrastructure” (Xiang & Lindquist 2014, p.133) shifts the attention to how these connections are being enacted and how these components come to engage with each other. This event in the hotel lobby draws on existing mobility infrastructures such as the facilitator-hospital tie-up or the WhatsApp groups that allows the dissemination of information as an impetus to mobilising international patients towards TNHC markets. However, what matters now in this situation is how these connections between patients and healthcare provider is being mediated and smoothened by medical travel facilitation in a way that forges contact, connectivity, and eventually patient mobility:

Rashid introduces Mr S. to the doctor who is offering consultations today and suggests they sit down around the table in the hotel lobby. Whilst they exchange a few words, Rashid guides the women and children to the nearby seating area and asks the receptionist to bring them the drinks menu.

In the meantime, Mr S. asks his wife to bring the medical reports and to sit with them. The doctor looks through the documents and starts asking questions about different tests and symptoms. Mr S. speaks English but Rashid steps in to translate for his wife who is one of the patients. They talk about previous treatment and
reoccurring health problems and the doctor recommends carrying out some further investigations to find the root cause of the illness. Mr S. is already convinced and says: “Okay, when can we go? We want to go now. We only have little time”. The doctor responds: “You can come, it’s easy”. He is back in India on Monday and will prepare the investigation plan. During the next consultation, Mr S. goes outside to arrange the journey and Rashid takes the lead and translates between the other patients and the doctor.

All of the parties come to be involved in some sort of mediation work and begin to carry out their duties, with regard to their role in the meeting: Rashid facilitates the meeting by introducing people to each other, chairing the session, participating in the consultation by offering language translation, asking questions and making comments based on his experience and knowledge, in order to steer the conversation in the right direction. It is also Rashid’s job to smooth out issues which arise during the consultation, such as language gaps or other cultural aspects of communication, mistrust or doubt in the adequacy of addressing the healthcare concerns. The doctor gives his professional opinion and together, along with the marketing team, they promote services to potential clients. For Mr S. and his wife, this opportunity to connect with the doctor means a possible healthcare gain and they use the consultation to ask questions which will form the basis of their decisions. The interests and mechanisms for creating smoothness are distributed among these actors who are collectively invested in this achievement. Smoothness becomes a good with personal and commercial value. For the patient, the value lies in its contribution to the restoration of health. For the facilitators, smoothness is a both a job and a profit. Systematic mediation turns smoothness into a quality of the facilitation work with commercial value. The product or rather service of facilitators may “transform it temporarily into a tradable good in the market” (Callon et al. 2002, p.199). The value of smoothness moreover has a certain temporality. On the one hand, smoothness is an in-situ manoeuvre realised in the act of facilitation. On the other hand, the projection of smoothness as a quality on to the future medical travel experience is the assets that facilitators make profit with and justify their service. One of the managers of a medical travel company in Delhi says: “I'm not offering a medical treatment; I am not a doctor. I am not able to treat the patient. But I have to create a setting which ensures that no unexpected development takes place” (I.62). It is the facilitators job to create this setting, mitigate roughness and prevent unexpected developments, interruptions or sudden changes. The projection of smoothness that results from these efforts is their business, so to say. Facilitation is about “tending the tensions” (Bingham & Lavau 2012), so to speak, which applies to such meeting but also other situation that will be further illustrated in the following sections of this chapter. Through the mediation work, which acts to generate smoothness, the connections that we started with in the vignette were developed further and turned into connectivity. This
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canadiaw. drawing on Pordié’s (2013) concept of ‘spaces of connectivity’, is suggested to be understood as “a potential that needs to be actualised; that is, enacted and embodied, to become effective” by Kaspar and Reddy (2017, p.229). This immanent potential is actualised in this moment whilst these connections are formed in the hotel lobby and also in future practices such as the upcoming trip of Mr S.:

A few minutes later Mr S. is back; he cancelled the planned trip to the hospital in Kochi and booked flight tickets for Kozhikode instead, leaving on Monday morning. The hospital offers a complimentary airport pick-up, but Mr S. says that Rashid already told him that he has a friend who will be their driver. The marketing manager of the hospital says: “Rashid, if you were not there, it is not convincing. We need him to be there”.

The ease with which Mr S. was persuaded to go to this particular hospital in Kozhikode and the immediacy with which he changed his travel plans is considered to be a result of multiple instances of connectivity. Firstly, there is his familiarity with India, which is due to his transnational personal biography that heightens the receptivity for seeking treatment there. Mr S. went to university in India and he has travelled there for medical treatment before. Moreover, many of his employees are Indians. As already discussed previously (Chapter 5.1.3) there is this sense of normality among Omanis to travel to India for treatment. Secondly, the face-to-face consultation with the doctor in the hotel will have persuaded Mr S. and his family to follow his advice and change their plans. Thirdly, the development of trust and rapport building within the consultation seems to be greatly facilitated by the presence of Rashid as a mediator and by his ability to project his competence, his experience and his expertise within the field of medical travel. Rashid’s presence at the meeting, as well as his confidence in facilitating medical travel, which is demonstrated by his ability to successfully organise the meeting, connect with trustworthy partners and interested clients and intervene in the medical consultation if necessary, is reassuring for both parties: Patients feel like they are in safe hands for being facilitated by a local resident, who has longstanding experience within this field. The healthcare providers also feel confident that these patients will actually travel to their hospital being provided with business by this entrusted channel. This capacity of building trust between actors (Marsden 1982 in Obstfeld et al. 2014, p.140) and thus “the alteration of an existing tie by adding or increasing strength of a specific relational dimension” (Obstfeld et al. 2014, p.144) are defining qualities of brokerage (Marsden 1982 in Obstfeld et al. 2014, p.140). Moreover, the setting up and unfolding of the meeting that was carefully managed by the facilitator and the care demonstrated for both clients makes connections smooth.

Connecting also means to provide continuous handing over, the smoothing of the transfer from one link to the connecting one. Connections can be thought of as forming a chain with links that are activated intermittently and travelled through according to the different stages of
medical journey. Such a chain of connections guides patients and attendants: Starting off with Rashid’s text message, Mr S. and his family were drawn in on their quest for treatment abroad and guided to the meeting in the hotel lobby where the medical travel facilitator hands them over to the doctor for the consultation. The clients are then connected with the marketing team of the hospital that is also on site and that links them up with the rest of their team in India who will welcome the clients upon their arrival. What happened next in the vignette is that the marketing team and Rashid both provide the family with a contact person (a driver) to spin the connection further and ensure that the family is directed to the next/ ‘right’ place once they are at the destination site. In parallel, both, the designated facilitator and the marketing team, propose to hand the family over to one of their entrusted contacts who are already enrolled in the mobility infrastructure of which they are part of and waiting, so to say, to be activated. It is upon Mr S. to choose which option he wishes to take, and his trajectory is likely to go across multiple intersecting mobility infrastructures. The chain of connections built by this individual case, is then only one pathway, that was chosen among many possible links of forward connection, likely because of its promise for smoothness that is actualised by seamless ‘handing overs’. This infrastructure can be mediated by humans or technology; it may connect bodies which are in immediate proximity or entities separated by physical distance; it connects heterogeneous entities such as people to places or institutions, medical reports to computers and doctors, a text message to an event, a piece of paper with a phone number written on it to a person with a car, for example.

Yet again, what matters just as much as articulating spaces of TNHC and establishing some sort of infrastructure for seamless handovers are those immediate moments of connecting, as explored in the vignette of the meeting in the hotel lobby. This is because the handing over of a case holds the capacity to smoothen spatial and temporal roughness alike. Spatially, a chain held by different links (or: an articulated space) is inevitably going to hold roughness. However, this is mitigated by providing adequate forward connections. Temporally, roughness in the form of interruptions and delays in the process is mitigated by providing forward connections in a timely manner. The success of handing over is also determined by its timing. Practices of medical travel facilitation thus act to translate this capacity into spatial and temporal smoothness. The effect of successful translations allows patients to move continuously (connectivity solution provided through handing over), quickly (established connections pave the way and prevent from losing time) and relatively directly (level of guidance prevents detours or getting lost along the way).

On the basis of this vignette of the mediated consultation in the hotel lobby, this section explored different ways in which connecting acts to generate smoothness. Connecting in the sense of putting someone in touch with someone else creates smoothness by bridging the gap
between previously unconnected actors, providing an opportunity for direct interactions and establishing some sort of mobility infrastructure that smoothens future trajectories. Certain systematically established connections between different sorts of facilitators or facilitators and providers for the purpose of facilitating medical travel build channels constituting such mobility infrastructures (Xiang & Lindquist 2014) that, at the same time, retain certain openness for offering multiple options of forward connections. The ongoing active mediation of interactions (Obstfeld et al. 2014, p.146) as a way of forging connections, acts to create smoothness by building relationships, trust and confidence. Both of these practices are typical brokerage activities that “enable relationships between different groups of actors” (Hiteva & Maltby 2014, p.121) and result in “mutual enrollment and the interlocking of interests” (Mosse & Lewis 2006, p.13). In this process of translation (Latour 2005, p.65) medical travel facilitators play an important role and are in a powerful position. Although Hiteva and Maltby (2014, p.121) use the notion of the more passive ‘intermediary’, they also point out that they act to “pursuing their own agendas and creating new realities and meanings”. Varied interests within the analysed connections, and within the investment in their mediation, make smoothness to be not only a common goal of patients and different facilitators, but also a good with commercial value. The promise and projection of smoothness through managing connections becomes the asset that facilitators try to capitalise on. Providing continuous handovers is thus another way in which medical travel facilitation acts to creates smoothness, in the sense of realising this potential in a spatio-temporal manoeuvre, which enables relatively quick and direct progression. All of these ways of connecting create smoothness as an outcome of enabling diverse entities to travel forth and back more easily than if the relationships were un-curated. Furthermore, the different forms of connecting contribute to smoothness in their own ways, holding smoothness as a disposition that can be translated and realised in a spatio-temporal manoeuvre.
6.1.2 Testing connections and projecting connectedness

As established in the previous section, connecting is an important practice of medical travel facilitation especially in the initial phase of setting up medical travel with new clients. Given the transnational set-up, a common way in which patients connect with healthcare providers abroad, is by enquiring online with the hospital directly or with a medical travel company. At this stage, medical travel facilitation is particularly important for mitigating some of the initial barriers of TNHC such as physical distance, disconnect with relevant actors, uncertainty about selecting a healthcare provider, mistrust or concerns about the hassle of travelling abroad.

Drawing on an exemplary case of pre-travel facilitation, schematically illustrated in Figure 8 and Table 7, this section explores connecting not only as a matchmaking-brokerage practice but also a way in which patients and medical travel facilitators test the connections within their networks and a way of gauging smoothness in the current and future processes.

Figure 8 illustrates a typical process flow of medical travel facilitation in the pre-travel stage, in the form of a diagram that is, for better legibility, also translated into a table (see Table 7). The figure shows schematically the number of actors that are, sometimes only temporarily, enrolled in the process (circled in black), the number of interactions between them (blue arrows with description of the action in blue), and the documents that are being sent back and forth (noted in black, above and below the arrows). The numbers (in green) give a sense of how these proceedings unfold, in a quasi-chronological order. The example starts with a patient based in Oman, who enquires with a medical travel company in Delhi about treatment options in India. From there, different people get connected and documents get mobilised in the course of pre-travel facilitation that aims at turning medical travel into a feasible option for the patient. The illustration shows the proceedings as they typically unfold for a patient who pays out of pocket and travels individually, without extra requirements (for example, the urgency to travel within a certain timespan, the need of the patient to be accompanied by a medical team or ambulance escort). Most interactions focus on sending out enquiries, clarifying information with the patient, sharing medical reports and passport copies with selected healthcare providers, collecting doctors’ opinions and possible treatment plans, sorting formalities and bookings. The medical travel facilitator becomes the focal point, mediating most interaction and passing on information and documents to other parties such as the patient and his/ her local support network or the actors on the provider side from the healthcare, travel and hospitality sector.
Figure 8: Visualisation of interactions in the form of messages sent between different actors in the pre-travel stage (own illustration)
Table 7: Actors, interactions and documents mapped in the Figure 8 translated into a table with temporal progression following the number of interaction/ from top down (own figure)
The way that facilitators talk about the importance of providing patients with quotes from different hospitals and the relevance they ascribe quick turnover time and ease in interacting with patients and partners indicates that there is more to the connecting work than it being a mere matchmaking exercise. Based on the data, I suggest that the way in which such connecting and interacting is being done and the quality of connections matter, for practical reasons and for projecting competence and connectedness.

Connecting patients with healthcare providers, getting quotes from different hospitals and supporting patients in the decision making process is seen as a crucial aspect of medical travel facilitation in the literature and in the narratives of the interviewees (more on that also in Chapter 7). It seems like they pride themselves with the number of healthcare providers they are associated with, the reputation of doctors in their network, the geographical spread, the ‘star classification’ of the hospital and price range covered. This suggests that patients evaluate the facilitators competence in handling their case based on their connectedness with healthcare providers. Having a wide choice of healthcare providers in their portfolio and the ease with which they obtain quotes projects their facilitators reputation in the field, their ability to build and maintain good relations, to speed up the process, or maybe even their ability to solve issues. The ability to connect thus stands for the facilitator’s competence, forward connectedness, and even the promise of smooth processes.

The way in which connections are formed in the initial stages of enquiring and preparing for medical travel, acts as an indicator for the smoothness of the process. Facilitators, just as patients, are testing their network for smoothness to ensure a hassle-free experience to their clients. They forward the patients’ queries to their network partners in the healthcare, travel and hospitality sectors and they see who responds within a reasonable amount of time and what they have to offer. Connections that propose adequate offers are further maintained; others, which are deemed unsuitable for the given case, are temporarily rejected. The illustration of the example shows that the medical report was sent to five different healthcare providers but after consulting with the patient only the connection with provider No 1 was pursued further.

The number of messages which are passed on are shown in the illustration and the table, and the number of formalities that need to be sorted, in order to set up medical travel, act to set up medical travel and also test the connection. Each interaction simultaneously constitutes a potential obstacle and forms a way of overcoming it. On the one hand, each interaction can be one step closer to establishing whether or not medical travel can be carried out successfully and whether the connection can be deemed worthy of being maintained. On the other hand, each interaction constitutes a potential issue, a cause for delays, or even a dead end if the connection breaks down or is not considered suitable to be pursued further.

What the visualisation only indicates with the temporal succession of the interactions is the temporality of connecting. The number of times in which messages and documents are sent
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from one actor to another represents the frequency and to some extent the continuity of checking in and progressing the process. For medical travel facilitation it is crucial to keep in contact with multiple people simultaneously, keeping information and documents circulating and ensuring that they are with the right person, at the right time and processed in a timely manner. Such continuous connecting work can be handled effectively, if assigned to a central facilitator who is familiar with the process, who is aware of all the important factors and details within the case and who is checking in regularly on progress. The facilitator is then responsible for following up with the different people involved in the process and ensuring all other parties involved are completing their duties. These measures contribute to the timeliness and efficiency of the process, in a sensibly ordered manner, which prevents delays.

Connecting as in regularly checking in, taking care of timekeeping and coordinating with the right people at the right time to keep the process continuous acts to generate smoothness in the sense of a temporal quality. This despite the connections in itself being of episodic nature, interrupted and event based; both in terms of the practice of connecting and interacting being temporally constrained, and in terms of medical travel being an episodic event in the patient life (which does not mean that these episodes are not repeated). Thinking of the connections that are concerned with the health of an individual, it is usually the patient’s family and local doctor who are enrolled in the care team on a long-term basis. All other actors mapped in the illustration emerge relatively suddenly, their contribution towards the caring of the patient is likely to be of more temporary nature, and then they fade out again. Connections with some actors such as the embassies or healthcare providers that were deemed suitable are established and after it served its purpose, the connection is shut down, from the patient’s perspective, or temporarily unmaintained from the facilitators point of view, until the next case. Those connections that are still currently relevant are maintained by the person organising medical travel who is usually busy working on multiple fronts at the same time.

This example from the pre-travel stage of medical travel facilitation explored smoothness, as a manoeuvre of managing connections and circulations in a timely and continuous manner, and as a quality and outcome of medical travel facilitation resulting from carefully setting up and testing connections. Moreover, the findings suggest that the different parties involved (patients, facilitators, healthcare providers) take the way in which they connect and interact as indicating for the smoothness of their future collaboration and the medical travel experience of the patient. The ability to establish and maintain associations with suitable stakeholders and to manage different ties of the network despite the episodic nature of some connections seems to be an important aspect of medical travel facilitation and the mediation of care.
6.1.3 Benefits of having connections and collaborations among facilitators

To assist is about people. You know, the more you meet people, the more you have acquaintances, then your work becomes easier. (I.46)

This statement from a freelance medical travel facilitator in Delhi highlights the importance of having connections for their work. This section focuses on connections among facilitators, different forms of collaboration and the asset of ‘having connections’ for making the everyday work of medical travel facilitation smoother. In what follows different ways in which collaborations among facilitators generate smoothness are explored and how this affects the patients’ experience of medical travel.

The first example relates to business development and its facilitation through transnational connections between facilitators based in Oman and India. From the point of view of the facilitators based at the medical travel destination site, enrolling people in the patients’ countries (such as other facilitators, doctors, travel agents, insurance companies, embassies) as referral partners, who have the ability to connect with patients and channel them to the facilitators, is an effective way of making the acquisition of new clients easier. Connecting with partners abroad is a common strategy of patient mobilisation, which builds on the principle of “outsourcing the trust-building processes to local partners in the patients’ countries” (Hartmann 2019, p.73). One of the Indian facilitators says:

We have a partner in Uzbekistan, Iraq, Oman. They are sending us the patients (…) Local person (…) sometimes they have the company, sometimes an individual, who has no company but has the reputation, name and fame. They go to patients and say that they have the partners in India who will take care of you and they are good, my friends. (I.61)

Such collaborations make the contact with new clients smoother by removing obstacles given by physical and cultural distance. Apart from facilitating the connection with new clients, local partners can also play a role in mitigating issues, given their knowledge, network and embeddedness in the local context. As they speak the local language, they act as interpreters and they are able to offer a better understanding and explanation of what is occurring in a given situation. One of the interviewees says: “Local partners are our ears and eyes in the region” and further explains:

It is about having a contact in the region, for example in Saudi Arabia, who knows people from the ministries and who is on good terms with them – they are the ears and eyes – they can understand. If we go, we can only say hello-goodbye. But we cannot find out the problem. They are able to catch the problem (I.91)
Cross-cultural interactions pose multiple difficulties such as difficulties to communicate adequately for language issues (more on that in the next section), unfamiliarity with the local context and customs or also mistrust among parties who are not so well-acquainted. Connecting with local partners can thus enhance a more in-depth understanding and helps to overcome these challenges.

A second way in which collaborations between facilitators based in different countries act to create smoothness is by providing access to key stakeholders and influential gatekeepers. A medical travel facilitator based in India says: “local partners make our job easy as they can find an agreement with the government and get approval more easily” (I.101). The facilitator gives an example of when he once needed an emergency travel visa for a patient on a Friday, when all of the local offices were closed. Fortunately, the facilitator had a connection with a partner in the patient’s country, who was able to resolve the issue, using his local connections with influential officials. It is not just the facilitator who profits from such connections; patients themselves will also benefit, if their problems and concerns with regards to their medical travel can be resolved more easily through the involvement of multiple mediators. They can “produce an outcome that would not have been possible, or as effective, without their involvement” (Marvin & Medd 2004, pp.84–85).

A third way in which collaborations smoothen medical travel facilitation is by establishing and maintaining relationships with colleagues in everyday work. Tie-ups between healthcare providers and medical travel companies or individual facilitators constitute the most prevalent form of collaboration. On the one hand having a formal work relationship streamlines processes and clarifies rights and duties of the different parties involved. On the other hand, connections which go beyond the formal tie-ups and form more informal relationships between colleagues were particularly valued by the participants. Handling the patient’s cases jointly on a daily basis becomes easier if more informal ways of communicating and interacting are established, they say. One of the individual medical travel facilitators, based in Delhi, recalls how the help of a friend helped him to get started within this business in the first place and how the connections he has built over time make his job easier and smoother now:

There was no formal meeting, we [facilitators] all just go to the doctors. He [the interviewee’s friend and work colleague] said, this is my friend, he starts working here, so please help him. Like this. And then I started. Now, I really know all the doctors. Regarding reports, I can send the reports to doctors and whenever he’s free he will send me the response. (I.46)

Since there is no official training for medical travel facilitators, most of them follow a “learning by doing” approach and many of them are introduced to the job and other important contacts by colleagues, again “through connections”. As this facilitator is now familiar with the
doctors, he can connect with them directly. If facilitators have a question or need some information and if they know which field of speciality is likely to be required, rather than enquiring with the marketing team they can contact the doctors directly. Such collaborations thus allow medical travel facilitation to be easier and smoother by providing direct access to knowledge and expertise. The facilitator cited before confessed that at the start of his career, he was completely unfamiliar and unaware of the processes within the hospital, as well as the medical conditions presented by patients. By having regular interactions with the doctors, the facilitator was able to build the knowledge that now allows him to assist his clients on a more professional and efficient level:

> When I came to the hospital, I start connecting with doctors. And here [India] doctors are very nice. For example, if you bring patients, the doctor starts by simplifying the form firstly, in very simple words, and then he explains all the difficult medical terms, explains it to you. So that gradually you would be able to understand the medical terms. Yes, and to convey it to the patients. (I.46)

A positive and effective relationship between medical travel facilitators, the hospital staff and management contribute to smooth handling of international patients throughout the day-to-day operations. Medical travel facilitators may solidify their collaboration with certain healthcare providers and gain some sort of “VIP status” (I.47) by bringing a significant amount of business to the hospitals. One team of freelance facilitators, for example, has been directing hundreds of international patients to one of the multispecialty hospitals in Delhi over the four years that they have been working together. This puts them in a powerful position and is one that they are aware of. One of them says confidently: “I’m on very good terms with the hospital manager. Whatever I request I will get” (I.47). They are able to move freely within the hospital, without restrictions and without being stopped and questioned by hospital staff. They have access to most areas within the hospital, including the ICU, laboratory, doctors’ offices, patients’ rooms, the manager’s office, stairs and elevators for staff, nursing desk, admin offices. This allows them to move around quickly and to accompany patients to areas that other attendants or facilitators are unable to access. By being on good terms with the hospital staff, this allows facilitators to ‘skip the queue’ and to receive appointments with doctors, consultants and even the hospital manager before others, which in turn helps to speed up the process.

