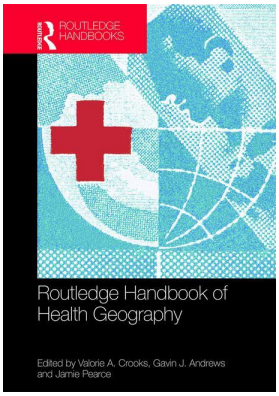

Routledge Handbook of Health Geography

Valorie A. Crooks, Gavin J. Andrews, Jamie Pearce

Rethinking care through transnational health and long-term care practices

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315104584-34
Meghann Ormond, Mika Toyota
Published online on: 11 Jun 2018

34

RETHINKING CARE THROUGH TRANSNATIONAL HEALTH AND LONG-TERM CARE PRACTICES

Meghann Ormond and Mika Toyota

With more people living longer than ever before, populations' medical and long-term care needs are increasingly placing strain on individual and collective resources and capacities. National governments are gradually withdrawing from responsibility for direct welfare provision for their citizenries and adopting neoliberal policies that facilitate and expand market-based involvement in health and social care. This has profoundly (re-)structured care relations by (re-)domesticating, individualizing, and commoditizing responsibility (Huang, Thang and Toyota, 2012; Raghuram, Madge and Noxolo, 2009). Yet, while much earlier research focused on this (re-)distribution of care responsibility *within* countries, a growing literature traces how formal and informal health- and social-care provision extends well beyond the national. The transnational (i.e., spanning of international borders) dimension of health and long-term care has been significantly heightened not only by neoliberal trade policies facilitating transnational flows of people, goods, and services, but also by advancements in communication technologies and biotechnological innovation (Gatrell, 2011; Sparke, 2009).

In this chapter, we draw health geographers' attention to the increasingly diverse transnational flows of caregivers and care seekers as well as the complex networks that they and their movements constitute and in which they get enfolded. To do this, we highlight contributions by scholars working at the crossroads of migration studies, transnational studies, health and social geography and anthropology, and social gerontology. This set of literatures critically engages with how transnational care practices challenge conventional conceptualizations and territorializations of care responsibility and entitlement between (non)citizens and states; individuals, families and communities; and consumers, workers and markets.

Transnationalizing the provision of care

Transnational health- and long-term care provision involves many people: from skilled health workers (SHWs) temporarily deployed by national governments engaging in health diplomacy and volunteers with not-for-profit organizations in countries in humanitarian emergencies (Snyder, Dharamsi and Crooks, 2011), to longer-term movements of SHWs from lower-income countries in search of better salaries and greater professional opportunities in middle- and higher-income countries; or from de-skilled migrant residential care-home workers caring for their elderly charges while at the same time caring from a distance for their own aging parents in their countries of origin, to the intimate and domestic labors of migrant women in commercially arranged marriages caring for their ailing spouses in their spouses' home countries (Piper and Roces, 2004).

In light of the ever-growing movement of foreign health, residential and domestic care workers to many rapidly ageing upper- and middle-income countries, the concept of global care chains (Hochschild, 2000; Parreñas, 2005) stands out as perhaps the best developed and most widely applied framework in research on transnational care in the last two decades. Based on a political economy of care approach, this concept effectively draws attention to the ways in which the care labor of women in globally more advantageous positions is substituted by that of women from more marginalized positions. For instance, a woman migrates from a city in a poor country to a wealthy country to work as a domestic maid. She, in turn, relies on a woman from the countryside to migrate to the city to care for her children in her absence. Along the chain, care deficits are passed downward in distinctly gendered, racialized and classed manners, with care labor – undervalued and sometimes even stigmatized – hierarchically extracted from the periphery to benefit those in the core (Raghuram, Bornat and Henry, 2011).

Yet, while migrants employed in various types of care work ameliorate care deficits in destination countries at the cost of care provision in their home countries, the phenomenon cannot necessarily be understood as neatly unidirectional care-resource extraction (i.e., brain drain) (Raghuram, Madge and Noxolo, 2009). In addition to remittances, migrant care workers can also usher in processes of brain circulation and other types of tacit knowledge transfer through their physical return or by developing long-distance collaboration (Connell and Walton-Roberts, 2016). Some sending countries are taking notice of their population's global care-labor potential and seeking to harness the benefits. In the Philippines, for instance, where 10% of the country's population works abroad, nurses are trained specifically for export as part of the government's national development strategy (McKay, 2016).