As the hospital is profiting from the steady flow of international patients – and of money – it does not want to risk the team of facilitators channelling their patients elsewhere, to an alternative provider. Therefore, they invest in the collaboration and they are eager to satisfy the facilitator’s requests, as a way of remaining on good terms with them. By ensuring that the
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Facilitators feel well-respected and by providing them with favourable conditions for themselves and their patients, they can be considered to be part of the “facilitator-pampering”, as one of the interviewees calls it. The facilitators can profit from benefits, such as an office place or a driver, more room in negotiating a discount for their patients, and also higher referral fees. On the one hand, these special conditions can be critical for patients, because the facilitators’ advice on which hospital or doctor to choose is likely to be biased and may not be in the patients’ best interest. On the other hand, patients also benefit from the close collaboration between facilitators and healthcare providers in multiple ways. Their case may be handled more efficiently and with higher priority; special conditions or discounted rates are more likely to be negotiated and more capacities can be mobilised to solve any issues. As suggested above, such connections do not only make the facilitator’s work easier, but they can also be beneficial for a smoother medical travel experience for the patients.

There are different money flows involved, directly as in the payment of commission fees to facilitators for referring international patients and indirectly as in a higher volume of patients channelled to a particular doctor or hospital. Whereas these are formal aspects of the political economy that shapes these relationships, there may also be an informal economy of connectedness and other forms of exchanges between the different actors involved that configure the making and unmaking of associations and circulations along these networks. Some of these connections seem to be rather fragile and volatile while others evolved over a longer period of time and solidified through continuous and ongoing interactions.

When facilitators and doctors work alongside each other in the same industry for many years, the stability of their connections can also make medical travel facilitation easier, smoother and more efficient. Many directors of medical travel companies in Delhi and Muscat used to work in the healthcare industry, before starting their facilitation business. They gained knowledge and experience in healthcare administration and the handling of international patients and they were able to build a network which helped them establish their company and sustain their business. Being recognised within the industry and forming successful collaborations with former work colleagues can have a substantial and positive impact on all parties involved. The director of a relatively new medical travel company explains that he was able to build his business quickly, by drawing upon existing connections:

I have 17 years of experience in healthcare. So right to starting my organisation I was working with previous healthcare companies. (…) And everybody knew me. So, I had a good team which came along with me and then we started this. (…) People know me. So, they keep referring. (…) Because of my relationship with everybody. So, it is like a chain. So, I help them, they help me. (I.44)
A rather surprising form of collaboration was found to be cultivated between two medical travel companies that are operating in the same market. For them, ‘ease of operation’ seems to stand above competition. In a conversation of the interviewer (I) with the managers of these companies (A and B), they describe their relation as being “collaboration-competitors”:

B: Okay, okay. It’s a teamwork. Certain hospital they [company A] don't work with, they route it through us. Certain hospitals we don't work with, so we route the patients through them.

A: It’s an ease of operations. Like, we are based in Delhi and they are based in X [satellite city that belongs to Delhi National Capital Region]. If you go to the other side [of the city], it will take two hours one way; so, four hours [both ways]. You know, then it is easier if we work together.

I: So, you send your patients through your company and vice-versa?

A: Yes, so we collaborate in that sense. (...) See, that is all in the interest of the patient. So, if it takes three hours for me to reach than it is better.

(I.62, I.63)

This level of teamwork, as described by the interviewees, acts to smoothen daily operations in the sense of facilitating the formalities or logistics of handling patients. This has a number of benefits for the different parties involved. The patient has a contact person nearby and is free to choose any hospital, even those which the company is not directly connected to. The facilitators can reduce their amount of travel to assist patients on site in the hospitals and use their time more wisely. The two managers developed a working relationship from their previous employment in healthcare. They describe the market in which they operate as, “a small world” in which “everyone knows everyone else” (I.62). Not many, but some companies work together: “Not everybody does that, but we do, certain number of facilitators do collaborate” (I.62).

A fourth motivation and form of collaborating is that of building industry associations, which unite people, with the common goal of advancing and improving the industry, which acts to smoothing transnational healthcare in broader terms. As outlined in the previous chapter (5.3), the large-scale exhibition and conference, “Advantage Healthcare India”, is a collaboration of the Ministry of Commerce of India and the Service Export Promotion Council (SEPC), the Federation of Indian Chambers of Commerce and Industry (FICCI) and aims at promoting India as a medical travel destination and increasing inbound medical travel. Another example of actors collaborating and making a joint effort in improving the industry is the Medical Tourism Development Alliance (MTDA), an organisation based in Delhi, which represents medical travel facilitators. The head of the MTDA explains why he started the association, in 2014:
When we started to sit together there were two things that we were facing. One is there is not a single voice that can speak on behalf of the medical tourism facilitators or the interpreters and the medical tourism companies. So, we need to give a voice to the voiceless. To speak to the ministry, to show our proposals, sometimes our patients face visa-problems, so we talk to the external affairs something the like. (...) Second one, there is not a certain parameter to start a company or to be a medical interpreter. Unfortunately, there is no defined course for medical interpreters. (I.55)

Running such an association demonstrates the efforts made to bring together and enlist actors with similar interests in a project, unifying their voices and coordinating their efforts in defining certain standards. Joining forces to organise themselves and improving the industry, is another way to work on streamlining processes, reducing issues and smoothing transnational healthcare. Simultaneously, it can make the facilitators work easier.

This section explored four forms of collaborations in medical travel facilitation and how these connections among colleagues in the same industry act to generate smoothness. Collaborations between different sorts of facilitators, officials and key persons in hospitals and TNHC in general lead to the ‘ease of operations’ in terms of connecting more easily with potential clients, delegating tasks to actors who are better positioned to do them, drawing on the expertise or network of colleagues, having more direct forms of communication, speeding up processes or handling them more efficiently. Such collaborating and the relationships between colleagues that evolve can be seen as holding the disposition to smoothness as they can be drawn on, in certain moments or more regularly, to facilitate medical travel. If this disposition is successfully realised within manoeuvres of medical travel facilitation, smoothness becomes an outcome in the experience of international patients. They profit from the facilitator’s ability to negotiate better conditions, to speed up processes, to gain access to gatekeepers and to exert influence in mediating TNHC and improving the industry.

6.1.4 Conclusion

Connections, or rather how connections are established, maintained (or not), and shaped in collective efforts by different constellations of actors and how connecting acts to create smoothness was the focus of this subchapter. Smoothness was found to be a quality of connections in which different actors have different investments. Whereas smooth connections may provide patients with healthcare gains, for facilitators it means fulfilling their job successfully and facilitating their own work. For them, smoothness as the outcome of their mediation work becomes a good with commercial value that is realised in their ability to both
project forward connectedness and then actually provide continuous hand-overs. This is possible by drawing on already established connections that form some sort of mobility infrastructure. However, new connections need to be established as well. Thus, a considerable part of medical travel facilitation consists in forging connections, smoothing interactions, building trust and confidence.

Such connections are tested in terms of their ability to provide smooth progression in a patient’s medical travel journey. The ability to provide forward connections with relevant stakeholders, and ease of interacting seem to be taken as indicators for connectivity, competence – and smoothness. Medical travel facilitators need to deliver their promise of mediating TNHC smoothly by managing multiple network connections simultaneously and in a timely manner, over distance and in face-to-face encounters.

Having connections with work colleagues that allow for collaborating in everyday practice acts to generate smoothness in multiple ways. Having partners in different countries facilitates connections with potential clients by outsourcing the trust building process and with relevant gatekeepers by delegating negotiations to local partners who may also provide a better understanding of the situation. Building and maintaining formal and informal relationships with work colleagues, medical travel facilitators are able to significantly smoothen processes in everyday business by helping each other out and mutually supporting the interest and efforts of each other. Uniting different stakeholders working in the same business by forming associations also act to generate smoothness by counteracting difficulties, trying to find solutions for existing problems and advancing common interests that improve the work and experience of the different parties involved.
6.2 Communicating

Communicating is a fundamental form of interaction that is relevant for much of medical travel facilitation. It is closely entwined with ‘connecting’, but whilst the focus in the previous sub-chapter was on establishing contacts and building relations, this sub-chapter focuses more specifically on the practicalities of using certain communication technologies and language translation and how this relates to smoothness in medical travel facilitation. These two sets of practices are of particular importance for mediating transnational healthcare (TNHC) and the way in which communicating acts to generate smoothness may be insightful for other transnational phenomena as well. The first section looks at WhatsApp communication and suggests that smoothness is already built in in certain media, but that this potential requires clever handling in order to accommodate ambivalent requirements toward smoothness. The second section looks at some of the aspects of medical interpretation as a smoothing manoeuvre and it raises the question of what level of smoothness can be achieved and if in some cases translation might even be too smooth.

6.2.1 Purposeful handling of communication media

Information and communication technologies (ICT) are constantly used in the context of transnational healthcare and in particular, mobile phones and applications, such as WhatsApp, are indispensable. Based on the experiences of job shadowing and interview data this is due to multiple factors: 1) people involved in transnational healthcare are often dispersed across distant geographies; 2) a certain unpredictability of healthcare matters, which require the frequent communication of updates and adaptions to a patient’s case; 3) modes of medical travel facilitation rely, to some extent, on flexible arrangement and in situ finetuning; and 4) arguably it is also related to a certain culturally conditioned style of communication. ICT has fundamentally changed the ways people interact over the past decades; it permeates most areas of life and became important in healthcare, for data management and communication. In the discussion of more conventional and also new approaches to “Everyday Technology in Healthcare”, the authors establish that the “use of digitally enabled technologies facilitating exchange of clinical and administrative healthcare is generally accepted, offering value to all actors operating within healthcare environments” (Hayre et al. 2020, p.6). Many healthcare organisations make use of such technologies: “Information technology (IT) is increasingly being used to facilitate the communication of information across healthcare teams
and groups with the aim to make the delivery of care safer and more efficient” (Cresswell et al. 2010, p.1). There are different studies that analyse the use of, for example, WhatsApp as a communication medium among groups of healthcare practitioners for internal communication (Kamel Boulos et al. 2016; Nardo et al. 2016; Johnston et al. 2015). This particular social media application was found to be a “viable medium for sharing and discussing clinical cases and medical and health knowledge” (Kamel Boulos et al. 2016, p.1). Telemedicine refers to “the delivery of health care and exchange of health-care information across distances” (Wootton et al. 2006, p.4) and is concerned with ways in which ICT can facilitate virtual interactions with and patients. It has evolved as a revolutionary development in healthcare when it was being introduced and used more frequently around the early 2000s. For its reach and overcoming the need for copresence between patient and healthcare professional that is not always possible, ICT have come into use to facilitate medical travel (Hong 2016; Mishra 2014; Duclos 2014).

Another strand of literature engages with the use of everyday modern communication technology as a way of receiving and giving care among transnational communities of families and friends who are physically separated, mostly by migration. In this context, communication media such as Facebook and WhatsApp are seen as “Multi-Directional Transnational Care Bridges” (Plaza & Plaza 2019, p.11). In her recent publication, Ahlin (2020, p.69) finds that “everyday information and communication technologies (ICTs) are key members of transnational care collectives”, actively contributing to the generating and delivery of care. The following section, however, does not focus on communication among family members as much of the migration literature does but will explore how intermediary brokers come to engage in care using these established communication media. Moreover, the analysis is guided by the question on how certain media and its clever handling act to generate smoothness in transnational healthcare.

Based on this research, it was found that an element of smoothness is already built into the communication media most frequently used in medical travel facilitation between Oman and India, namely mobile phones and the application WhatsApp. Their features allow for certain modes of communication. Mobile phones can be carried around easily and make it possible to connect from anywhere, as long as there is network connection and the phone is charged with energy. To ensure their availability over phone, most facilitators carry two or three phones with them at the time and power banks. All sensible precautions given their extensive use of mobile phones. WhatsApp, found to be by far the prevalent application used to communicate, has several benefits over other forms of communication: Firstly, the easily accessible application uses Internet data and thus allows for communication that spans across different network providers, without roaming fees that apply in conventional text messaging. Secondly, different modes of communication are enabled through the application such as text and voice
messaging, as well as audio and video calls. It also supports data sharing: photographs, documents and links can easily be shared with a range of others, which facilitates, not only communication, but also the processes that draw on these kinds of data. Access to these applications and the use of mobile phones, allows all of the individuals involved in medical travel facilitation, to take pictures and scan documents instantly, from anywhere, for example, to share medical images, including photos of medications or scans of the body. Thirdly, the chat-style communication and the ability to create group chats, allows for different group constellations to communicate easily, which is helpful when working in a team. Internal communication among the team members of medical travel companies or for hospital staff is often organised in group chats. This allows individuals to quickly inform and update multiple team members simultaneously, share documents, give a briefing before handing over patients from one unit or case manager to another, or to follow up with other stakeholders involved in facilitating medical travel. Furthermore, the group chat option is used to spread information or send promotional material to a large group of people. In the previous sub-chapter, it was outlined that Rashid informed his community about medical travel events using WhatsApp and the organisers of Advantage Healthcare India also commented on the usefulness and efficiency of WhatsApp and social media as platform for communication. All things considered, the interviewees agreed that communication technologies, in particular, WhatsApp, greatly facilitates their job and medical travel, in general. One of them goes as far as saying it can be lifesaving:

   Earlier, to get in touch with the patient or when there was a query, to send it to another country to get a doctor’s opinion, it wasn’t that easy. But nowadays it isn’t the case (…) It really facilitates certain things and saves the lives of many. (I.69)

It is evident that the widely accessible application is easy to use, and it makes communication between members of the ‘care collective’ (Ahlin 2018; Winance 2010; Mol et al. 2010a), even if dispersed over long distances, quick, varied, efficient – and thus smooth. Communication with everyday technology and media such as WhatsApp hold a disposition to smoothness, enabling a certain style of communication. It offers a way to communicate across different healthcare institutions and to circulate data between data management systems that are likely to differ from one place to another. This in-between space is being shaped and to some extent owned by medical travel facilitation and the diverse technologies and people that engage in it and hold a powerful position – and smoothness comes at a price.

Data protection and confidentiality of sensitive personal and health data is strictly regulated in the healthcare domain through different protocols and data management. However, the use of group chats and WhatsApp in general for sharing medical data in the process of medical travel facilitation through the involvement of third-party intermediaries raises questions. In different
instances this kind of circulating data shares it with people who do not need to know certain
details and it is questionable if patients are aware of possible consequences if they share con-
fidential information freely in group chats or not encrypted media. Such concerns seem to be
outweighed by the practicality and easy use of this application and communication style, and
also the urgency with which information needs to be processed in certain situations; more on
negotiation of different ethical values in Chapter 7.
In terms of smoothness, the argument here goes further than acknowledging the importance of
these media for having a disposition to enable smooth communication. I prop-
ose that it is the
clever handling of different modes of communication and media that constitutes smoothness
as a manoeuvre that translates this potential into the smoothness as an outcome of TNHC. The
following four examples explore how certain media can both increase or disrupt the smooth-
ness of communication and show the importance of assessing the situational circumstances
carefully.
The first example of smoothness as a manoeuvre means communicating different type of data
differently, depending on the content and its relevance. The manager of the international pa-
tient department in a hospital in Kochi explains:

Direct patients they call us through WhatsApp or mobile and we say please
send us the [flight] ticket. But in WhatsApp we don’t receive medical re-
ports. Because see, medical reports are something that we have to say, yes,
we have received the medical reports form the patient. Doctors usually
won’t check medical reports in WhatsApp. So, they prefer to send it though
mail. So, we learn to ask the patient to send it through email. (...) If there
is an immediate report that needs immediate response, then we talk to doc-
tors. (I.7)

The interviewee makes clear that they differentiate between different sorts of data that are
handled differently according to the value of the data, the preferences of the actors involved
and the urgency in communication. Moreover, they always have a plan B ready. Whilst flight
details and general enquiries are handled on WhatsApp, doctors request that medical reports
are sent via email. It seems that this differentiation is made according to the importance or
purpose of the data, as well as the preference of the doctors. Medical reports contain sensitive
data and constitute the base of the treatment plan and the billing at the end of the process.
Receiving these reports via email provides the hospital administration with proof of the records
and this means that they can be filed correctly. Additionally, by receiving these reports via
e mail doctors can access them on their computers, rather than their mobile phones, meaning
they have a better overview of the documents. Where matters are urgent, exceptions are made,
and facilitators revert to speaking to doctors directly or via the phone.
The second example shows that smoothness as a manoeuvre has a certain temporal component, which means choosing the communication media wisely with respect to the level of detail it provides and the options to file the data at least in the medium term. Voice-messages and email, for example, differ greatly, as information shared via voice messaging are unable to be retrieved or filed easily. One of the International Patient Managers in a hospital in Kochi reflects on the advantages and disadvantages of voice messaging saying:

人民 do not even text anymore but use the voice recording to make the pictures and requirements clear. It is a much simpler but then I need to go back and check the details in the spoken messages. (I.10)

The interviewee refers to situations whereby patients have sent medical images via WhatsApp and then comment on them using voice messages. The advantages of doing this is that information can be easily and quickly recorded and consumed, and it allows patients to provide significant amounts of detail. However, difficulties arise later, when the facilitators in the hospital or doctors need to scroll back through the chat history and replay the messages, having to search through them for specific pieces of information. Furthermore, the information cannot be easily filed for administrative purposes. There is therefore a discrepancy between the practicality of recording the message and the practicality of handling the data afterwards. The smoothness of the communications changes over time and its quality is situational.

The third example shows that choosing communication media cleverly conjures professionalism or a certain informality that both can act as smoothing manoeuvre. The same interviewee that was cited before adds that the majority of communication with facilitators and patients is via WhatsApp, despite the fact that he likes to “keep it professional” (I.10) and also uses email. Different interviewees express that using WhatsApp allows for a certain informality within the communications and exchanges between doctors, patients and facilitators and may sometimes be considered as less professional. This informality, as previously mentioned (see section 6.1.3), shapes communication and relationships between people, which can have both positive and negative effects. A more informal and direct style of communication may be beneficial for smoothing communication between colleagues and for building rapport and trust with the patient. Being able to access an application such as WhatsApp on the smartphone anywhere at any time enables a certain virtual co-presence and the integrated option for more personal and intimate ways of connecting through video calls and voice messaging make such applications popular media to interact with family members and friends, and as a way of giving and receiving care and support (Ahlin 2020; Plaza & Plaza 2019; Ahlin 2018; Baldassar 2016).

Medical travel facilitators consider such direct and instant ways for communication integral for maintaining the relationship with the patient, both when located in another country or when they cannot be with them, for example because they are busy with another client. Reaffirming
their support and reachability over phone, literally 24/7, is considered to be very important by most facilitators. One reason is to finetune the logistics of transnational healthcare but just as important seems to be that they can provide emotional support whenever the patient is in need. Being temporarily one of the close members of the patient’s care team, medical travel facilitation often requires emotional labour that is sometimes carried out without face-to-face contact, enabled through such personal and less formal communication media. However, in some instances such informal modes of communication are considered to be less adequate. In the business context, they can give the impression that facilitators may not take their job very seriously and that some data or information shared is less substantial or binding. These reflections show that balancing professionality and informality and making use of the strengths of different media in the right moment is a manoeuvre that makes communication smoother.

The fourth example illustrating the importance of choosing an adequate medium of communication to make interactions and processes smoother suggests that the availability of the recipient towards certain modes of communication and the urgency of the given situation are two important factors to consider. This is because different ways of communicating are suitable for different situations. For example, in some situations somebody can answer a phone call, but is unable to respond to text messages. Whilst driving for example, communication via phone call can continue if a hands-free car kit is available. Alternatively, someone may not be able to take a phone call but can respond to a text message. Doctors may be able to take a moment to check their text messages or photos received, for example, when the interpreter is speaking to the patient during a consultation. Whilst shadowing facilitators, it was evident that they were carefully choosing and switching between different methods of communication, based on the given situation. Understanding which method of communication is suitable and purposefully choosing one over another, can make interactions much smoother. This is especially relevant if a response is urgently required, with regards to a patient’s health, and one can speed up the process by choosing the right medium of communication in that given situation. The facilitators’ ability to handle different medias and modes of communication appropriately, suggests they can actualise the potential for smoothness, which is already available as a disposition.

This section suggests that the prevalent media of communication that are currently used for medical travel facilitation hold a disposition for smoothness. Moreover, some applications such as WhatsApp have also been approved for the provision of care over distance for the immediate and personal communication and the frequent checking in that they allow from anywhere. These technologies thus respond well to the requirements of mediating TNHC, both for finetuning logistics of travel and treatment and also supporting the patient throughout the process. In particular, mobile phones and applications such as WhatsApp, enable a relatively
immediate, rapid and efficient exchange of information and data, as well as allowing communication in groups and communication across borders and network providers, without additional costs. These features are essential for bridging spatial distance and mediating communication in situations that involve multiple actors or which require quick turnaround times and situational finetuning, which are common in travel and healthcare alike. Nevertheless, purposeful handling of these means of communication is required to make use of this potential. This means that the media, mode of communication and form of data should be chosen according to the situation, the preference of, or availability of the recipient and the urgency of the situation. Finding the most adequate means of communication often involves some tinkering with the different options available and learning over time. Different actors have diverse conceptions of smoothness; patients and facilitators may prefer to interact with doctors and hospital staff through WhatsApp, because they can easily share information anytime and from anywhere, using their mobile phone. In contrast, for the hospital staff, smoothness may be achieved when clearly defined channels are used to receive, distribute and file information. Having a sense of what communication medium is the most appropriate in a given situation, in terms of availability, reach or style of communication and making choices accordingly also acts to smoothen communication, by speeding it up and being more target oriented. Furthermore, the findings indicate that smoothness has some element of timeline; some practices may act to generate smoothness in the actual moment (e.g. sending a voice or text message on WhatsApp), but then lead to complications – or roughness – long term (e.g. difficulty to trace information or to file data properly). It is suggested that with their clever handling of communication methods, medical travel facilitators may also influence future smoothness in mediating TNHC. Their ability to appropriately use technology mediated communication is indicative of their reachability, approachability and professionalism.

6.2.2 Translating across different languages and registers

A critical roughness of TNHC are language barriers, which makes language translation one of the key concerns for medical travel facilitation in order to smoothen communication in multicultural settings. Medical interpreting is a necessary practice specific to medical travel, but it applies also to other healthcare settings with transnational character: sometimes “the patient is a migrant, refugee, tourist or temporary visitor, in other cases, the member of an indigenous or long-established minority” (Schouten et al. 2012, p.312). Medical interpreting has evolved as a specialised field that responds to the specificity of medical terminology and the requirement to translate across different registers of language. In medical consultations that require ad hoc translation, language translation and conveying medical genre may be further complicated by other socio-cultural peculiarities, emotionally charged situations and the need to
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negotiate the doctor-patient relationship. Cross-cultural communication in healthcare and nursing result in a complexity (Montalt-Resurrecció & Shuttleworth 2013; Schouten et al. 2012; Gunaratnam 2008; Hudelson 2005; Robinson 2003; Davidson 2001; Pöchhacker 2000) that cannot be fully addressed here. One aspect, however, will be analysed in the following sections, namely the ways in which language translation as an important practice of medical travel facilitation (Suryanarayanan 2017; Fallah & Akbari 2017; Kaspar 2015; Penney et al. 2011) acts to make communication smoother.

Some medical travel facilitators are aware of the double challenge posed by medical interpreting and they produce an ambivalent picture of the issue. On the one hand, they acknowledge that language barriers hinder communication between patients and medical staff and they promptly find an interpreter to resolve the issue. On the other hand, some of the facilitators seem to be aware that sometimes the extent to which this roughness can be mitigated is limited and that translation does not provide a satisfactory solution. This ambivalence is evident in the statement from the manager of the international patient department of a hospital in Kochi. First, she says: “Communication works, it is, the patients that come over here they don’t need to speak in English. We have translators.” (I.7) Then she concedes that some difficulties cannot be resolved, in situations whereby staff, patients or interpreters, communicate medical issues in a language other than their mother tongue:

Some patients they speak English but when it comes to medical pain, they also find it difficult to express, also the local translators speaking English. They speak English but the medical thing this has to be – see, if some doctors explain to me some medical terms, it will be difficult for me to understand. But if it is in my mother language which is Malayalam mother tongue it will be much easier to get understood. People don’t know English nor Hindi, in English language the medical terms are difficult. So, we have translators. It is not that the patient needs to request. It is normal thing. (I.7)

Offering a translation service in hospitals can solve patient’s queries and concerns to a certain extent. Translation allows communication to be possible in situations where it may not have been before. However, the difficulty of conveying health-related sensations and fully understand a doctor or medical staff’s communications still remain. Smoothness in the communication in which foreign languages are involved seems to be only achievable to some extent. As noted by the interviewee, interpreters also face difficulties when it comes to translating, due to the technical medical language that operates through scientific vocabularies and knowledge systems that are shared by medical as a specific community (Wenger 1998b). On multiple occasions, translation is provided by a member of the hospital staff or a medical travel facilitator who is not specifically trained for a role within the medical field. As one of the statements
in a previous section (6.1.3) showed, medical travel facilitators are only rarely introduced to the medical register, acquiring words or phrases in the consultations they facilitate and building up their knowledge over time. Nevertheless, a few of the facilitators with experience in the field seem more confident in discussing health problems and treatment details using adequate terminology. In some cases, they are able to identify the medical speciality and the respective doctor that needs to be contacted, or even provide a preliminary diagnosis after screening the medical reports. A medical travel facilitator in Muscat, who has a background in Social Sciences but over thirty years of experience in TNHC, laughs and says: “People say I am more than a doctor! After handling thousands of patients, reading their reports, reading opinions of the doctors. So, you get to really know.” (I.14).

Hayward et al. (2003, p.116) explore different aspects of “becoming a translator” and they discuss practices of mimicking and imitating, asking the rhetorical question: “What is a medical translator doing, but pretending to be a doctor or a nurse?”. The facilitators’ knowledge, acquired in the medical field, is just one of their many skills which generate smoothness within medical travel facilitation by reassuring patients and building trust. Some of the interpreters seem to be convincing and patients may not even realise that their interpreter is not from a medical background, which can mislead their perception of the quality of translation.

Interpreters are in a powerful position within their role and as “interactive participant[s] in cross-cultural communication”, invested in mediating communication as “co-constructors of knowledge and meaning-making symbols” (Montalt-Resurrecció & Shuttleworth 2013, p.14). During a consultation, interpreters need to simultaneously listen to both the doctor and the patient, whilst also attempting to understand the medical matter and translate that accordingly. This means that making immediate decisions about should be said and what can be filtered out, and about how to convey the meaning behind what is being said, whilst balancing understandability and simplifications with complexity and accuracy. A study by Fallah and Akbari (2017, p.2) identified “omission, personal interpretations, replacement, and wrong usage of medical terms” as the most common mistakes “committed by non-professional interpreters” in medical contexts. Such errors can have drastic consequences and the marketing manager of a hospital clearly states:

Speaking a language is not the same as knowing a language. Only when you use a language regularly you get to know it. Otherwise it is difficult.

There are communication gaps. And errors can be fatal (I.10)

Translation across different languages and registers therefore constitute a balancing act of smoothing communication. Depending on the skills of the interpreter with regards to their level of language and the degree of his or her intervention in terms of simplifying translations,
different levels of smoothness can be achieved during consultations. Communication may be particularly smooth if everyone involved shares a certain understanding of the subject matter and are able to navigate different knowledge systems and to communicate adequately. However, communication may also be smooth if complexity is kept at bay and medical matters are communicated using simple words. There is a danger of overcomplication and oversimplification. The smoothness it allows in the situation can have negative consequences that may only surface later on in the process. Therefore, it is possible that communication is ‘too smooth’ or ‘not smooth enough’ in certain circumstances.

Moreover, I suggest that smoothness is not necessarily ‘good’ or desirable. For example, if complex matters and critical details are bypassed, for the sake of understandability and speed of processes, translation may be too smooth and oversimplified. On the contrary, translation may not be smooth enough if processes come to a standstill, because the patients are overwhelmed by the amount of information and level of detail, or if the interpreter is lacking the translation or language skills needed. In all these cases, medical travel facilitation misses the target if it does not provide the patients with the ability to make informed decisions. Such negotiations around what is considered good or ‘good enough’ is further explored in the next chapter (7).

Whilst translation and interpreting are critical in consultations between patients and doctors, the data from shadowing and interviewing shows that they are also important for smoothing processes in many other situations. Having an individual on site who is able to speak the patients’ language, can build trust and make patients feel more comfortable. The manager of the international patient department in a hospital in Delhi is convinced that the interpreters provided by the hospital also have a calming and trustworthy effect with their presence: “If we find someone who speaks your language, you get relaxed through mind also you trust that person in a better way” (I.48). This indicates that “communication involves more than simply the transmission of messages” (Leszczynski 2015, p.740). It is not only about the language and translation work in itself: “Translation is about language, but translation is also about culture, for the two are inseparable” (Bassnett 2007, p.23). Language is also a cultural connector (Riley 2007) and communicating with a translator means to connect on more levels than just a linguistic one, which, as the interviewee says, helps to make international patients feel more comfortable and cared for. However, the issue is that the availability of interpreters in the hospitals is limited and the need for an interpreter in consultations with the doctors is prioritised. This means that patients may not have a translator readily available, if they need to communicate with a nurse or other medical staff in other encounters. One of the interviewees describes this issue in the following way:

Let’s say there is a patient going to do a CT scan and the technician who is dealing with the patient who is not a doctor, any words that the patients
should be aware of, when to breathe, when to hold the breath and when to release, he can’t say that. He needs a translator. (I.48)

Another obstacle is that hospitals employ and provide interpreters who help with medical language translation only on site. Patients and their attendants are unable to use this service once they leave the hospital or when they need support with non-medical, unrelated matters. Getting help with translation may also be constrained by the physical space and the inability to be co-present in face-to-face encounters. As discussed in the previous sections, many facilitators working for medical travel companies or individually connect with their clients using their smartphones and communication media such as WhatsApp around the clock, also to help them with language translation in situations when they cannot be present with them. The manager of a medical travel company in Delhi argues that patients need to be provided with a ‘concierge service’, which would provide translation services beyond the medical field, which is important for handling everyday situations:

They [patients] know English or they don’t know English but outside the hospital they need support. It’s okay in the hospital but outside there are many barriers to them. They go, they are hiring a cab, or they are at the guesthouse and the staff they don’t know English. Or if they are taking some medicines, they need the support of the medical facilitators or interpreter as well, to get a genuine medicine. (I.55)

The commercial importance of smoothness, as an achievement and tradable service of medical travel facilitation, is also mentioned within this statement. Furthermore, it highlights how translation contributes to the smoothness of the medical travel processes. Firstly, medical interpreting acts as a smoothing manoeuvre that has an immediate effect in those moments of communication by translating between different languages and mediating different registers of language. Secondly, language translation may achieve a quality of smoothness that goes beyond the immediate situation of communication and extends to the proceeding of medical travel facilitation further down the line.

By exploring aspects of language translation in TNHC, this section has shown that medical interpreting is an important part of medical travel facilitation, which generates smoothness in different ways. On the one hand, medical interpreting acts as a smoothing manoeuvre in terms of facilitating immediate moments of communication, by translating between different languages and mediating different registers of language. On the other hand, language translation may achieve a quality of smoothness which goes beyond the immediate situation of communication and extends to the general proceeding of medical travel facilitation. Furthermore, it is suggested that the quality of smoothness can be achieved in different degrees, with varying
Implications. Smoothness as an outcome or achievement may be limited, firstly, due to the extent to which roughness can be mitigated and, secondly, there are situations in which too little or too much smoothness may be generated. By exploring the smoothness of communications, question about the extent to which smoothness is achievable, desirable and considered to be ‘good’ were raised which are relevant, potentially also in other practices and contexts.

6.2.3 Conclusion

For different reasons, communication in TNHC is often highly mediated and medical travel facilitation is aimed at making interactions smoother – either in the immediate situation of communication or by conveying information that is useful for future interactions. The mobile phone and WhatsApp as the most frequently used application mediating communication by the participants were found to have a disposition for smoothing TNHC. The different features and modes of communication enables quick, direct and cheap exchange of information and diverse options for sharing data from anywhere with individual people or designated groups. Using the potential of such different modes of communication sensibly and in accordance with the given situation, context and communication partners, communication itself will be smooth for being target oriented and supported by adequate media.

Smoothing communication is an integral aspect of successful mediations of transnational healthcare overall, and of providing patients with individualised support and care in face-to-face encounters and over distance. The use of communication media shows the cleverly thought through and situational adaptive practices of medical travel facilitation. The examples furthermore show that smoothness may be conceptualised differently by different people but what is important is that the individuals involved tinker with technology in an attentive and responsive manner, establishing some good practice while still remaining flexible to changing circumstances.

Language translation, especially in the medical context, is a practice generating smoothness by overcoming language gaps, interferences between different registers while also navigating the social, cultural and relational aspects of communication. The complexity of medical interpretation raises the question about achievable level of smoothness, the implications of its limits and also its normative stance (is smoother always better?). The examples discussed here showed that smoothness is a gradual quality. Different levels of smoothness can be achieved, and their adequacy is situationally contingent, which means that smoother is not necessarily better and vice-versa. More important is to find a way to advance processes, for example with language translation, as smoothly as possible but also without removing too much detail/roughness. This should be taken further in this analysis and could contribute to interesting debates around (un)desirable qualities of mediation work in various contexts.
6.3 Coordinating

The third set of practices that was identified in the empirical material as being particularly relevant for dealing with major roughness of transnational healthcare and for generating smoothness evolves around ‘coordinating’. Coordinating means “to make many different things work effectively as a whole” (Cambridge Dictionary 2020) and is thus a practice of aligning actors and actants purposefully in a way that generates a certain effect, which is calibrated on effectivity. In transnational healthcare, “the full potential of this sector requires strategic planning and coordination among key players such as hospitals, medical travel agencies, hotels, and the medical tourists themselves” (Mohamad et al. 2012, p.360) and the authors emphasise the contribution of medical travel facilitations in the industry. However, in much of the medical travel literature, ‘coordinating’ seems to be used almost interchanging with ‘facilitating’ or it is referring to overseeing travel logistics (Snyder et al. 2012; Turner 2011; Cormany & Baloglu 2011) without further unpacking the practice itself. In the following, the coordination work performed by medical travel facilitation is analysed in more depth to further the understanding of how different actors and actants become purposefully aligned in ways that make TNHC work effectively – or smoothly – as a whole.

The first section presents a vignette following a medical travel facilitator in Delhi coordinating an ambulance airport pickup for a patient. Slowing down the practices of coordinating happening on the ground gives insight into coordination work and how it acts to generate smoothness through anticipating, planning and adjusting in a given situation. The second section shifts the focus onto coordinating as a manoeuvre of mitigating existing issues and re-establishing smoothness and the importance of mobilising and aligning non-human entities such as documents and money for smooth mediation of TNHC.

6.3.1 Anticipating, aligning, timing

The fieldnotes presented in the interlude offered a first insight into the work of on-site medical travel facilitation as carried out in a hospital in Delhi. You may recall Nasim, the freelance medical travel facilitator buzzing around, assisting multiple patients simultaneously and coordinating his efforts with his fellow team members, doctors, other medical and administrative staff and the many patients that were on site and entrusted to his care that day. In the following vignette we are back with Nasim: We follow him along to Indira Gandhi International Airport in Delhi in the middle of the night in order to receive a patient who needs ambulance assisted transfer to the hospital.

Receiving international patients at the airport is a common practice of medical travel facilitation but only by stepping through it slowly brings out the complexities of coordination work
involved in this spatio-temporal manoeuvre that is conditioned by the peculiarities of healthcare and it being mediated transnationally. Managing travel logistics is often summarised in a few words only: medical travel companies “offer to arrange air travel and hotel accommodations” (Turner 2012, p.2), “Their roles as facilitators also included overseeing travel logistics, including arranging for visas and advising on which airports to use” (Snyder et al. 2011, p.532), or they “focus on making foreign medical care more accessible to patients through commodifying the medical experience and providing logistical support” (Dalstrom 2013, p.23), for example. Travel assistance or logistical support are rarely specified any further. For Nasim, however, coordinating such travel logistics seems to be a science in itself and he became a master in finetuning and optimising the course of action. After all it is about health he explains, patients have certain medical requirements, you cannot let them wait; the details matter. Because it is a patient who travels, making the transition from one place to another as safe and convenient as possible is a priority. Preventing interruptions in the process flow is important as this may result in delays, detours and at times also additional costs.

Given these peculiarities of coordinating the travel of international patients, medical travel facilitation acts to generate smoothness by anticipating difficulties and preventing issues. Nasim has planned the transfer of the patient in advance and made the necessary arrangement. Tonight, he is concerned with continuously checking in that everything goes according to plan and is invested in coordinating the ongoing contributions of the various actors and actants involved in receiving the patient.

*It is 1:45 am and Nasim is on the way to the international airport in Delhi to receive a patient who needs an ambulance transfer to a hospital in one of the satellite cities of Delhi NCR. While the driver navigates the traffic on that foggy night, Nasim checks the arrival time of the plane online and calls the driver of the ambulance provided by the hospital. It is tricky to coordinate the arrival of the patient, the ambulance and himself factoring in the traffic and the proceedings at the airport, but he has gained a lot of experience. He can estimate fairly well when to tell the hospital ambulance to leave for the airport, so it won’t be there too early or too late. (FN, 6.12.2017)*

The condition of the patient arriving tonight requires an ambulance shuttle service, first from the plane to the arrival at the airport and then from the airport to the hospital. In coordination with the flight status, Nasim makes sure that the hospital ambulance leaves on time. This is important because first and foremost, the patient should not be left waiting at the airport in his critical condition. Moreover, charges apply if the airport ambulance needs to wait for the hospital ambulance beyond a certain time window that is reserved for handing over the patient. Nasim learned about such logistics and processes as a learning by doing. The experience he gained over time allows him to anticipate and prevent issues today. Based on previous
mistakes or inadvertences, he developed some good practice in coordinating: he keeps checking the flight status and updates the ambulance driver and team who are receiving the patient in the hospital accordingly. The facilitator has developed some strategies to gain some more control over the situation at the airport and provide the patient with additional handholding.

Nasim makes another phone call and he is annoyed when it does not go through. I ask him what happened, and he tells me that he tried to call someone from the airline who is working on the ground at the airport. He says that he got to know this guy because he himself is flying frequently. He thought that connecting with someone who has access to the transit zone could be useful and one day they exchanged numbers. For a tip this man keeps an eye out on Nasim’s patients and keeps him posted about what is happening, whilst the patients and attendants are in transit. (FN, 6.12.2017)

This move of enrolling another person into the project of assisting the patients transfer is an example of the “resourceful creativity” (James 2011, p.319) that brokers may display in order to make a situation work. The facilitator attempts to make the patients’ experience smoother by routing them through the regulated space and administrative landscape at the airport and providing almost seamless handholding. Airports and hospitals are highly regulated places with spaces conditioned in certain functional ways that make their transition smooth for insiders who know how to navigate them and difficult for outsiders who lack knowledge or routine. Travelling as or with a patient is challenging and Nasim is making additional efforts to facilitate the transition at the airport as much as possible but success is not guaranteed. Delegating tasks to the airline’s ground staff at the airport involves additional coordination efforts but in turn allows to extend influence into a space that was previously inaccessible. This “trick”, as Nasim calls it, serves a dual purpose: It anticipates difficulties medical travellers may face in the transit zone, which could make them feel stressed and could lead to delays that affect the carefully planned course of action. Moreover, it is a way to connect with clients right upon arrival, which anticipates another issue, namely that of ‘snatching patients’ as Nasim explains later on:

We reach the airport about half an hour later. Nasim tells the driver where to wait and checks the arrival chart. The plane has just landed so there is still time to have a cigarette. Then, he hides the lighter in his sock, as you are not allowed to bring it inside the airport. “I will show you all the tricks”, he says and laughs. The next trick is to use a special entrance at the airport, which allows people to wait and receive the new arrivals inside the building instead of waiting with hundreds of others at the gates outside. It costs 100 rupees to get in, you need to show your passport and there is a security check. Nasim is joking with the officers. He sees them multiple times a week and knows them by now. The airport is busy, even
at night. In the arrival hall Nasim says: “You see all these people here? You just have to be there and speak to them [international patients] in their language and they will follow you”. For this reason, you have to receive the patient in person instead of sending the hospital’s driver only who waits in the car park. Nasim explains: “Otherwise someone else might ‘snatch’ him and who knows where they end up. I’m telling you; it happens a lot.” (FN, 6.12.2017)

Nasim draws on different kinds of knowledge and experience to coordinate the ambulance assisted transfer effectively: knowledge about travel routes and timing, about spaces that some people may find difficult to navigate such as airports, hospitals, foreign cities in general, or knowledge about processes flows and regulations. Importantly, he also has knowledge about the peculiarities of the business and is aware of the fraudulent practice at the airport. This allows to anticipate the issue of patients being ‘snatched away’ and to take measures that contribute to preventing patients from being misguided and facilitators from losing clients. Based on that he developed some good practice (e.g. regarding time management or tasks that he can delegate or not) and draws on tricks such as using another entry at the airport or enrolling a helper in the transit zone.

A man is heading towards Nasim; it is the person from the airline ground staff who is sometimes assisting his patients in transit but didn’t take the phone call earlier. With a big grin because his helper turned up unexpectedly Nasim shows him a photo of the patient and attendant on his phone, gives names and flight details and asks him to go and find them.

It is 3:30 am when he returns and brings the news that the patient and attendant are both waiting outside. He had troubles recognising the attendant because he shaved his beard and doesn’t look like on the photo anymore. On the way to the ambulance we meet the attendant and Nasim gives him a heart-warming welcome, takes his suitcase and guides him to the car. (FN, 6.12.2017)

Although Nasim could not reach the person from the ground staff at the airport by phone earlier, the man who he was able to unofficially recruit as a helper turned up just in time. Provided with a photo – again this is readily available at any time in anyplace on the smartphone and can be shared easily – but not without some struggles he was able to identify Nasim’s clients. This anecdote with the beard shows just how important certain details are and how easily the facilitation network can collapse, potentially creating confusion, delays, or, in the worst case the patient is lost to a ‘tout’. That night, however, everything goes according to plan and Nasim’s helper navigates the new arrivals through the different administrative steps and makes sure they are guided from the transit to the car park from where they will be shifted to the ambulance of the hospital.
Humans and non-human entities such as mobile phone, photos, contact numbers, passports, visa, cars, stretchers, planes, and much more become related through practices of medical travel facilitation. But to handle the arrival of the patient effectively, those different activities, actors and actants need to be attuned to each other and their working ordered in a sensible succession. The virtue of medical travel facilitation lies thus in coordinating the multiple practices that run in parallel, spatially and temporally in a way that smoothens the patients travel: While Nasim waits for the attendant in the arrival hall overseeing the whole process and connected with others over his phone, his helper guides the medical travellers through the special pathway of the patient immigration, the passport and medical visa they carry let them enter the country after the officers checked the documents. Meanwhile the hospital ambulance is approaching the airport, the team in the hospital is getting the room for the new patient ready and Nasim’s driver is waiting for his call. In order to make it work effectively as a whole, time management is of particular importance.

The airport ambulance driver is in a rush to hand over the patient. If the hospital ambulance does not arrive in the next five minutes additional charges apply. Nasim calls the driver and hands his phone over to the driver of the airport ambulance, so that the two can coordinate directly while he can move on to the next step. Nasim gets into the car from the backdoor to welcome the patient. He makes a few jokes to make the young man feel more at ease and in safe hands. Then, Nasim starts moving the stretcher so they can shift the patient over to the other car. As soon as it arrives, he gives directions to the men who all help to lift the patient. Nasim collects the handover forms and the patient’s passport before he sends the ambulance to the hospital and calls his driver. In a swift movement he pays his helper from the airline 500 rupees and around 4:30 am the driver follows the ambulance to the hospital. (FN, 6.12.2017)

This episode illustrates the importance of collaborative efforts in smoothing the transfer of the patient from one ambulance to the other on the one hand and on the other hand the benefit of having someone taking the lead in coordinating those efforts and holding the different practices together to work effectively and under time pressure. Nasim as the designated facilitator in the example is checking in with the other actors involved, connects them and gives instructions so that eventually everyone and everything is in the right place at the right time, set with the necessary documents or equipment, doing their assigned task. Having the lead in coordination, it is also upon the Nasim as the broker to prioritise different tasks and decide on strategies on how to complete them best possible (Zarazaga 2014, p.29) As the example shows, smoothness may be enhanced by money and there is an informal economy supporting medical travel. Alignment as a “aspect of coordination” (Hönke & Müller 2018, p.339) “requires the ability to coordinate perspectives and actions in order to direct energies to a common purpose”
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(Wenger 1998a, p.187). In the end, processes running smoothly are always a collaborative effort – and when it comes to mediating TNHC also a matter of saving lives.

In this vignette, smoothness manifests itself as both a spatial and temporal quality of the patients’ journey through airport passing by different administrative checkpoints, transportation vehicles and spaces, but also of the facilitation work. Medical travel facilitation acts to enrol different actors and actants, to align them and coordinate their activities in a timely manner that allows for a smooth transition through space and time, without interruptions or sudden changes. Knowledge and experience and the competences of individual actors and actants are skilfully employed in order to anticipate possible difficulties, taking preventative measures and developing good practice of handling processes. Such coordination work then combines established with flexible practices in order to streamline processes while keeping important leeway for fine-tuning were necessary.

6.3.2 Mitigating issues

As established in this chapter, coordinating different mobilities and keeping things running smoothly is one of the main contributions of medical travel facilitation in order to make transnational healthcare practicable and feasible. The mobility of patients is only possible when other circuits are running as well, before, after or simultaneously. Patient mobility relies on the circulation of information, documents, and also very importantly, money, among other entities. As the previous section showed, actors and activities are aligned in a certain way, following a particular order and succession, in order to mediate TNHC effectively. If the process flow is mixed up, for example because one mobile entity pre-empts another one, it may get stuck and affects other processes from running smoothly. This section takes such moments of failure into account: Bases on a vignette that illustrates moments in which effective alignment cannot be achieved or is falling apart temporarily, it is explored how practices of medical travel facilitation act to mitigate issues and eventually recreate smoothness.

Ananya, one of the managing directors of a medical travel company, seems to be stressed. She tells me about the current issue: One of the patients is travelling back to her country today with the 6pm flight and therefore needs to leave for the airport in about two hours’ time. To continue her treatment back home, she needs to bring the medicine from India. She needs medicine for 6 weeks and this is very costly at about $8000 per week. They are currently facing two difficulties: One is that pharmacies usually do not have that particular medicine on stock; it has to be preordered. And second, in order to purchase the medicine on behalf of the
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The patient in question needs to travel home at short notice for family reasons. The time pressure in organising her travel and the continuation of her treatment back home puts Ananya and her team into this particularly challenging situation. They need to solve the problem of organising the required medicine and money within a very limited time frame.

The unforeseen situation requires them to deviate from their standard protocols that have been established within the company. Instead of the routinised proceedings, flexibility and responsiveness are needed and the team starts tinkering with the options available in order to accommodate the new situation best possible. One of the difficulties is the dependency on other actors being reachable and willing to find a solution even if the normal order of things needs to be bypassed for the sake of helping each other out and keeping things running.

Ananya and her colleagues managed to organise the medicine sourcing it from different places: they called every pharmacy in their network and in sum got enough of the required medicine. They asked for it to be couriered directly to the guesthouse since there is no time to send someone to collect it from the various places. However, the issue with settling the bill is not yet solved: they are still waiting for the guarantee of payment, which is difficult to get within the couple of hours left before the flight. (FN, 5.12.2017)

Having multiple pharmacies in their network allows them to get enough medicine ready by the time needed, which shows again that having connections and choosing the right medium for communication matter. Whereas an individual patient would probably get stuck in a situation like this, the team of facilitators can mobilise their knowhow, resources, network and experience to handle the extraordinary situation. This explains the benefit and power of medical travel facilitators: “the power of brokers depends upon their capacity to identify and access resources – from goods, to contacts, knowledge and/or information – that are desired by one actor or set of actors, and that another actor can provide” (Hönke & Müller 2018, p.337).

While the medicine could be sourced practically, it remains difficult to process the financial side of it. An employee is in touch with someone from the insurance company, but the guarantee of payment can only be issued by one of the managers who is currently unavailable. The facilitation company needs to make a decision; can they take the financial risk of paying for the medicine before having the guarantee of payment? Or can they justify letting the patient go without the medicine or keeping her in Delhi until the financial issue is sorted? Which strategy is riskier? In the end, Ananya decides to personally call the responsible authority of the insurance company on his private number. She explains the situation and manages to get the guarantee of payment by email just in time to settle the bill with the pharmacies.
Intervening in the situation and making use of her personal contact with the manager of the insurance company who is in charge of making decisions, the facilitators can mobilise the required document or money respectively to solve the financial issue. However, in the meantime another issue turned up, and again it is about finances:

The manager of the guesthouse called the patients case manager saying that he cannot let the patient check out without paying for the room. It turns out that the woman and her attendant already spent all the money they had available for their stay in India. After speaking to Ananya, the case manager can provisionally solve the problem. The company decides to lend the money to the patient to pay for accommodation. (FN, 5.12.2017)

In order to mitigate this issue, the team of facilitators has to quickly react to mobilise money, both from the insurance company and from their own funds. The situation requires careful weighing up of what is the right thing to do in a given situation and then implementing the strategy. They decided to support the patient by lending some money to sort the issue quickly and also because they did not want to spoil the patients’ medical travel experience at the very end (more on this in the next chapter). Making the medical travel company, pharmacies, insurance company, guesthouse and patient work together in order to overcome the issues and recreate smoothness did not last for long. As it turned out, the patient’s journey back to her country was interrupted again just a bit later. Ananya gets another call, this time from the patient who is stranded at the airport:

Ananya gets a call from the patient who cannot pass emigration with the amount of medicine she wants to carry. At the customs they think the medicine is for trade. The patient forgot to show the prescription form the doctor in her name and the receipt of the bill, although she was advised to do so by her case manager. Ananya passes the phone over to the head of operations who advises the patient again what documents exactly to show. When the facilitator sees that the patient struggles with explaining the situation, the facilitator steps in to speak with the officer at the airport over phone. (FN, 5.12.2017)

Only with another intervention from the facilitator’s side, the issue could be solved right on-the-spot facilitating once again the patient’s onward journey. This vignette shows that although processes and protocols are in place, interruptions can happen any time and some sort of mediation from the facilitators side is constantly required in order to solve problems. Mitigating roughness thus constitutes another way of smoothing.

This vignette shows that human mobilities are closely interlinked with the mobilities of other entities such as money, medicine, passports, images, documents etc. If any of these entities get stuck or is not in the right place at the right time, TNHC may break down temporarily or even
completely. Practices of facilitation should therefore not only be concerned with managing people’s travels but also managing these other mobilities at the same time. It requires a lot of work of careful coordination and alignment given the number or entities involved in the whole circuit of medical travel, their dispersed locations, the simultaneity and dependencies. Although medical travel facilitators are proficient in doing so, anticipation and prevention do not always work enough to smoothen the process. Health related things and human beings still bear some uncertainty and may develop or react in unexpected ways that call for quick solutions negotiated on the spot. Sometimes smoothness requires tinkering and generates creative, risky, and unconventional strategies.

6.3.3 Conclusion

This section showed that ‘coordinating’ as the third practice of medical travel facilitation analysed in this chapter involves the previously discussed practices of connecting and communicating and yet draws attention to other aspects of the facilitation work that acts to generate a quality of smoothness. Coordinating has been analytically divided in anticipating (working ahead, establishing good practice, preventing issues), aligning (cleverly associating and positioning people and non-human entities in space and time), timing (managing time and overseeing the whole process) and mitigating issues (managing disruptions and difficulties and working around them accordingly). Exemplified by the carefully orchestrated airport pick up of an international patient by a medical travel facilitator and his associates it became apparent that smoothness is achieved by a combination of relatively fix logistical operations and ad-hoc practices of finetuning to respond, as a team, to the situation and processes as they unfold. The continuous effort and the attentive coordination of the facilitator in charge making the arrival of the patient as smooth as possible suggests that medical travel facilitation is not just setting up care but caring in itself.

This also applies to the different practices in the second section that looked at how medical travel facilitation responds to and acts to mitigate issues that could not be prevented. The examples show that unforeseen challenges require additional coordination work and that collaborative efforts, immediate actions and adjustments generate solutions that prevent patients from getting stuck in certain situations and the process flow from breaking down apart from temporary disruptions. Again, coordinating as in mobilising and aligning people, documents, money and other essential entities requires some tinkering in order to mitigate issues and re-establish a certain smoothness. With these practices, medical travel facilitation contributes in itself to the care of international patients.
6.4 Conclusion: making transnational healthcare feasible

This chapter zoomed in on connecting, communicating, and coordinating as three sets of practices that are integral to facilitating medical travel and to mediating transnational healthcare. The doings of connecting, communicating and coordinating proved to be particularly important for handling a number of different kinds of ‘roughness’ that healthcare as it is mediated between Oman and India poses to patients on an everyday basis – such as, for example, disconnect between different parties and physical distance between the members that have become enrolled in the care team of an individual patient, language barriers or disruptions in the process of treatment abroad caused by one actor getting stuck at a crucial transition point or bad timing. Slowing down those practices and unpacking different aspects of connecting, communicating and coordinating, multiple answers to the research question of ‘How do practices of medical travel facilitation act to create a quality of smoothness in order to mediate healthcare transnationally?’ were found, elaborating how TNHC becomes feasible, and moreover, suggesting that medical travel facilitation is an integral part of the care that international patients receive and that TNHC requires to run smoothly.

Medical travel facilitation acts to create a quality of smoothness by tinkering with different ways of managing ‘roughness’ such as mitigating, anticipating, bypassing, omitting and explaining. Especially practices associated with coordination work demonstrate how difficulties are anticipated and bypassed by careful planning and aligning the many actors, non-human entities and practices that mediate TNHC in a sensible and well-timed manner. This starts even earlier by making connections with relevant actors, shaping the qualities of these relationships and maintaining rapport so that processes can be handled smoothly by the collective involved. A sensible use of different means of communication can likewise contribute to make communication and, as a consequence, processes smoother. Applications such as WhatsApp support quick interactions between individuals and groups of people which helps facilitators to closely monitor and adapt processes, all of which is conducive for smoothness. Such manoeuvres of counteracting roughness, and at the same time working towards smoothness in an ongoing process of adapting to different situations and making efforts as a collective of different actors invested in mediating transnational healthcare, however, usually come with a cost. Creating smoothness may require paying less attention to some details than to others or to accepting a compromise instead of losing time and energy working towards an ideal solution. The modality of these practices resonates with the idea of a “persistent tinkering in a world full of complex ambivalence and shifting tensions” (Mol et al. 2010b, p.14), a prevalent conceptualisation of care in STS literature. The concern of medical travel facilitation with “how various actors (professionals, medication, machines, the person with a disease and others concerned) might best collaborate in order to improve, or stabilise, a person’s situation” (Mol 2008, p.23)
suggests that these practices of socio-technical mediations are not simply setting up the logistical infrastructure to provide medical care to international patients but that they are in themselves a form of care for international patients. However, care is an “affectively charged and selective mode of attention that directs action, affection, or concern at something, and in effect, it draws attention away from other things” (Martin et al. 2015, p.11) and by shaping this care medical travel facilitators thus hold critical agency.

This chapter also advanced the empirically driven elaboration of ‘smoothness’ as a relevant aspect of medical travel facilitation and a productive conceptual tool. Throughout the analysis smoothness has not only been considered as an outcome of tinkering and engaging in connecting, communicating and coordinating, it has also been discussed as a disposition and spatio-temporal manoeuvre. Based on the data, smoothness seems to be already built in into some of the practices of medical travel facilitation and the different ways in which they shape and form the socio-technical mediations of TNHC. Certain communication media, for example, are conditioned to smoothen communication with applications prompting certain ways of interaction, and as an effect of effective communicating, smoothness in the process further down the line is being laid out. Translating smoothness from a disposition or a potential into an overall outcome of medical travel facilitation suggests that smoothness may also act as a spatio-temporal manoeuvre. Medical interpreting, for example, is such a manoeuvre that enhances smoothness in the immediate communication encounter and the overall process, or the continuous and timely management of interactions over distance with technology. Smoothness as a disposition, manoeuvre or outcome of medical travel facilitation thus becomes a quality – and criteria – of medical travel facilitation, and thus, possibly, of care more generally.

Moreover, virtues such as attentiveness and responsiveness but also competence and responsibility that are integral to the conceptualisation of care in care ethics (Tronto 1995) proved to be guiding principles in those everyday practices of medical travel facilitation analysed in this chapter. The next chapter will analyse these principles of care ethics further in terms of interpersonal relationships and the complexities they open up for discussion. Based on the relevance of smoothness for making transnational healthcare feasible and the discussion of smoothness as a quality that furthers the conceptualisation of medical travel facilitation, also as a form of brokerage, I propose that smoothness may also become relevant as a normative category in the conceptualisation of care. I will return to this suggestion in the conclusion after discussing some of the ethical complexities involved in mediating care and creating smoothness in the next chapter that is concerned with the ways in which different ‘goods’ of medical travel facilitation are being negotiated and what this tells about care as an ethic.
7 Negotiating ethical complexities in transnational healthcare: working on a good enough compromise

After following the practices of medical travel facilitation, in how they articulate and relate spaces making transnational healthcare possible and analysing how everyday practice of mediations work towards smoothness to make it feasible, this chapter looks at how medical travel facilitation acts to make transnational healthcare ‘good’, or rather ‘good enough’.

By studying the practices of medical travel facilitation, it became apparent that medical travel is actively mediated, shaped, and changed along the way, in a tinkering manner. Multiple actors are involved in this process and they are not neutral in doing so, but instead they hold certain agency in transforming and shaping the course of action. Given the need for continuous tinkering and the involvement of multiple, spatially dispersed actors, realising healthcare transnationally is not a straightforward endeavour. Different interests and values need to be negotiated which is challenging and ethically complex. This chapter centres around some of these ethical complexities and the ways in which they are being negotiated through practices of medical travel facilitators. Therefore, some of the critical moments and aspects of transnational healthcare, that the empirical material offers, are analysed with regard to the interviewees’ reasoning and logic and what that says about care ethics. This analysis is guided by the third and last research question:

How do practices of medical travel facilitation negotiate ethical complexities involved in transnational healthcare?

In line with the proposition, to view medical travel facilitation as a form of care in itself, rather than just a service to set up medical care, I draw on the literature on care in STS and the ethics of care. This can illuminate aspects of medical travel facilitation, which have so far been back-grounded and can work through some of these complexities and negotiations. Remaining true to the empirical path, whilst also attempting to feedback into the theoretical discussions with some empirically developed suggestions, I follow Raghuram’s (2016, p.524) view that geographers should build “care ethics back up through a deliberate and sustained engagement with their empirical research”.

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The first section breaks down how patients select healthcare providers abroad, with the help of medical travel facilitators, which can be seen as one of the core practices of medical travel facilitation, but also one that is criticised by practitioners and academics. Stepping through different ethical issues, that oscillate around the four ethical values of care (attentiveness, responsibility, responsiveness and competence), illuminates different logistics and how they are made to relate.

The second section brings the relationship between patients and medical travel facilitators into focus and illuminates how facilitators negotiate tensions around their positions within the transnational configuration of market and the care logistics. Although these two sections discuss different kinds of ethical complexities and how they are being negotiated, both indicate the ways in which medical travel facilitation is concerned with producing good care, or rather, care that is considered *good enough* to realise it as transnational practice – good enough for patients to go down this route and good enough for facilitators to flourish in their business.

7.1 Selecting healthcare providers: between advising and letting patients choose

One of the difficulties that patients who consider treatment abroad face early on, is selecting a healthcare provider. Giving advice on how to select a doctor or hospital has become one of the core competencies of medical travel facilitators – or at least a common practice – as the notion of ‘competence’ needs to be considered more carefully. Revisiting and rethinking the practice explicitly, as a caring encounter, and analysing it from the viewpoint of the four ethical values of attentiveness, responsiveness, responsibility and competence (Fisher & Tronto 1990) highlights some of the complexities involved. The aim is then to illuminate the reasonings that guide this practice and how medical travel facilitators go about negotiating different motives. This allows us to extract some of the ethical complexities involved in medical travel facilitation, which at the same time, reflect some of the issues of TNHC in general.

7.1.1 The patient’s need for guidance in the decision-making process

What are the patient’s needs when it comes to selecting a suitable healthcare provider abroad? Patients who pay for treatment out of pocket are theoretically free to choose any healthcare provider and since their treatment options are not limited to any specific place, their possibilities are multiplied when it comes to transnational healthcare. However, they may be curtailed by aspects of practicability and the patients’ financial situation. Nevertheless, the numerous
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options and the difficulty of assessing healthcare providers abroad complicates the process of selecting a suitable provider, making patients “apprehensive about the practice” (Dalstrom 2013, p.30). Different studies point to the importance of word-of-mouth recommendation, social networks and facilitators in consulting patients in the decision-making process (see for example Bochaton 2015; Dalstrom 2013; Kangas 2002): “Once a decision to travel to a country had been made, the actual decision to visit a clinician or hospital relied in most cases on personal recommendation, referral or other direct connection” (Hanefeld et al. 2015, p.362) and many “seek help from medical travel facilitators to avoid critical preparations of finding reliable providers” (Mohamad et al. 2012, p.360). Questions around patient choice leads right into the complex ethical terrain. Mol (2008) who questions the logic of choice and instead proposes a ‘logic of care’ argues: “choice may be a great ideal, but only in situations in which people are indeed able to make their own choices. When they are patients, people often lack this ability” (Mol 2008, p.6). The recasting of international patients in the course of “healthcare consumerism in which self-empowered customers make savvy choices, actively self-managing their care” (Sobo et al. 2011, p.129) raises questions about the consequences that such a “move toward patient empowerment” (Ormond & Sothern 2012, p.395) has for the patients, especially with regard to transnational healthcare. The actual situation of patients may be disregarded: “Market assumptions about the consumer – that she is rational, autonomous, capable of making a choice, and possessed of adequate information to do so – may not characterize the situation of people in care settings” (Tronto 2010, p.159).

The patients’ lack of competence in the medical domain, the overlay of multiple stressors given by the prospects of travelling to an unfamiliar place for treatment and the difficulties, specifically in selecting a suitable healthcare provider in the transnational setting, articulates a need for help and assistance within this regard. This may apply in all sorts of healthcare contexts, but in the case of translational healthcare the cost associated with this decision-making process is further accentuated; additional time and effort is involved in informing themselves about foreign healthcare providers and circumstances relevant to medical travel. Evaluating this information and accepting the risk involved in making a decision must also be considered. In this sense: “making choices takes a lot of energy, energy that not everybody has to spare or likes to spend on it.” (Mol 2008, p.4). Even more so, if there is a medical urgency and patients need to find a healthcare provider quickly, they may be unable to do the extensive research required to ensure good care. Patients may abandon the project of treatment abroad if they feel that they cannot find an option that seems good enough or they need to compromise on the level of control they hold in this process and delegate this task to someone with more competence.

Medical travel facilitators have identified the patients’ need for assistance in this endeavour of finding and selecting a suitable and trustworthy healthcare provider abroad and they have
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readily positioned themselves in this market niche (Dalstrom 2013; Wagle 2013; Turner 2012). With their articulation of medical travel as complicated and risky without their support and their depiction of patients as vulnerable and in need of help in order to make their endeavour successful, these companies might actually co-constitute this need (Hartmann 2017). From an economic point of view, raising awareness of the difficulties and elaborating the advantages of having a facilitator at their side, consolidates their position as brokers and makes a case for using their advice as a counselling service. Thinking beyond the mere exchange of information and shifting the attention to the relational constellation, the effects that the relation with the facilitator may have upon the patient in terms of making them feel supported and empowered, then observing and interpreting someone’s needs, is also a matter of attentiveness and care (White & Tronto 2004). Given that medical travel companies and individual facilitators professionalise such attentiveness and provide care in commercial settings, this means that the peculiarities of that type of relation in realising care (Barnes 2012c) and the fact that they “might have their own agendas in determining others’ needs” (Tronto 2010, p.163), need to be taken into account when thinking through this example, from a care ethics perspective.

7.1.2 Competence in decision-making and giving advice

Competence has two meanings: firstly, it is “the ability to do something well” or “an important skill that is needed to do a job” and secondly, it is defined as “the power of a person, business, court, or government to deal with something or take legal decisions” (Cambridge Dictionary 2020). It seems that the second presupposed the former meaning, however, the question remains: does the individual with the ‘power’ actually have the competence to use it? Similarly, the question to debate is whether medical travel facilitators, who hold the power to influence the patient’s decision in choosing a healthcare provider, actually have the competence to do so. From an ethical perspective, competence, the ability or skills to care, is one of the four elements on which good care is calibrated (White & Tronto 2004). The fact that most medical travel facilitators are medical lay persons, and yet they advise patients in their decision-making process of selecting healthcare providers, results in certain ethical complexities. Additionally, it results in confusion about which aspect of facilitation competence specifically refers to: it could be the giving of medical information, the matchmaking service or the caring for a person who is in a difficult situation – or actually all three aspects together.

The involvement of medical travel facilitators in the patients’ decision-making process in health-related matters is contested. To some extent, criticism is directed to the broker or third party agents in general, for profiting from the patient’s lack of competence in the medical domain, whereby facilitators may actively contribute to shape situations, in which their services are needed (Wagle 2013, p.31; Stovel & Shaw 2012, p.141; Lindquist et al. 2012, p.12).
Others question the facilitators’ competence in health- and medicine-related matters specifically. Drawing on earlier conceptualisations of medical travel as a niche form of tourism it has been argued that they “might have greater expertise in tourism than in medical affairs, and in many cases, they might not have any medical expertise or personnel” (Spece 2010, p.2). There is the “danger that potential medical tourists will make treatment decisions without the benefit of direct consultation with medical professionals and rely instead on the recommendation of facilitators who may lack medical training” (Snyder et al. 2012, p.5) and concerns with the quality of information provided by medical travel facilitators are raised (Lunt et al. 2010). A representative of the Oman Medical Association shares this opinion and clearly states that medical travel facilitators should not give medical advice:

Medical travel companies, you know, they are facilitating the things, but they should have a limited role for this. They should not give medical advice. They should only facilitate the things. The medical provider or consultant who is actually specialised should be licensed to process the things. And any consultation done, for example here in Oman or any country, and taken by the medical travel agency outside, should be done by a proper channel. It should be a centre who is licensed, and the doctor should be qualified and licensed in that country and they should be seen in a medical centre or a hospital. And not only in the office or by telephone consultation. (I.23)

The interviewee insists on the importance of professional and licensed consultants or healthcare providers to review the medical cases and counselling patients, finding that medical travel facilitators are incompetent when it comes to these matters. The way competence is circumscribed by the interviewee relating it to skills and knowledge (specialisation) and also formal qualification (license), shows that there are struggles over professional boundaries. Another interviewee who works as medical travel facilitator, but who is a doctor by training, agrees on this and stresses many times how his medical background and work experience in hospitals make him a competent advisor, in the healthcare domain, unlike his colleagues who are advising patients without having the necessary knowledge to do so competently: “Some people travel with someone they can’t trust. A taxi driver or travel agent cannot give you guidance, it’s a doctor” (I.8).

Medical travel facilitators without a medical background, which applies to almost all of the participants in this study, counteract such concerns. Competence is not static, rather it is continuously being developed and established. They stress on their longstanding experience in the field, through which they did not only build connections with reputable healthcare providers, but also learned a significant amount about the medicine, investigations and treatments. On
some occasions, they handle medical jargon with such ease and they discuss medical reports and possible treatment plans with patients so convincingly, that patients mistake them for doctors. The facilitator saying that he is “more than a doctor” (I.14) argues that he has gained enough knowledge to be a competent advisor “after handling thousands of patients”. He was not the only one who stretched his competence into other professions. Other participants showed messages in which they were addressed as ‘doctors’ by patients, or they report that some patients mistook them as doctors, which is almost presented as a proof of their competence by the participants, rather than being considered misleading. One of the managers of a company based in Muscat outlined his opinion on stem cell therapy and the current advances in research about chemotherapy, going into significant amounts of detail. Expressing astonishment about the level of detail, with which he evaluated the advantages and disadvantages of different therapies he says: “Actually, I sit with the people and they are calling me doctor. There are people still calling me doctor” (I.26) – this is despite his background as a technical engineer. Such conscious and unconscious blurring between different roles can mislead patients. This can result in a situation in which the facilitator considers themselves to have the competence and the power needed, when influencing patients’ decisions, without having the skill to do so, in terms of having medical training and formal qualification – a divergence that levels criticism at medical travel facilitators. However, assessing competence is complicated in many ways, which applies also to the assessment of doctors’ competence (e.g. technical competence, accessibility or caring competence). Competence might not even be recognised in the first place, and referring to care competence Raghuram (2019, p.620) highlights: “competence is not natural or obvious but is diverse because care itself is defined differently in different parts of the world”.

If we are, however, not focusing on giving medical advice but shifting the attention to the care work involved in supporting and advising patients in the process of selecting a suitable healthcare provider, then medical travel facilitators may be competent in doing so. Learning about medical matters on the job and having the knowledge about how to assess healthcare providers, about different players in the market and experience in supporting patients in this process is also considered to contribute to competence, albeit a different kind of competence. Interviewees draw on such experience in handling patient queries to justify their competence in assessing the market and actors in the industry:

Most of the time, we select the doctors. Because we have more experience than them [patients] and we know which doctor has more success rate, who has a lower budget, we know better. (…) We are here, I am working here since 2011 so we know which doctors in Delhi, which hospitals have the
better doctors, the best surgeon. I know the best doctor in cardio, neurosurgery. (I.61)

In this case, the facilitator compares his level of competence with that of his patients and thereby grounds his competence in how much better it is, compared to the patient. When considered within in the patient-facilitator relationship, competence becomes relative and it is calibrated on the patient’s incompetence, so to say, which reinforces the asymmetry often discussed in care relationships (Conradi 2015; Lynch & Walsh 2009; Henderson 2003).

Advising international patients by using one’s competence shows different ways in which this practice becomes ethically complex. Firstly, it raises the question of which elements of practice is competence refers to and then which skills are required to be competent. Does it refer to a service of relatively clearly identifiable scope or a caring practice in which the relational component is of particular value in itself? How are different types of competences negotiated? Can formal training be compared to experience gained on-the-job? Can competence be generalised or is its specificity that it is situational? It also raises the question of what it means if care competence is constituted relationally, as well as who actually assesses the level of competence and how. The fact that many patients put their trust in medical facilitators, in the process of arranging medical travel and finding a healthcare provider, suggests that their advice, help and care make them competent enough, in their perspective.

7.1.3 Interventions in the decision-making process

There is a relatively consistent pattern in how medical travel companies and the majority of individual facilitators participating in this study intervene in the patients decision-making process, of selecting a healthcare provider abroad; firstly, they respond to the patient’s enquiry and then they make a pre-selection of healthcare providers in their network, on behalf of the patient and shortlist a manageable number of around four to six. On some occasions, up to ten providers are selected, if they are considered to be suitable. Next, the facilitator allows the patient to select a provider themselves, from this pre-filtered list, based on the treatment plan and cost estimate that they provide (see also Chapter 6.1.2). Otherwise such a middle way between letting patients choose and respecting their autonomy and decisive power or even paternalism on the facilitator’s side has crystallised as a promising strategy. On the one hand, this allows facilitators to demonstrate their competence when it comes to screening healthcare providers and giving patients advice. On the other hand, they empower the patients, by allowing the final decision to lie with them. However, the question is raised, as to whether patients
are actually making their own decision? Again, practices on the ground provide insight into how these strategies of letting patients choose and giving them advice are actually negotiated:

Sometimes the patient tells the interpreter that they are from outside of the country and you know better, who is the better doctor. So, you select them. And we are selecting them sometime. Sometimes the patient has a picture or a profile of the doctor, so then we take them to that doctor. But sometimes I assist in selecting the doctor. (I.61)

When the interviewee was asked how often he selects the doctor, on behalf of the patient, he responds “most of the time, we select the doctors” (I.61). Although most interviewees stress the fact that they provide the patients with multiple options to choose from and they do not direct them towards a certain provider, many report that patients ask for their personal opinion and then they follow their advice.

I: Do you show the patients the options and then he or she decides?
A: Yes, yes. Or they leave it to me sometimes, many leave it to me: whatever, you decide for us. Because they know I’m in the field, so you can give the proper advice. I’ve visited hotels and hospitals, I know the area, so wherever I am sending the patients I have seen it all. And I know where he is going to stay and what is going to happen. (I.33)

With regards to how the decision-making process typically works, many interviewees seem to respond in a way that indicates that they are aware of it being difficult terrain and they felt the need to explain themselves. On the one hand, the facilitators seem to be aware of the principle of not influencing the patient’s decision too much (beyond the shortlisted options, which is already a considerable intervention in the decision-making process) and not ‘forcing’ them to select any of the suggested providers. This is either as a recognition of the patients’ autonomy or a mechanism to protect themselves, in case the patient is not happy with the healthcare provider or outcome and they make a complaint. On the other hand, actively shaping the decision also provides an opportunity for demonstrating their competence and strengthening their position as broker or mediator. This tension between letting the patient choose and giving their own advice is also negotiating a middle ground between preserving the patients’ autonomy and acting on their behalf of them, in a paternalistic way. It seems as if many of the facilitators feel like they have to justify their intervention in the decision-making process:

A: Then I will contact the patient with the summary of what is my finding [regarding treatment options and healthcare providers]. But I would never insist that you should go to that hospital or that hospital.
I: But you would give advice on which one to choose?
A: Yes, sincere advice. But advise that is based on money that is not a good advice. (1.26)

The interviewee is concerned with clarifying that the patient is free to choose. By considering whether their advice is sincere and good, or corrupted by money and therefore not good, this makes the interviewee explicitly aware of the ethically complex situation and the power involved in this practice. The fact that the facilitators advice may be biased, by the varying percentages of commission fees, paid by different hospitals, is a significant issue. Exploring the ‘ethical concerns about roles and responsibilities’ in relation to facilitators, Snyder et al. (2012, p.7) discuss the “potential for a conflict between the interests of the facilitators and those of patients”, if facilitators receive fees from the hospitals for referring international patients to their hospitals. Incentives of commission fees or other benefits are likely to distort the relationship between the hospital, the facilitator and the patient. Referring patients to the hospital that provides the best conditions may interfere with acting in the patient’s best interests. This is especially critical, given the trust that patients put into the facilitator, and the failure of integrity towards the patient given the “potential tension between their business interests and their role in serving as a patient advocate” (Snyder et al. 2011, p.531). Referring to them as “brokers – who prefer to be called ‘facilitators’” in his analysis, Spece (2010, p.1) evokes common negative connotations and stereotypes of brokers and criticises their business model, which is often not disclosed to the patient, or in some cases, it is only partly disclosed.

The interviewees explain that they consider multiple factors when shortlisting hospitals for the patients or when giving advice on which one to choose. Most interviewees say that the specialty of the hospital or the reputation of a certain doctor as an expert in this medical specialty field, are the most important criteria. However, fieldwork over an extended period of time and shadowing facilitators during office work shows that, in practice, the suggested hospitals often reflect the facilitator’s close network and their immediate geography. Whilst facilitators based in Oman tend to have partners in different cities and countries, facilitators at the destination site in India, are most familiar and closely networked with healthcare providers in the city where they are based. Furthermore, facilitators are likely to choose hospitals with whom they have had positive experiences, where they know the staff well and where they feel comfortable negotiating any issues that may arise. Multi-specialty hospitals seem to be preferred, as patients with different conditions can be sent to the same institution, which makes it easier for the facilitators to handle multiple patients on-site simultaneously. Through a positive feedback loop, frequenting a particular hospital strengthens the connection and contributes to the smoothness of future interactions.

Do such factors compromise the pre-selection or advice that medical travel facilitators provide? The answer is debated: it can compromise the patients experience, in terms of omitting
specialists or providers, with exceptional reputation, which may in some medical specialties provide the most promising solution in terms of medical outcome. Nevertheless, other factors apart from the medical proficiency may also affect the overall outcome of the medical travel experience and patients may benefit from them. If facilitators are on good terms with the hospital team, processes can be sped up and special requests are more likely to be granted. Being in a multi-speciality hospital can also be beneficial for patients, as it is not uncommon to discover further health complications, once patients are on site. It is then convenient to have different specialists available, all under one roof.

Despite the justified criticism of exploitative and unethical practices, medical travel facilitators also offer a value proposition, from which patients benefit, when in the hands of an individual acting in the patient’s interest. They provide a service and if it is done properly, it involves a significant amount of work, that should receive some sort of reimbursement. In this sense ‘broker fees’ can also be considered as “payments for actual services provided to both the tourists/patients and the foreign medical providers” (Spece 2010, p.21). Despite the criticism around those mechanisms of funding, medical travel facilitation may still provide a valuable service to patients and Spece (2010, p.3) outlines its “economic justification” as the following: “Many of these patients, moreover, would have no idea of whether or where they might obtain needed care without the involvement of medical tourism companies. These companies can only exist if they are adequately funded, and broker's fees might be the only practical way that a sufficient number of companies will be adequately funded”.

A somewhat different situation presents itself if patients are on the verge of making a bad choice or they are already committed to a less promising option, than what the facilitators would have suggested. Should they intervene, to the best of their knowledge and belief, or respect the patient’s choice? Facilitators report that, relatively often, patients hear of a particular doctor through word-of-mouth, from their neighbour, friend or relative for example, and they then ask to be connected to that same specialist. Many patients do not appreciate that their particular health concern requires an individual solution and a specific specialist and what may be right for one patient, may not be suitable for another. One of the Delhi-based facilitators shares such an example:

Some guests before they travel, they prefer to see the profile [of the doctors]. Sometimes their neighbours have been treated by those doctors and they prefer only those doctors. One of my patients came to Bangalore and he contacted me from there and he said, I need the neurosurgeon here [in Delhi] and I said, there is also a good doctor in Bangalore. But his neighbour said the one here was good. So, the doctor contacted me and said, I have a patient who wants to go to Delhi for the neurosurgery. So, we are
ready to help. We welcome the patient in the airport, and they came here and were treated here. Good surgery, they were happy, only $7000. Sometimes, even if it is more costly, they prefer the same doctor. (I.61)

In this example, the doctor in Bangalore and the facilitator in Delhi shared their opinion and suggested that the patient considers a different doctor to the one he had set his mind on. However, the patient evidently trusts the recommendation of his neighbour more than the competence of the facilitator. The facilitator has had to honour the patient’s wish, even if this results in further travel and additional costs for the patient. The chosen option was not the most appropriate, in his opinion, however, it is considered to be ‘good enough’. Another interviewee reports a similar experience and he seems to feel slightly uncomfortable in situations where his ability to act, according to his best knowledge and belief, is restricted and where he cannot fully support the patient’s wish:

Sometimes it is difficult to convince them [patients]. It is a psychological factor: if someone has something on his mind, let’s say that Hospital X is the best or this or that or something, they insist for Hospital X, some of them. But there are others who listen to the advice and listen and would like to go to any of the hospital that I recommend. People with some trust. But there are others who do insist. Because Hospital X in Y location is very famous in Oman. They say I want to go hospital X, Hospital X, Hospital X. But by and by they come to realise that there are hospitals that are even better than Hospital X. (I.33)

In this example, the projection of the competence of the hospital, interferes with how local facilitators assess the service level. Nevertheless, by insisting that patients reconsider their choice or trying to impose their opinion on the patients, medical travel facilitators run the risk of paternalism assuming “that they know better than care receivers what those care receivers need” (Tronto 2010, p.161). Excluding them “from making judgments because they lack expertise” (Tronto 2010, p.165), such an attitude “can smother agency and construct the recipients of care as weak and vulnerable” (Robinson 2011, p.108).

An extreme case, in which a strong intervention from the facilitators side may be considered as ethical, is when patients and attendants reach out to them with medical cases of diseases in an advanced state, in which treatment abroad seems to provide an unreasonable option, with very limited chances of improving the patients’ health. Here the interviewees agree that facilitators and doctors are morally obliged to inform the patients correctly and if necessary, to advise against medical travel. One of the facilitators in Delhi elaborates on ethical values in medical travel facilitation:
As I told you, a guideline is there, moral and ethical values mean, ehm see, the relation with the patient is started when they share the query. The patients share their query in the last state of onco[logy], and there is no cure, the patient share all the papers but there is no treatment available. There is no treatment available in the whole world. So, our moral values say that there is no treatment available. If you come, maybe there is a certain chance that you will benefit, maybe not. If there is no treatment available, we don’t say that you come and say there is a treatment available if there is no treatment (I.55)

Caring for a patient in such a situation involves clear communication, which does not raise false hope and firmly advises against medical travel.

A completely different strategy from the one that the majority of medical travel companies follow, which pre-empts the patient in the process of selecting a suitable healthcare provider, is followed by the Treatment Abroad Scheme of the Ministry of Health in Oman. If medical travel is facilitated by this institution, it is up to the committee to decide whether the patient will be offered treatment abroad, if there is no suitable solution available locally, as well as where and to which hospital they will be referred to. The committee consists of four doctors and the chairman, who is himself a doctor by training. After reviewing the case they send the reports to a selection of their hospitals, to obtain an opinion and a quote with regards to the treatment plan. Next, a committee meeting is held, to decide which of their empanelled hospitals the patient will be sent to. One of the employees explains how they are choosing the provider from the list:

It is according to their knowledge; they are picking the treatment plans. Sometimes they are similar, and it is easy to choose but sometimes it is complicated. So, it is better for the committee to choose. Then they decide, all this should be decided by the Treatment Abroad Committee, because they are the one who are responsible. Whether it is beneficial for the patient or not. And for us we have to ask for the feedback of the patient. (I.25)

In this case, the facilitating institution has full control over the whole process of choosing the healthcare provider on behalf of the patient and as the interviewee indicates, they have control over the responsibility to ensure that this selection will be beneficial for the patient. Given that the committee members are all doctors and they are familiar with the process, they are also considered to be competent in acting on behalf of the patient. As they are also the funding body, patients are fully dependant on the committee’s decision, as it is also an economic one. With regards to the countries which patients are sent to, through the Treatment Abroad Committee, it is evident that the costs in India, compared to other medical travel destinations, is an
important reason for choosing an Indian healthcare provider. However, other factors were also mentioned, which relate to the ease of process when collaborating with Indian hospitals, such as the support through a dedicated health attaché, the speed with which a case can be handled, and the flexibility of Indian healthcare providers, in terms of appointments and specialists.

When evaluating the factors, which facilitate the work of the Treatment Abroad Committee, it appears that smoothness is one of the key factors, on which the suitability and preference of a healthcare provider and destination country are pinned down. This raises the question of whether the committee acts in their own interest, considering these factors, or whether they select a healthcare provider that is most promising in terms of medical expertise and care for the patients’ situation. Does this approach meet the needs of the facilitating institution prior to responding to, and meeting the care needs of the patient? One can also argue that it is a win-win situation, as the patient will benefit from the smooth handling of their case, the increased assistance abroad and less time away from their families. Most significantly, patients are able to access medical care through the scheme, which they might otherwise not be able to afford or gain access to. As long as patients depend on a funding scheme, whether it is the Treatment Abroad Scheme in Oman or an insurance company that covers only certain interventions and the expenses for certain healthcare providers only, the patients’ autonomy is curtailed to some extent. As shown before, medical travel companies follow a strategy that involves the patients much more; deciding on behalf of the patient as default procedure is unlikely to be successful and therefore, they developed this compromise between advising and letting patients choose.

7.1.4 Conclusion: working on a good enough compromise

This section looked at the process by which international patients choose a healthcare provider and medical travel facilitators assist them, by intervening in the decision-making process to varying degrees. By understanding medical travel facilitation, as a form of care, this process is understood to be an extended care encounter (Noddings 2010b, p.49). By analysing it in reference to the four ethical phases and virtues defined in care ethics, namely attentiveness, responsiveness, competence and responsibility (Tronto 1995, p.142), different ethical complexities surface, which are involved in the practice and the patient-facilitator relationship.

The data offered insight into how these are negotiated through medical travel facilitation. This provides an approach which attempts to answer the question of how medical travel facilitation works by creating compromises, which is relevant for the transnational mediation of care.

The first complexity arises from respecting patient autonomy and agency, whilst also being attentive and responsive towards their need for assistance in realising medical travel, or here exemplified in choosing a healthcare provider abroad. Medical travel facilitators act as ‘coordinator’, by presenting themselves as assisting international patients in making informed
choices. This maintains their autonomy to some extent or even empowers them in the decision-making process, but in a manageable scope, after facilitators provide the preliminary filtering and guidance through the process. Finding the right balance between letting the patients choose and giving advice is the art, so to say. The attentiveness and responsiveness to do so allows medical travel facilitation to be considered as ‘care’ and the industry it forms shows that it has been professionalised to some extent with these ethical virtues being valued in market transactions. Pre-filtering the numerous healthcare providers gives patients with a more manageable, tangible and accessible selection, which enables them to make the next step towards accessing treatment abroad, without curtailing the patient’s autonomy too much. Generating such a compromise, which is not ideal but is ‘good enough’, can then be considered ‘care’ in the sense of an “effort to improve the situation of a patient” (Mol 2008, p.20). This is achieved firstly, by providing support throughout the process, working together with patients to find a solution for their specific requirements, and secondly, by making other forms of care, in this case, medical care, more accessible. For facilitators, the compromise seems to be good enough, if they are able to deliver the assistance in a manner that is beneficial for their business, which can be sustainable in the long-term, and is also compatible with the ethical principles, that the facilitators follow personally. Word-of-mouth was found to be an important reputation and practice-regulating mechanism, which shapes the extent to which facilitators can realise a profit-oriented agenda, whilst also delivering good care.

The second complexity explored in this section centres around competence, as an ethical virtue. One of the findings shows that there is confusion about which element of practice or task of medical travel facilitation, competence actually refers to and in fact there are multiple competencies involved in the process of choosing/giving advice on healthcare providers and in medical travel facilitation in general. Moreover, it is about the technical competencies in the medical field, as well as in the strategic manoeuvring in the medical travel and healthcare market, competence in establishing rapport with patients and in conveying information, language skills, cultural competence, organisation skills and more. These competencies are valued differently (Kofman & Raghuram 2015) and medical travel facilitators act to negotiate these by comparing them to each other and articulating combinations of them, that speak to the patients multiple needs. This is a way that constitutes a ‘good enough’ compromise, that convinces patients of their competence. Understanding competence not as fix, but as being established relationally, is important to understand the dynamics of its negotiation. Constituting competence in relation to other competencies and other people and with respect to the given situation, requires sensitivity and continuous tinkering – which feeds back to the ethical principles of attentiveness and responsiveness.

The third ethical complexity consists exists in negotiations around respect towards the patients’ wish, the responsibility or moral obligation to intervene and the carers’ pursuit of their
own interest, within this particular relationship. A close look at the empirical material surfaced a certain divergence between ideally letting patients choose a healthcare provider themselves and the actual practice, in which it is often the medical travel facilitator’s advice or suggestion that is followed. This exemplifies the fact that the ideal of patient choice often fails in practice (Mol 2008). Patients may not have the resources to make well-informed decisions individually and the collaborative effort of multiple parties involved in the health project turns out to be feasible and more promising (Mol 2008, p.4). Referring back to the previous point, having competence or presenting themselves as competent enough, medical travel facilitators take responsibility or are given agency of – ideally – acting with the patient (and not on behalf of the patient). Nevertheless, being more experienced, it is then to some extent left to the individual facilitators to negotiate their own interests and the patients’ needs, which challenges their integrity and responsibility to act ethically and in the patient’s best interests.

Smoothness reappears as a critical and additional quality to consider, in this process of negotiation, of both different people’s interests, but also different logics and values. The analysis showed that a ‘good enough compromise’ is calibrated on smoothness, in practical and ethical concerns. On the one hand, care is only good enough when feasible and smooth enough to be realised. At the same time, it shows that ethical principles cannot be considered as detached “from other norms (be they professional, technical, economical or practical)” (Mol et al. 2010a, p.13). They are negotiated by assessing them against the given situation and perceived needs, temporarily favouring one over the other and making attempts to combine them in a way that is considered as good enough, by the parties affected by, and involved in, the practice. Negotiating these principles is not straight forward, instead it requires an element of tinkering, which means that in the process, they are combined, prioritised and compared against each other. Since such tinkering is such an important aspect of care as a practice, I suggest that care ethics that is developed through practice should take this with tinkering on board. Moreover – and in relation to that – smoothness, as developed more thoroughly in the previous chapter (6), is found to be an important quality, not only for facilitation, but in particular, for care. The calibration of care – to some extent – on smoothness is thus seen as a relevant addition to the virtues discussed in care ethics and it is worth theorising it further.
7.2 Facilitator-patient relationship:

The ethical complexity analysed in the previous section consisted mainly of issues with discretion with regards to how much and what kind of involvement from the facilitators side is appropriate, beneficial or harmful in the patients’ decision-making process. As shown in the examples above, negotiating these questions is a relational manoeuvre that always happens within relationships. The constitution of these relationships pose their own sets of ethical complexities and this section sets out to unravel some of the particularities of the facilitator-patient relationship, in terms of its qualities as ‘caring relation’ (Noddings 2010c, p.49) and characteristics that are defining for certain types of care relationships (Barnes 2012a, p.85). These complexities are found to be indicative of the complexities involved in articulating spaces of transnational healthcare, as well as in generating smooth care, which makes transnational healthcare possible, feasible, and subsequently, ‘good’ or rather ‘good enough’. It is important thus to “attend to the ways in which historical and institutional relationships produce the need for care” (Lawson 2007, p.1). Additionally, extending the conversation about care between practical and theoretical approaches in STS and care ethics, contributes to answering the question about how medical travel facilitation acts to generate ‘good’ care.

7.2.1 Between ‘case manager’ and ‘people manager’

The evolution of medical travel facilitation from a niche form of tourism operation to a more distinct brokerage service (Mohamad et al. 2012; Casey et al. 2013a; Dalstrom 2013; Turner 2010; Lee et al. 2014) serving the healthcare industry, overshadowed the care work involved in it to some extent, maybe not at least due to the association of brokerage and middlemen with exploitative and shady practices (Lindquist et al. 2012, p.12). The formalisation of medical travel facilitation into an industry evolving alongside the development of the transnational healthcare, situates medical travel companies within the market dimension as one of the four institutional sites of care, as configured in the care diamond (Razavi 2007). The care they provide for international patients, whether recognised as such or not, is therefore carried out within a commercial setting. The ways in which patients’ temporary displacement from their local context and the circumstances at the medical travel destination site produce the need for care, requires in-depth exploration (Lawson 2007, p.3). Moreover, “the characteristics of care and how these can be realised in different types of relationship” (Barnes 2012b, p.8) are analysed in the following with regard to how they generate certain tensions.
Exploring the social relationship between medical travel facilitators and international patients, as a particular type of relation, highlights different types of care to those analysed previously. Aside from the continuous mediation of transnational healthcare, tinkering for smoothness or providing advice, the relationship in itself becomes relevant for its characteristics as a caring relation. Reflecting on this relation, Rajiv, the head of the international patient’s department of one of the big corporate hospitals in Delhi explained that in this hospital, they usually assign one person as a ‘case manager’ to each international patient. He further specifies that this “individual is an expert in empathy and provides them [international patients] care knowing more about the whereabouts of the patients” (I.48). This is interesting as he explicitly refers to ‘care’, a word that does not actually feature prominently in the data as such. Furthermore, he suggests that this care is provided by expanding the attentiveness to “the whereabouts” of the patients. This suggests gaining knowledge about different aspects of their life and pathology. “You have to understand the person you are dealing with”, Rajiv continues. Patients come with different mind-sets and clues such as the educational level and language skills, economic status, religion, travel experience and the situation in their countries that are often used to situate patients and assess their needs. Rajiv continues with the following statements, reflecting on how he understands the facilitator’s job:

We have to not be a case manager but to be a people manager. We have to manage ourselves and also the person who is coming to us. We have to understand what is his or her need and then respond accordingly. (I.48)

He introduces the notion of a ‘people manager’, as an alternative and supposedly more adequate version of the ‘case manager’. These notions encapsulate the complexity of the facilitator-patient relationship, which results from the entwinement of client-provider and care relations nicely. On the one hand, facilitators are concerned with efficiently rendering a certain service and the notion of the ‘case manager’ distances the patient as being just one of many, an objectified case that is handled systematically. On the other hand, the notion of the people manager shows there is concern for the individual and this means entering a relationship and extending the attention to the multifaceted needs of the patient as a person. This points to a different kind of relation with between the patient and the ‘managing person’ and a more encompassing approach to caring, one the “establishes and sustains caring relations” (Noddings 2010a, p.22).

How does managing relate to care then? ‘Managing’ means “to succeed in doing or dealing with something, especially something difficult” (Cambridge Dictionary 2020). It also means to “handle or direct with a degree of skill” (Merriam-Webster Dictionary 2020) and such skills are required in order to respond ‘accordingly’. This was a common phrase used by many interviewees to express attentiveness towards the patients’ specific needs and situation, to which
the course of action and their investment in a caring relation are adapted. This also means that if a patient does not show an interest or need in a more encompassing and caring approach from their facilitator, then facilitators can amend their approach, focusing more on their case-managing and practical tasks. As the head of the international patient’s department, Rajiv is particularly concerned with developing the skills of his employees, in order to render them more competent in caregiving and managing their cases, so that the business runs smoothly. The hospital thus offers regular courses in basic and advanced communication skills to educate Rajiv’s team and turn them into ‘experts in empathy’, as he established earlier. When Rajiv was prompted to elaborate on what he means by empathy, he said the following:

Empathy, empathy is not just a word, you have to learn empathy and then you will understand. It is not just about routine. What will happen to me when I am in his or her shoes? If you say to someone that you empathise with them, it doesn’t make a difference. You have actually to make a person understand. It’s ehm, Ma’am, what is going through with you? And even, it is not by word, it is by your actions that I can understand what is going through with you. But not by saying it but by making the person realise that yes what you are going through this. (I.48)

The interviewee makes it clear that empathy is not something you learn easily or that is a behaviour which is straight forward, or which simply follows a protocol or template. Instead empathy is considered to be an action or rather interaction, between multiple sensing bodies that communicate with gestures and language. Empathy, itself a “contested concept in the field of care ethics” (van Dijke et al. 2019, p.1282), is here mobilised by the interviewee to express what is conceptualised as ‘cognitive empathy’, which “refers to the capacity to mentally reconstruct the other’s experiential world” (van Dijke et al. 2019, p.1284). The interviewee’s rhetorical question ‘what is going through with you?’ attempts to mentally focus on imagining what their patient is experiencing, in order to show empathy. This allows the facilitator to attempt to understand the other person and provide them with the feeling of being understood. Such “care work requires ethical sensibilities and relational as well as practical skills” (Barnes 2012c, p.83) which the facilitators need to learn and develop interpersonally, as empathy is not a given human quality. Rajiv’s delineation of empathy delves into the core values of care ethics (Fisher & Tronto 1990): attentiveness - used to identify the needs of the other person, responsibility – to meet those needs that are here assigned to the empathic facilitator in the hospital, competence – referring to the skills needed to care and responsiveness – if they succeed in making the patient feel understood. As indicated by Rajiv earlier, being empathic and being a people manager involves both managing others and one’s relationship with them, meaning that one has to manage his or her own feelings.
Managing the emotional state, expectations and demands of patients – and no less important – their attendants, is considered to be one of the most challenging aspects of facilitating medical travel by the participants. One of the interviewees says: “The most challenging is not in our work but it is maybe the behaviour of the patients” (I.28). They refer to patients who become stressed, anxious and frustrated if something does not go according to plan or if they do not understand that some processes and rules must be followed. The interviewees acknowledge that such behaviour is understandable given the current circumstances, but they are also concerned about handling their ‘cases’ smoothly and efficiently, which sometimes requires interventions from their side to keep on track, if the patients get carried away. One of the interviewees admits that sometimes she struggles with managing patients: “Sometimes they are very hyper and it’s very difficult to control them” (I.71). This notion of control resonates with the idea of setting rules, which the manager of a medical travel company based in Delhi, compares to managing teenagers:

Handling a patient is like handling a teenager. It is a rollercoaster. So, the way you would handle a teenager, you would handle that. You will not allow them to do what they want. But you have to set the rules in a very sophisticated manner. (I.62)

The image of the rollercoaster alludes to an unruly journey, with ups and downs, but also one that should run along an orderly course. Keeping sight of this course is seen to be the facilitator’s job and at times, it involves some sort of strategic intervention without being overtly patronising. Here, the interviewee refers to giving advice on different practicalities, such as where to stay, how and when to shift from the hospital to the guesthouse, where to exchange money, whom to contact in a specific situation. Additionally, in some cases, the facilitator must make a decision on the patient’s behalf, in order to prevent them from finding themselves in a risky or challenging situation (e.g. early discharge from the hospital or issues with medication) or they may need to interrupt the proceedings entirely. This idea of controlling, both as a way of caring for the person and a way of handling cases efficiently, was a recurring phenomenon.

After a long working day in the hospital, one of the freelance facilitators seems exhausted because his patients, of which there are many, are all demanding his attention at the same time. He states:

B: But it is very important to not do the patients wish always. Because you will get tired. Frankly. After that they will start coming. Sometimes we must be strict with patients. Because they will cross the limits, trust me. I mean you must be kind and helpful, all this; yes of course, but to some extent. Otherwise, as I said, they will cross the limits and start demands
more than their needs.

I: I imagine it’s difficult to negotiate when to say ‘yes’ and when ‘no’ -

B: Actually, I am telling you this, but you can’t say ‘no’. You get angry
and you get tired but it’s very difficult to say to the patient no. Because
first of all he is here, he does not know anyone, he’s patient, eventually
he’s patient, he came here for treatment. And yeah, you get angry, but you
keep it to yourself. (I.46)

The requests from the patients, asking the facilitator to stay with them all the time, from early
morning until late at night is understandable, he says, but not practical. The facilitator cannot
be by their side all the time, because he is looking after multiple patients and their families
simultaneously. So, he switches between them and makes sure he is available via phone for
the parties who he is not able to be with. He repeats that he thinks some of the demands are
unreasonable and that they ‘cross the limits’. He talks about being asked to engage in physical
forms of care, such as nursing the patient’s wounds after hospital discharge, helping with bath-
ing, dressing and using the bathroom, reminding them to take their medicine, bringing them
food from outside the hospital, sitting with them for dinner and/or accompanying them on
outings. There are multiple reasons why such demands are perceived as unreasonable, includ-
ing the fact that they are time-consuming, the facilitator may not feel qualified to engage in
certain activities or simply because they may not feel comfortable with some of the requests.
Nevertheless, the interviewee states they have to manage their own emotions and keep their
frustration to themselves. In practice, he finds a way to take control of the situation, offering
to be contactable via phone and establishing rules which must be followed, as well as finding
the confidence to simply say ‘no’ sometimes.

These examples show a degree of pragmatism from the facilitators’ side, to make care man-
ageable and realistic, even if it goes against the patient’s wishes, whilst still being able to show
concern and to be personally invested as a human being. Medical travel facilitation is thus a
continuous process of finding a balance between the facilitators’ interests and the patients’
wishes or requests. It is a form of tinkering, to work towards improvement that generates care
as a compromise that is ‘good enough’, meaning that it accommodates both market logics and
care logics, so that medical travel facilitation contributes to the well-being of the patient and
the facilitator’s business. The juxtaposition of patients as ‘cases’ and ‘people’ does not trans-
late as such in practice but it is more that these are two versions (Mol 2012) of patients, that
exist at the same time but which are fostered to varying degrees in different situations. They
can be understood as different “events in time” (Mol 2012, p.120), because on the one hand,
medical travel facilitation treats patients as ‘cases’ and on the other, it is more appropriate to
consider them as ‘people’, with different sets of needs. These examples here showed how these
versions are made to relate in practice and how medical travel facilitation is intervening in this process and articulating these multiple versions of patients in the first place. The ways in which the tensions between them are negotiated or how they are made to operate together, shapes both the practice and ethics of care as it unfolds in the facilitator-patient relationship.

### 7.2.2 Pseudo-familial relationships

Different from other fields in which the commodification of care is a subject for debates (Green & Lawson 2011; Madörin 2010; Folbre 2006; Lynch & Walsh 2009; Yeates 2005; Hochschild 2003; Pellegrino 1999), the facilitator-patient relation and the entwinement of caring relations with economic relations are here closely tied to the particularities of the transnational healthcare setting. One of the drawbacks of treatment abroad is the temporary detachment of international patients from their usual support network. This creates a certain care vacuum or gap which medical travel facilitators try to fill to some extent, for the time patients are with them at the destination site, mobilising a rhetoric of pseudo-familial relationships. This raises the question not only about the spatiality, temporality and intensity of those care relations generated by TNHC, but also about how medical travel facilitation can make patients feel well cared for and the ethical implications of this practice.

Medical travel facilitators intermittently become members of the collective, that forms the patients care team (Mol 2008) and they get involved with caring which is “shared by doctors, nurses, patients, relatives and friends, and even technologies” (Mol et al. 2010b, p.75) in otherwise mostly spatially relatively bounded configuration. These individuals were strangers, or distant others previously, however, they have become temporarily invested as a carer. This relationship challenges the common spatial categorisations of caring relationships, into proximate or distant (Corbridge 1993; Silk 2000; D. M. Smith 2001), an the temporal ascription as either a ‘caring encounter,’ an ‘episode’ or a ‘long-term relation’ (Noddings 2010c). Transnational healthcare offers multiple options to think through the idea or moral obligation of caring at a distance (Silk 2000; Eger et al. 2019; Pols 2012; D. M. Smith 2001) in terms of the inter-relation of national or economic or technically mediated spaces, for example. Here, “micro-landscapes of care” are taken into account by analysing the care relationship between patients and facilitators more deeply, as a response to the call for “further investigation of the experiences of paid caregivers in medical tourism (…) including both medical and non- medical caregivers (e.g., coordinators, translators, cleaning staff, drivers)” (Whitmore et al. 2015, p.117) from an ethical perspective (Eger et al. 2019; Silk 2000).

One of the particularities of this relationship is that it is temporally and spatially bound to the patient’s stay abroad (although sustaining the relationship beyond that is not uncommon). From the perspective of the patient’s care team, the inclusion of an initially distant stranger
can also be thought of as a spatially stretched or dispersed care collective. While the patient’s care network, apart from one or two companions, are left behind for some time, the facilitator becomes intermittently one of the key members of the care team. This does not only result in a spatial stretch, but it also implies a stretching of the institutional configuration of care provided in TNHC. Looking at the configuration proposed by the care diamond (Razavi 2007), facilitators as entrepreneurs are ascribed to the domain of the market, but they may situate and present themselves as if they were part of the family, temporarily, blurring the line and reaching out to the family/household domain, in their rhetoric and to some extent, in their practice. The delineation between the state, family/households, markets and not-for profit as the four institutional sites for care provision is “neither clear-cut nor static” (Razavi & Staab 2008, p.5), but instead they are entwined and dynamic (Kofman & Raghuram 2015). These configurations matter but the different sites should also be separated to understand the different logics at work. The “social and economic relations through which care work is organised” (Barnes 2012c, p.83) need to be critically analysed. According to many interviewees, caring for international patients becomes, to some extent, the facilitator’s responsibility because of the care-vacuum affecting international patients for being far from home. Although they usually have the support of an attendant taking the role of an “informal caregiving-companion” (Casey et al. 2013b), being detached form their usual support system is one of the main differentiators between international and domestic patients. Rajiv, manager of the international patient’s department in a hospital in Delhi NCR, explicates this specificity:

Then we obviously keep it in mind that the patient who is coming to us is coming from a far land. And it is not like any person who is just walking down form the city because that person is having financial, mental and social support around her. But a foreign patient at times it happens that we are the family for them. Right? Because the patient is having one to maximum two attendants, as a family member as a medical escort. If I will be falling sick and I will be going to hospital I know that my home is in the town, my family is in the town, my friends are in the town. But for a foreign patient it is not the same. So, we provide them more support as a friend. So that they are focusing on the treatment and not on anything else. (I.48)

Rajiv goes as far as saying that he and his team are “the family for them” (I.48), an often-heard analogy, which requires specific attention. The logic presented is that foreign patients are detached from their normal support system, which is why medical travel facilitators are temporarily stepping in, replacing the missing care from family and friends, while they are abroad for treatment, which can range from a few days to several months. The relationship resulting
that could be observed between many facilitators and patients and that many participants articulate explicitly, could be described as ‘pseudo-familial’.

Although basically being strangers, their relationship was repeatedly articulated as being familial by many interviewees: “we become their family” (I.61), “we basically replace the family. It’s a huge responsibility” (I.46), “I feel like a family” (I.55). Drawing on and perpetuating the perception of care provided within family relations as being superior to care provided in commodified care arrangements, the interviewees see the family as “the naturalised location of care” (Green & Lawson 2011, p.650). Providing a family feel is taken as indicative of the quality of the care they provide, following the logic that family care is, presumably, especially good and desirable.

The manager of the international patient department of a hospital in Delhi sometimes takes patients who travel on their own to his home, so they do not feel lonely:

Sometimes we face these issues that patient feels alone here. So, we will provide like a family. They come to my home and they can feel better. (…)
Sometimes when they are feeling alone, I will take them and we will have a breakfast or lunch with me. They will feel like a family here after that.

So, the personal touch with the patient. Even patients sometimes come single, no attendant, at that time we will face that issue. (I.65)

In those moments when patients are abroad and detached from the care of their families, facilitators are, to some extent, substituting the care. Being a “friend away from home” (Sobo et al. 2011, p.128) is also about “sharing their sadness and their grief if someone passes away” (I.68), about “holding and massaging his [the patient’s] hand, making him relax and praying for him” (FN 1.3.18), about “going to the guesthouse to sit with the patient, talk with them, eat with them, check if they need anything” (I.46). Another interviewee, who works as freelance facilitator within a team, explains how she responds to the need for care that medical travellers, especially attendants of patients undergoing treatment express, by being there for them and providing emotional support:

A: Sometimes surgeries are high risk and attendants don’t feel good. So, they expect someone to be here in India to get emotionally attached to them, to listen what is going on in their mind or heart. What they want.
I: So, you mean you provide emotional support for the attendants?
A: Yeah, yeah. Because the patient is in ICU, anaesthesia going on, he half died. He doesn’t know anything, but the attendant, they were crying, and they want someone to be with them. I said to them, explained to them, nothing to worry, all will be fine. Sometimes I give books to them as well and tell them to think positive. When there are high level surgeries, things go negative in the mind, like, what will happen? What condition? Will he
live? So, emotions are very important, apart from services. Emotions are more important.
I: So, sometimes they need someone to just sit next to them to chat?
A: Yes sometimes, whether it is for 5 minutes or 10 minutes, no problem. We have to give time to them; they are travelling from so far. Not for treatment only. Treatment, sí, but if I go to a country with someone and they are meant to be getting treatment and I am sitting there alone so ... From inside I feel, I want someone to come and sit with me, ask me what’s going on. Otherwise I will feel lonely and all negative thoughts come into my mind. (I.71)

Caring for international patients requires co-presence, a body that senses and sends signals and someone who is empathic, who knows when to show emotions and when they need to be managed and also repressed. Just as Rajiv outlined what he means by empathy, this interviewee seems to actually have this skill, whereby she puts herself in the patient’s shoes, taking the time to simply be there and listen, to comfort them, reassuring them to think positively. The young woman views her role as being present to provide emotional support, for the patients and attendants, especially in difficult situations and emotionally strenuous times. Interestingly, she presents emotions as opposed to service and stresses on the importance of emotions.

Catering for people who are coming from foreign countries is almost seen as an obligation, but one the interviewee is readily willing to take, expressing that she would hope for the same if she was in a similar situation, and she assumes some form of mutuality. Although clearly stating that she is talking about herself and how she feels ‘from inside’, the idea she puts forth resonates with more fundamental ethical questions about responsibilities, to care about distant others in terms of recognising the interconnections in a globalised world and the “the moral obligation to care about one another” (Silk 2000; Corbridge 1993). Whereas this literature conceptualises mediated interactions of groups of people living in different parts of the world and forms of care, that do not require co-presence, the situation here is much different. The caring encounter is much more immediate with both patient and facilitator present on site, former strangers that are no longer distant but mutually invested in the relationship and “hands-on care” (Silk 1998, p.167). Due to the fact that international patients are travelling for a significant distance to seek healthcare abroad, this seems to reinforce the responsibility of helping them. Arguing from a position of being emotionally attached, the interviewee speaks about expectations without clearly assigning them to her personally or to facilitators or a subjectified ‘India’:
When we spend a lot of time with the patient, whether they are from a
different country or have a different language, we are emotionally attached.
I don’t know about all, but I am like this. People come and ask for help,
and I just go. They travel to India. They expect a lot from us. (I.71)

Whilst stating that not everyone feels the same, the interviewee expresses that she feels that
international patients articulate certain expectations about receiving help in accessing treat-
ment abroad. However, not all facilitators/other actors may recognise
the responsibility to ‘help’. The way she links her own experience with a rhetoric, that addresses India as a country,
also resonates with discussions of articulations of transnational spaces of healthcare developed
previously, about taking the specific geo-histories of care seriously (Raghuram 2016;
Raghuram 2012). Based on the analysis, the geo-historical relations between Oman and India,
are found to create a certain receptivity towards being cared for in India and perception of
India having a certain history and reputation as caring authority, in Oman (see Chapter5).

By exploring their practice and how facilitators view their role, this allows an understanding
of how the facilitators scope of activities are stretched into realms that go beyond the tasks
that are typically associated with their role, as brokers and service providers. Many parallels
can be drawn to Bastia’s (2015) study of Bolivian migrants, who look after elderly people in
Spain, in terms of how economic and social relations become entwined in transnational set-
tings. The author elaborates how these care workers are “practicing a transnational ethic of
care that goes beyond the remit of their marketised responsibilities” (Bastia 2015, p.121) and
furthermore explains: “By turning the elderly people they care for into fictional family mem-
ers – into their ‘grannies’ – elderly care workers transform their commodified care into a
familial social relation” (Bastia 2015, p.121). However, whilst this study makes a case on how
this process results in the exploitation of the care workers (Bastia 2015, p.121), the debates in
the context of TNHC and medical travel facilitation revolve around the vulnerability of pa-
tients towards exploitative practices. The reason why the transformation of medical travel fa-
cilitators into temporary quasi-family members does not just provide international patients
with a particular kind of care, but also raises ethical concerns, is further elaborated in the next
section.

7.2.3 Capitalising on the facilitator-patient relationship

Another layer of complexity is added to the facilitator-patient relationship by the intricacies
of the business model, which is followed by the majority of participants, and their motives of
capitalising on the facilitator-patient relationship. Whilst the data shows that the facilitators
participating in this study – who are not a representative group of facilitators, not least because
of a social desirability bias\(^5\) – convey caring for, and caring about, their patients, those designated facilitators are evidently also entrepreneurs, concerned with sustaining in the industry and increasing their business. The investments in caring relationships, between facilitators and patients, serves the double purpose of responding to the patients’ needs and enhancing their experience, and benefitting the facilitators’ reputation and subsequently their business. The allusion to family-like care sometimes becomes part of the programme:

But in Company X, we are focusing on the quality and ease of the patient.
To feel a wow-moment here. They feel like a family, that they are in India,
they are feeling ‘oh family’. (I.55)

Creating a positive surprise, a ‘wow-moment’, a feeling of being looked after by someone who cares for them like a family member and who makes them feel at ease, seems to be somewhat strategic and the relationship is engineered to some extent, serving the purpose of business generation. This is because building the relationship with a patient is also nurturing the relationship with a customer, who may give a positive testimonial that mobilises friends and relatives to use the same service, which is a known marketing strategy (Ng et al. 2011; Gremler et al. 2001). This is particularly relevant as word-of-mouth is, for most participants, the most effective promotional channel, by which they gain new clients: “So, a major junk of our business is through word-of-mouth. And word-of-mouth is again coming from somebody who came here and is very happy. And he goes back and recommends us.” (I.62). However, they first need to deliver a ‘wow-moment’ and provide the patients with a satisfying experience: “If you provide him with a good service, he might recommend us to someone else. And it is you meeting that service level as well.” (I.62). Word-of-mouth, to some extent, works as a control mechanism for the facilitators’ practices, as negative testimonials quickly have adverse effects on their reputation: “If we are not ethical, we will run out of business even before we can blink our eyes.” (I.62). The power relations within the facilitator-patient relation are intricate, given its entwinement with both market and care logics.

These different motivations for their work seem to fit well together, in the narratives of a selection of facilitators. The employee of a medical travel company in Delhi blurs the boundaries between profit and benevolence, by framing their work as a ‘good deed’, that is motivated by humanity, despite the company being clearly profit-oriented:

I am happy in this field, learning and earning. I could not quit it. I hope to continue with happiness. I am telling you, here is learning and earning and also humanity. You can show your humanity and sympathy here.

\(^5\) Social desirability bias meaning that research participants tend to present themselves in a way that they think is more socially acceptable, which can lead to overrepresentation of what is generally seen as ‘good’ or desirable behaviour and the omission of ‘bad’ behaviour in a research context (see King & Bruner 2000)
Everybody should do some community work. If you help a patient, that is also humanity and you are helping in nature. (I.61)

This idea of framing their economic activity, as community or charity work, which represents another point in the care diamond, is also present in the statement of one of the medical travel facilitators in Oman and it is critical for blurring the lines between different motives and business models. He seems to combine those different motivations relatively easily: “So I took it [establishing medical ‘tourism’] as a service and it was an element of charity. So, my time, I use it professionally to help people.” (I.34). Although the relationship is not straight-forward, business and benevolence become entwined through medical travel facilitation and according to the interviewee’s logic, earning money with a job that also helps others, seems to be a ‘win-win’ situation.

Additionally, within the prevalent business model among the participants in this study, many of them are not charging the patients, but are instead being paid by the hospitals themselves, for referring international patients, in the form of commission fees. By removing the requirement of a financial transaction between the facilitator and patient, this obfuscates the commercial interests which facilitators are likely to have in the relationship. Furthermore, facilitators can articulate a ‘win-win’ situation, by drawing upon the specificities of this business model; international patients typically pay the same amount for the treatment, whether they are referred to the hospital by an external facilitator or not.

Due to interpreters, facilitators, the money of the patient or cost of the patient, does not go high. I mean, if someone comes for an open-heart surgery, $6500, if he comes directly to the hospital, the same cost will be taken, if they come to the facilitator, same cost. The hospitals don’t charge more, it’s the same charge. (I.61)

The mark-up is passed on to all international patients which allows the facilitators to frame their contribution as a benefit to the patients, at no extra cost. They may even cut the price if they use their knowledge, negotiation skills, or if possible, their powerful position vis-à-vis the hospital management. This logic may work for the individual, but it overlooks the idea that medical travel facilitators are players in the market, who are also shaping the industry, and the hospitals are budgeting the commission paid to the facilitators, in the mark-up for international patients. Additionally, the previous section, exhibiting the influence that facilitators have in terms of selecting the healthcare provider on behalf of the patient, continues to have a certain

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6 Although the prevalent business model of the participants in this study does usually not involve a service charge for the patients, there may be many other companies or facilitators who do ask for money directly from the patient.
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effect on the overall cost, given that the prices vary from hospital to hospital and they may suggest a so-called five-star hospital, which is reflected in the price.

There is another move that offers interesting insights into the motives and manoeuvres related to managing finances. At times facilitators refrain from their payout or use it against the patients’ bill, which further obfuscates the motives involved in the process. A medical travel facilitator working for a company in Delhi, talks about a case where the treatment cost of a patient rose by 50%, due to the extended period they spent in the Intensive Care Unit, and this was beyond the patient’s financial ability to be able to pay. Discussing the situation with the hospital and negotiating on the patient’s behalf, the hospital agreed to give a discount and the medical travel company offered to pay the rest of the additional costs out of their own pocket. Although this constitutes a temporary monetary loss, the informant explains the ambivalent reasons motivating the company’s generosity:

There is also humanity. We are earning the money every month, but these types of cases only happen sometimes, not every time. In one year, one or two happen. We are not totally professional, like blood sucking. They [patients] have to pay, we don't think like this. We are earning, so, sometimes we don't take [money], no problem. If they go back to their hometown, they will praise us and send us more patients. Advertisement has that effect. They will say, this facilitator was very good and helped us, like a guardian. That is better for the success. This is why we have the name and fame in India. And we understand that this person has no money. (I.61)

Absorbing patients bills, which has this ‘element of charity’, is at the same time a strategic manoeuvre, factoring in the power of word-of-mouth. The coexistence of these multiple circuits of values shows the multiplicities of ethics and how they are being stretched to accommodate them. Charity and business interest are not exclusive in practice, instead they may operate together as illustrated in this example. If the patient will spread the word about the company’s generosity and benevolence, in the long-term this will result in further positive marketing and business for the company. Generosity as “a modality of power” (Barnett & Land 2007, p.9) is used as a mean “out of a self-interested motivation to be seen to be a good person” (Barnett & Land 2007, p.13). Although it could also be seen as a form of manipulation, the interviewee focuses on the effect for the parties involved and presents it as a ‘win-win-situation’ from which the patients will immediately benefit from and which the medical travel company will benefit from in the long-term.

In line with the other examples in which medical travel facilitators use ‘humanity’ as motivation for their intervention in managing finances, some of them also adapt their practices with respect to the perceived economic status of the patient and they may take measures to
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accommodate the needs of different groups of people. One of the individual facilitators based in Muscat explains that he has different conditions with respect to what he believes the patient can afford. He is one of the individuals who charges patients a fee, if they want him to accompany them to the medical travel destination and justifies this fee with the fact that he provides a service and needs to earn money to pay his own bills. Patients are then at the facilitator’s discretion, so to say:

Sometimes I make condition. If you want to go with me, and I see the people and they are hard people I give the condition. If you go with me, give me 200 or 150 [OMR], if you want someone who cares for you. If you don’t want, well … Because you know, I have a house, I have two cars, I have many, many electric bills, petrol like this. I must be paying for this. My life now is high. Some people give me 50 OMR and I stay there 10 days. Why? Because if he is a poor man, no problem. But if he is a rich man and gives me 50 OMR, it is not good. (I.16)

The facilitator adapts his service fee according to what he thinks that the patient can afford. He expects wealthier people to pay more for his service and he articulates care as a tradable good. Nevertheless, if it is a ‘poor man’ asking for his help, the interviewee states that he asks for much less money and shows empathy and understanding for their situation.

A similar logic is followed by another individually working medical travel facilitator who is based in Delhi. He has a steady patient flow and has gained influence in some of the hospitals for bringing such significant amounts of business to them. He is invested in using this power for negotiating better conditions for his patients, specifically discounts for poor patients who cannot afford to pay the final bill. In order to save money on behalf of his patients, he also coordinates and brings together the services of the clinics, centres and hospitals, which offer more economic services even though this involves more logistical effort and time from his side; for example, carrying out tests and investigations in smaller clinics and buying medicine in pharmacies outside the hospital, is often cheaper. The facilitator was shadowed, over a day in the field, whereby his father and sister came to Delhi from abroad for treatment. Instead of having them stay in the multi-specialty hospital, where he usually brings patients, he put them into an auto rickshaw, to go to a nearby medical centre, for their investigations. He explains:

A: Actually, usually, two things – three things – are cheaper elsewhere than here [in one of the multispecialty hospitals]: Medicine, pharmacies things, investigation ehm as well as the lab investigation usually in India outside the centre. I am not in the hospital only for investigation. That is why we do it outside. (phone rings) Also, I could use my power from here and they [his father and sister] can get 30% discount. Okay. But I don’t want to put
such pressure on the hospital because I want to use it on poor patients. Not for them.
I: Even if it is your family?
A: Hmm yeah if there are some poor people than they deserve more than my family. (I.54)

Even for his own family members, this facilitator stays true to his principles. He deals economically with his influence and is devoted to use it in a sensible way, in order to help those patients who he considers to be most deserving of some extra support. The interviewee also tries to sensibly negotiate the demands that both sides, the patients and the hospital, have for him.

These examples illustrate how the facilitators’ discretion is often positive for the patients. Nevertheless, they can misuse their powerful position and exploit the social and economic dependency of the patients, resulting from the social and economic relation, just as easily. Although it seems that the way that ethical questions resulting from and concerning facilitator-patient relationship are negotiated depends considerably on the attitude of the individuals concerned, an ethics of care perspective can point towards some more structural issues, adding to the complexity of the endeavour to make care ‘good’.

7.2.4 Conclusion

This section illuminated some of the intricacies of the social and economic, but also spatio-temporal configuration of the setting, within which the facilitator-patient relationship unfolds, and care is being mediated. This poses some ethically complex situations for negotiation, and the combination of data from job-shadowing and interviews, offered insights into these practices and the explanations thereof, by the interviewees.

One of the complexities that surfaces in the analysis of the practices of medical travel facilitation, is that it has to integrate both an orientation towards a ‘case’ and a ‘person’, which partly translates into acting professionally and on an interpersonal relationship-based level. In some instances, the pulls of these approaches are divergent and in others, they are complementary, and it is often the facilitator’s job to balance different interests and bring them together. The notion of ‘managing’ has been introduced to capture this continuous negotiation effort, that involves elements of control and elements of tinkering. Facilitators have to balance the different interests involved in the process, in a way that respects the patients’ wishes and needs, as much as necessary, but also considers the facilitators’ requirements, in terms of practicality and profit. In practice, they adapt their personal investment in the relationship, according to the patients’ needs, respectively their perception of it, and of what they think patients accept in terms of intervention and care from the facilitator’s side. Simultaneously, medical travel
facilitators pursue their own agendas in terms of making profit and facilitating their own work. Smoothness features again in this process of negotiation as an indicator for the care provided, as to whether it is ‘good enough’.

A certain care vacuum, arising from the transnational setting, and the fluidity of the facilitators caring roles as service provider and pseudo-family member, makes the caring encounter between facilitators and patients even more complex. Although government schemes and healthcare markets offer medical care transnationally, the spatially dispersed and temporally intermittently involved care collective of the patient, can result in discontinuities in the care surrounding treatment abroad. The institutional configuration of transnational healthcare lacks some supporting infrastructure, which is otherwise usually provided by the local network of the patients. This leaves medical travel facilitators a significant amount of leeway in how they are responding to this gap. Some facilitators focus on providing mainly logistical support, whereas others are more invested in a caring relationship, offering emotional support, time, and friendship. The quality and amount of that work is left to the discretion of the individuals and it provides an understanding of their care ethics, as to whether they care not only for their business, but also the well-being of their patients. Drawing on a sense of responsibility for the wellbeing of their patients as individuals, or for patients who are coming from a distant place, in their rhetoric and practice, they often present themselves as partially substituting the care normally provided by the patient’s social network. This stretches their care agency beyond one that is configured within economic relations alone. Operating between different domains which traditionally provide care, such as family members and the market, could be looked at as creating some sort of “new spaces of marketised domesticity” (Green & Lawson 2011, p.646) within transnational healthcare, which are motivated by both benevolence and profit. Although the participants in this research convey their investment in a caring relationship, that benefits the patients’ emotional well-being in particular, blurring the boundaries between acting as a profit-oriented market actor and caring as a family member also offers room for exploitative relationships, pointing out “care’s darker side” (Martin et al. 2015, p.3).

The last ethical complexity involved in medical travel facilitation, that was discussed within this chapter, relates to the particular business model of most facilitators participating in this study and the ways in which they capitalise on the relationship with the patient, either monetarily or indirectly through the translation of word-of-mouth into future business. On the one hand, it is an ethical question: to what extent medical travel facilitators push their own agendas; on the other hand, the data shows that the extent to which this is possible is limited by its practicality and the importance of word-of-mouth feedback mechanisms. Patients and facilitators are thus both involved in balancing service, care and business interests, by testing what is possible, effective, and ethically justifiable – by tinkering and working on a case-by-case basis.
7.3 Conclusion: making transnational healthcare good enough

Understanding medical travel facilitation as a form of care raises one’s awareness towards some of the intricacies and ethical complexities of caring practices and caring relations. Some elements of these complexities are specific to the spatio-temporal configuration of care in transnational healthcare; some others feature in other care encounters as well, but unfold differently in this context, making certain aspects of care more visible when taken out of their usual setting. This last empirical chapter explored the practice of choosing/advising on a healthcare provider abroad, as well as the facilitator-patient relationship, in an attempt to answer the following research question: How do practices of medical travel facilitation negotiate ethical complexities involved in transnational healthcare?

The first set of complexities that this chapter unpicked, evolved around the four virtues of care, that are established in care ethics, which are attentiveness, responsiveness, competence and responsibility (Tronto 1995) and the ways in which medical travel facilitation engages with them. Thinking through competence revealed that there is confusion about what practice of medical travel facilitation competence refers to and about how to evaluate competence. The analysis showed that these competences are not fixed but that they are being negotiated relationally, also by facilitators themselves, in a tinkering manner. With respect to attentiveness, responsiveness and responsibility, an important question at stake is: how much involvement from medical travel facilitators is adequate so that the patients’ autonomy is not curtailed too much, and at the same time, they do receive the support needed to make medical travel a feasible and a good option? In this situation, medical travel facilitation acts to balance the tendencies of fully respecting the patient’s autonomy in decision-making processes, such as when it comes to finding a suitable healthcare provider abroad, and of being patronising, controlling and forceful, by making decisions on the patients’ behalf. This has also been discussed with respect to a certain responsibility that facilitators have, both to respect the patients’ wish but also to act in their best interest and intervene if necessary. Attentiveness and responsiveness clearly feature in the practices of medical travel facilitation, in their efforts of caring about their patients, but also in offering a service that excels in being customised to the individual needs of patients. Both sets of practices are concerned with improving the patients situation, which is one of the guiding principles of providing good care in STS literature (Mol 2008). So are the tinkering efforts towards “temporarily reconciling noncoherent logics and practices by keeping differences in a state of (always precarious) balance” (Law et al. 2014, pp.189–190), which act to sustain some sort of smoothness, as I suggest.

In line with continuous efforts towards this goal, to which the multiple actors of the care team contribute, the facilitators concern with ‘smoothness’ was found to become relevant, not only as a practical matter, but also as an ethical principle, which adds a new aspect to the
conceptualisation of care in both STS and care ethics literature. In order for something to function, to progress and to be established in transnational healthcare, a few of the values or virtues seem to be situationally and temporarily compromised, as long as it benefits the overall purpose. Drawing on the example examined here, trusting the advice of a facilitator, even if this means that not all possible options are considered and the patient does not have control over every single step, may still be better for one’s health, as opposed to not seeking care abroad at all or trying to evaluate the options as a lay person. From the facilitator’s perspective, suggesting healthcare providers that require less travel or waiting time and making a promise that the process will be routinised and efficiently handled, may be valued higher than connecting the patient to the most renowned doctor in the field. In particular, cost, time and proven cooperation among facilitators and hospital staff are factored into the process, in order to come to a compromise that is both good enough in terms of the quality of the treatment, and is feasible, with limited hassle, money and time. Smoothness, as a relational quality for being established in relation to other actors and factors, thus becomes a principle on which care practice and ethics are being calibrated.

The relevance of smoothness as a quality, on which care is oriented, at the same time reinforces the importance of taking practice seriously in care research, methodologically and theoretically. The favouring of certain values over others or the kind of compromise between them allows the process of transnational healthcare to run smoothly. As the examples show, the realities on the ground and with it the priorities of different values, are often different from the ideal that is envisioned, practically and ethically. Interviewees frequently report that, in the end, patients often ask for the facilitators advice and subsequently follow their recommendation, rather than making an independent decision. This shows that the process works differently in practice to the protocols which have been established and that the practices are reshaped through multiple actors working collaboratively, including the patient. This draws a care ethics that allows negotiations to be a contextual and a collaborative effort, taking both the micro-practices of tinkering and the overall purpose into account. These findings as an example of building “care ethics back up” (Raghuram 2016, p.524), by working through the empirical material, thus advocates for taking care as a practice seriously, in care ethics. To do so requires developing an adequate methodological approach, that accounts for the level of detail that makes the intricacies of care visible. For this thesis, working with the methods developed in STS research and adopting some of their theoretical approaches, that direct attention to certain aspects of practices, proved to be a productive method. Bringing these theoretical frameworks into conversation about care holds potential for further theorising and methodological refinement.

Another set of complexities that this chapter unpicks, relate to the facilitator-patient relationship that is situated, supposedly, in a field of tension between cases and people, benevolence
and profit, familial and marketised care. The chapter shows how these values are negotiated, to ensure that they operate collaboratively, in medical travel facilitation. A close look at what the interviewees understand by being a ‘cases manager’ or ‘people manager’, shows that they do not see these as opposing approaches in their work and care ethic, but instead, they are viewed as different versions of care that operate together. ‘Cases’ and ‘people’ are seen as different versions of patient, that can be understood as “events in time” (Mol 2012, p.120 italic in original) with one or the other coming to the foreground – or rather being made to do so – at a specific time, in a given situation. This is also where medical travel facilitation becomes involved, as it takes a powerful role in negotiating these versions, by fostering one or the other as it serves a purpose at a certain moment. Additionally, to refer back to the previous argument, medical travel facilitators are likely to attend to the version of the patient and to foster the version of the care that is more promising at the time, in producing or maintaining the smoothness, which allows a ‘good enough’ compromise. Based on the data, it seems that a carefully attuned combination of both is most promising in allowing medical travel to run smoothly, for both patients and facilitators. Lack of the ‘human touch’ and responsiveness to the patients’ needs or lack of control and ability to manage certain processes effectively, and in a standardised manner, are both seen as counter-productive for the overall experience and provision of transnational healthcare.

Blurring the lines between different institutional configurations of care, presents itself as another complexity involved in transnational healthcare, that offers interesting ground for care ethics. Entangled in social and economic relationships with their patients, medical travel facilitators use a particular rhetoric, referring to their role: many present themselves as pseudo-family members, as a way of reproducing a certain version of care, which is provided within familial relations and is assumed to be particularly good, meaning it can be used as a benchmark, in normative evaluations of care. As with other forms of cross-border mobility in healthcare, a certain care vacuum results from the physical distance of the patients from their normal support systems, which results in the care gap within transnational healthcare, within which medical travel facilitators position themselves. The fluidity of the role of the facilitator, who navigates caring responsibilities and business interests, allows room for negotiation but also exploitation, with regards to patients and facilitators. This blurring of different versions of caring relationships, is thus a result of the particular spatio-temporal configuration of care, involved in transnational healthcare. It is important to recognise this lack of supporting infrastructure and how the micro practices that constitute care in the facilitator-patient relationship respond to shifts in the institutional arrangements of care. This provides a safe, smooth and ‘good enough’ experience to international patients, in which medical travel facilitators can invest themselves as entrepreneurs and caring fellow human beings.
8 Conclusion

The journey of following practices of medical travel facilitation in and between Oman and India throughout this thesis started off with the interlude offering some first insights into the facilitation work and the happenings in a corporate hospital in Delhi where ‘so many of the threads of medical travel run together’. The following three chapters traced some of these threads that highlighted the intricacies of transnational configurations of care, allowed me to explore the relationship between facilitation and care and provoked theoretical reflections within and across the fields of ethics, policy and Science and Technology Studies. These threads are now reassembled in a brief recapitulation of the answers to the three research questions and a discussion of the implications this hold for current academic debates in the social sciences about transnational healthcare and care more generally. This is followed by some final conclusions about the benefits of bringing a geographical sensibility to the care literatures and the potential that bringing the conceptual frameworks of care ethics and STS into conversation holds for future research.

The first research question asked about how practices of medical travel facilitation act to relate/articulate different kinds of spaces and spatialities involved in transnational healthcare. Medical travel facilitation acts to articulate networked, stretched, and folded spatialities through practices such as establishing and maintaining mobility infrastructures like Oman’s Treatment Abroad Scheme, coupling spaces of medicine, education and migration, actualising geohistorical relations, promoting places with medical heritage, or organising international events. All of this involves considerable amounts of work and efforts in establishing, maintaining, monitoring, controlling, normalising and perpetuating connections, of which many span across different nations, institutions and medical systems. Thereby different forms of connections were identified and analysed, being networked, statutory, informal, biographical, geo-historical, eventualised, national or transnational.

With these different articulations of spaces and spatialities of TNHC, medical travel facilitation acts to set up care in multiple ways: With the Treatment Abroad Scheme, Oman provides care for its citizens by folding private healthcare services delivered abroad into the national healthcare system and by funding and regulating this particular healthcare arrangement. Stretching the national health authority beyond Oman through the persona of the health attaché facilitates medical travel but also contributes to care itself by monitoring transnational
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healthcare and safeguarding international patients. Similarly, the efforts of certain entrepreneurial individuals who translate existing diasporic networks into channels for health mobilities act to set up healthcare and engage in forms of care by carefully attuning actors and actants in the facilitation process. Organising international events is another way to set up care by providing temporary, event-based networking platforms that fold spaces in ways that reiterate existing connections and hold the potential to form new ones.

These findings prompt us to critically review spatially-inflected notions such as ‘national’ and ‘transnational’ healthcare. Besides the connection through medical travel, healthcare in Oman and in India are both considered to be transnational for being constituted by cross-border mobilities of people, things, money, ideas etc., and for being shaped by international policies, healthcare standards and accreditation schemes. Despite some connections being trans-local rather than trans-national with medical travel being routed through informal cannel that link particular places, questions of citizenship and the fact that patients travel abroad and seek treatment in a place where they are categorised and treated differently from domestic patients, tie these mobilities to nation states, even if only loosely. The spatial entities in which healthcare and care are thought of should consider the multiple national, transnational and global entanglements of healthcare spaces. Politically, this offers scope for international health diplomacy in attuning local, national and international interests, resources and needs sensibly. Moreover, the prevalence and normalisation of allopathic medicine or the practice of treatment abroad in Oman raises questions about the power of implicit geographies in articulating healthcare spaces and shaping the receptivity towards certain places, institutions, systems of medicine and forms of care. The example of Oman and India showed how geohistorical relations, educational mobilities, diasporic communities or tourism campaigns considerably influence the ways in which transnational healthcare is set up, practiced and experienced. It is important to acknowledge the multiplicity of medicine, health and care and to critically analyse the power involved in the normative ordering pointed out in the articulation of transnational healthcare spaces. Attending to certain peculiarities of the given geohistorical care context can provide important insight in explaining and shaping certain patterns and mechanisms of TNHC.

The second research question asked about how practices of medical travel facilitation act to create a quality of smoothness in order to mediate healthcare transnationally. Analysing how medical travel facilitation acts to mediate healthcare transnationally suggests that not only the connecting work matters but also the qualities that those connections hold, mobilise and generate are of particular relevance. The quality of ‘smoothness’ was found to be central in medical travel facilitation, as a disposition, spatio-temporal manoeuvre and a result, and integral to making TNHC feasible. On the one hand, medical travel facilitation acts to manage
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‘roughness’ by anticipating, mitigating, omitting or bypassing problems. On the other hand, it creates ‘smoothness’ by carefully planning ahead, attuning actors and things, and coordinating processes sensibly and in a well-timed manner. This involves tinkering: tinkering with different means of communication technology, the level of detail in medical interpreting, forming strategic relationships, constellations of members in a care team, or with optimising timing. Mediating healthcare transnationally and making medical travel feasible is thus an ongoing process of attentive and careful adapting, coordinating, testing, learning-by-doing and fine-tuning in order to improve the situation of international patients but also of work of the facilitators itself. This suggests that medical travel facilitation in such a careful and tinkering manner is about more than an auxiliary brokerage service but constitutes itself forms of care, for the patient and, to some extent, for the work of medical travel facilitation.

This has implications in multiple respects. Smoothness was found to act as a quality of medical travel facilitation on which care is being calibrated following the logic that care needs to be practicable and feasible – smooth – to be effective and hence ‘good’. This finding suggests smoothness to be some sort of a normative quality on which care is calibrated, alongside the values of attentiveness, responsiveness, competence and responsibility established in care ethics. Although empirically developed in the context of TNHC, this conceptual contribution is considered to offer new ground for thinking about care and its principles in care research more generally. Moreover, and in line with this suggestion, taking care as a practice seriously, ‘tinkering’ as a key feature of care in practices should also be acknowledged in care ethics.

Considering creating smoothness as a form of care and a result of tinkering has implications for the care literature in STS as well. Exploring smoothness as both a spatial and temporal quality elaborates the spatio-temporal dimensions of tinkering. The care medical travel facilitation provides is of temporary and intermitted nature but particularly well-timed while being constituted by geographically dispersed actors and therefore often mediated virtually with only a limited time of co-presence of multiple actors of the care team in the same location. Such care is thus conditioned by very particular spatialities and temporalities that require some sorts of ‘highspeed tinkering’ that is mediated across virtual and physical spaces. An implication worth considering is that these spatial and temporal constraints may lead to glossing over certain deficiencies along the way for being focused on the main goal of facilitating medical travel satisfactorily. Such potential drawback of calibrating care on smoothness, again has implications for care ethics in terms of resolving and generating ethical issues.

Some of these issues have been analysed in the course of answering the third research questions which asked about how practices of medical travel facilitation negotiate ethical complexities involved in transnational healthcare. Analysing the practice of giving patients advice on choosing healthcare providers abroad showed that medical travel facilitation acts to
negotiate complexities arising from attempts to comply with ethical virtues of good care (such as attentiveness, responsiveness, competence and responsibility) and patient choice as guiding principle in healthcare, while also considering business interests. Moreover, looking closely at the facilitator-patient relationship allowed a different set of ethical complexities to be analysed that results from negotiating different ‘versions’ of individuals (people and cases, friends and service providers), relations (care and service) and principles (benevolence and profit) involved in the relationship.

Medical travel facilitation acts to negotiate these complexities by identifying, prioritising, playing off, but also combining different ‘goods’ and ‘versions’ in a process of working towards a compromise that pursues the overall goal of facilitating medical travel successfully and balances different interests along the way, again, in a tinkering manner. This means weighing up different options, testing how far certain interests and ideals can be realised without compromising them so much that processes get stuck or patients, facilitators or healthcare providers drop out of the medical travel endeavour. Care thus comes to be a carefully customised and situationally adapted compromise that is valid if considered ‘good enough’ by the different parties involved. Tinkering and smoothness remain important principles, also in negotiating ethical complexities, which strengthens the argument to integrate these qualities in conceptualisation of care.

Working across different institutional contexts was found to be another way in which medical travel facilitation negotiates ethical complexities arising from a certain care vacuum that results from healthcare being taken out of local structures, national funding schemes and informal support networks. Medical travel facilitation responds to this deficit substituting some of this care by articulating pseudo-familial care relationships whilst operating in a marketised setting. Such informal and yet commercially underpinned forms of care hold the potential to improve transnational healthcare but also opens room for exploitative practices and care relations and the outsourcing of care responsibilities of certain institutions. This response to the care vacuum in TNHC, mostly informal, unregulated and unevenly distributed, holds opportunities and risks alike. The lack of informal support networks that provide necessary care along the way of getting medical treatment in TNHC arrangements may disenfranchise particular groups of people who do not have the knowledge or the means to access such alternative forms of care as provided by medical travel facilitation. The fluidity of roles that actors such as medical travel facilitators demonstrate can point out some structural problems in the national and transnational organisation of healthcare and care. Attending to the ways in which they enact these roles and negotiate tensions may disclose areas in which social policy could intervene in order to improve the situation. Moreover, this situation raises questions about the responsibilities and power of certain actors and institutions in stepping in and counteracting this care vacuum.
At the same time, the study of TNHC illuminates aspects of local healthcare arrangements. The need for medical travel facilitation in a transnational setting makes visible how much care is provided, partly unacknowledged, by local support networks and healthcare infrastructures in local healthcare arrangements. Many of the decisions that international patients need to make (which country, hospital, doctor, medical system, tradition of care etc.) are not taken or made passively if treatment is provided locally for being pre-empted by certain infrastructures. These are often linked to funding schemes, but also norms, traditions, beliefs towards medicine, health and care and thus reproduces certain modes, norms and ethics of care. This opens room to reflect on how the political economy of care shapes certain norms and ethics with the way in which (health)care is conceptualised, organised and delivered.

As the discussion of the research questions and some of the wider implications indicate, the findings and conceptual contributions of the three sections are interlinked. Smoothness, mainly elaborated as a quality constituted by and constitutive of everyday mediations of transnational healthcare, becomes relevant also in negotiating ethical complexities as quality on which compromises are calibrated. Articulating spaces of TNHC relates to smoothness in that establishing and curating transnational networks forms the basis for, or creates the possibility of, smooth medical travel. The ways in which these spaces are articulated, again, involves negotiating ethical questions and thus reflect and (re)producing certain care ethics. Articulating spaces, creating smoothness and negotiating ethical complexities are thus closely interrelated and integral to TNHC for setting up healthcare transnationally but also for constituting forms of care in itself. This for relating actors and actants who collectively work towards stabilising and improving transnational healthcare as a smooth experience, business and practice in an attentive, responsive tinkering manner, producing, at best, a ‘good enough’ compromise that considers different principles, interests and actors.

While the discussion above already indicated how contributions to STS and ethics of care can inform conversations about transnational healthcare in different social sciences, I would like to reflect specifically on the ways in which a geographical or spatial sensibility has shaped these conceptual contributions and vice-versa. A geographical sensibility has informed STS thinking about care in this thesis by attending to the ways in which spaces and spatialities shape and condition how health and care are organised, funded and practiced. The transnational, as a very particular spatiality, produced and is productive of certain forms and modes of care. This allowed to reflect on how tinkering, for example, is transformed when taken out of a rather intimate setting and instead carried out by transnationally dispersed care teams that operate under very particular temporal and spatial conditions. The multi-sited ethnographic fieldwork and the different analytical levels, zooming in and out, considering how practices
on the ground relate to those in other places and thereby create in-between spaces, provide a
different setting to analysing care from an STS perspective that has a different timeline and is
spatially less bounded and locally situated than in other STS studies. STS literature, in turn,
directed the attention to the work involved in articulating certain spaces and spatialities and
the conceptualisation of care as a continuous tinkering and collective effort of different human
and non-human entities lead to an interest in how spatially dispersed care teams operate over
distance and accommodate spatially and temporally limited copresence. This eventually in-
spired the exploration of smoothness as an integral aspect of both medical travel facilitation
and care itself. This conceptual move of looking into ‘smoothness’ offers an alternative ap-
proach to much other STS work but the focus on the work involved in making things run
smoothly, partly and temporarily, remains a common concern.

Combining the relational approach of care ethics with a geographical sensibility was integral
for attending to implicit geographies of care and enhancing a better understanding of how the
geohistorical relations between Oman and India result in care transfers and a receptivity to-
wards certain forms of TNHC. The example shows, how configurations of care are simultane-
ously locally contingent and influenced by normative concepts around medicine and care that
may geographically be located elsewhere. Looking closely at the ways in which implicit ge-
ographies of care reproduce the prevalence of certain medical systems and care arrangements
in TNHC raises normative questions and calls upon more sensitivity towards the specificities
of care geographies and the underlying power they hold. Moreover, the complex and entwined
spatialities articulated by medical travel facilitation between Oman and India show how space
and spatiality shape care ethics in very particular ways.

Bringing the care literatures of ethics of care and STS into conversation proved to be a pro-
ductive way for thinking through care and TNHC, provoking different conceptual contribu-
tions. Departing from their common interests in care as a practice and a relational understand-
ing, the two theoretical frameworks mutually informed each other in terms of the sensibilities
they bring to certain aspects of care, their understanding of key categories such as practice,
space, brokerage or mediation, as well as the conceptual moves and methodological tools they
offer to the analysis. The empirically grounded sensitivity of STS research towards practices
is suggested to inform care ethics methodologically since some strands of this literature lack
adequate tools to research care practices. Moreover, the conceptual openness towards multiple
versions of care, its processual nature and tinkering character, featuring prominently in STS
approaches, can inform care ethics on a conceptual level, as suggested, by taking tinkering on
board in care ethics. Care ethics, in return, draws attention to the normativity involved in care
practices and critically analyses explicit and implicit power structures and geohistories that
inform care. Moreover, it focuses on qualities of (inter-personal) relationships and how these
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affect care, which suggests to not only look at the relation work itself but the qualities that these connections hold and generate, illustrated by the exploration and introduction of ‘smoothness’ as a conceptual tool. Bringing ethics of care and STS into conversation is thus seen as offering productive conceptual and methodological reflections with relevance for the study of TNHC, but also that of care more generally.

The project of following practice of medical travel facilitation between Oman and India and bringing the empirical material in conversation with recent work on care in STS and the ethics of care in order to better understand how practices of medical travel facilitation act to set up care transnationally offered insights on care and medical travel facilitation on multiple levels. One of the main contributions of this thesis is the conceptualisation of medical travel facilitation not just as setting up the possibility of care transnationally but as forms of care in itself. As a consequence, key practices such as relating, smoothing and negotiating are seen as forms of care as a sociotechnical practice. Moreover, bringing ethics of care and STS into conversation holds potential to further conceptual thinking by considering ‘smoothness’ as a quality on which care is being calibrated and introducing tinkering as a principle in care ethics. Methodologically, this thesis suggests using the synergies of different approaches to care for refining empirical research and bringing new insights. Politically, this thesis calls for more sensibility towards different forms of care and their contribution towards the social, economic and political organisation and provision of care. Moreover, the structural problem of a certain care vacuum in TNHC and the opportunities and risks, that a response from the side of medical travel facilitators holds, have been pointed out, suggesting to critically analyse how the political economy of care shapes current modes of national and transnational healthcare. And last but not least, this thesis shows that care is a compromise that is eventually always realised in everyday practices on the ground, creating the realities to reflect on, research and debate.
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