Increased domestic and transnational mobility, the literature points out, may significantly reconfigure the family- and community-centered networks at the core of care arrangements. In the case of elder care, for instance, transnational mobility challenges the meaning and feasibility of popular concepts like aging-in-place and community care, since notions of place and community become decoupled from geographic location (Milligan and Wiles, 2010). In acknowledging the diverse and overlapping forms that care assumes (e.g., practical, financial, emotional, embodied), scholarship on migration and transnational families (e.g., Baldassar, Vellekoop-Baldock and Wilding, 2007; Parreñas, 2005) has been especially useful for highlighting the distinctions delineated by ethicist Joan Tronto (1993) between caring *about*, which involves recognition of care needs; caring *for*, which encompasses assuming responsibility to ensure care needs are met; and care*giving*, which entails physical, hands-on care work. Migrant workers' long-distance family-oriented caring *about* and caring *for* practices, for example, may improve the health status of their children, aging parents and alternative caregivers through frequent phone calls and remittances that enable access to better food, housing and health care in the places in which they live. Likewise, migrants are not only *providers* of care but also themselves *recipients*, entwined in global networks through which multidirectional and multifaceted care flows also support and sustain *them* (McKay, 2016). By challenging widely held notions that physical proximity is requisite for providing *good* care, transnational mobilities not only reconfigure the spatialities of care but also urge us to re-examine what constitutes care in the first place.

Transnationalizing the pursuit of medical care

Spurred by perceived medical-care deficits in their countries of residence, more and more people are engaging in temporary and circular movements abroad for the satisfaction of their medical needs. This phenomenon is popularly, if inadequately and inappropriately, dubbed "medical tourism" (Connell, 2011). Taking advantage of the international patchwork of regulation and currency-exchange differentials (Pennings, 2002), transnational care seekers – most of whom hail from lower- and middle-income countries (Ormond and Sulianti, 2017) – use the global market to circumvent national regulations and costs in order to access care, treatments and procedures that are not available to them in their own health systems. Commonly

sought treatments include chemotherapy, organ transplantations and fertility treatments that are inexistent, are in limited supply or face legal restrictions on qualification in care seekers' habitual countries of residence (Inhorn and Patrizio, 2009; Kangas, 2002; Scheper-Hughes, 2001). Other reasons that compel the transnational movements of patients include concerns about accessing good-quality pharmaceuticals and diagnostic testing (Ormond and Sulianti, 2017); the desire to take advantage of experimental treatments like cutting-edge surgical procedures and stem-cell therapies (Petersen, Seear and Munsie, 2014); the wish to avoid moral polemics certain practices, such as commercial surrogacy, abortion and euthanasia, may provoke in care seekers' places of residence (Cohen, 2014; Pande, 2010); or the prohibitive domestic costs of routine and elective procedures such as joint replacements and cosmetic surgery (Bell et al., 2011; Connell, 2011).

Many national governments – having already marketized various components of their health and social systems – have identified transnational medical care to be a lucrative engine of national economic growth. This is facilitated by a range of factors. First, the epidemiological transition in many lower- and middle-income countries, coupled with demand by their rapidly growing middle classes and the proliferation of private hospitals, clinics and imaging centers, have led to a global dissemination of specialized biomedical knowledge and equipment (Bookman and Bookman, 2007). This provides crucial socio-technological infrastructure for the development of transnational medical care seeking. Second, free-trade agreements, particularly the General Agreement on Trade in Services (GATS), have worked to eliminate national barriers to the transnational movement of SHWs, health consumers, telemedicine and foreign direct investment in the care sector (Chanda, 2002), thus providing critical legal infrastructure for transnationalization.

The development of a medical-tourism industry, in turn, significantly impacts the general regulation of health care. State regulatory structures on health and care become subsumed by multifaceted and multiscalar governance structures, with regulation of health and care falling increasingly within the remit of both government bodies concerned with trade and industry and (transnational) private-sector actors. The Malaysian government's desire to attract well-heeled, fee-paying foreign patients, for example, led to the relaxation of national regulations on medical advertising and foreign SHW recruitment as well as the widespread promotion of US-based Joint Commission International accreditation for medical facilities on top of meeting national standards (Ormond, 2013). In the same vein, the Indian, Malaysian, and Thai governments have reduced import tariffs and provided other fiscal incentives to hospitals and clinics acquiring cutting-edge medical equipment and internationalizing their wards, lounges, and menus in order to tout world-class credentials (Crooks et al., 2011; Whittaker and Chee, 2015). Even airlines and airports are learning to adjust their spaces and border procedures to travelers who may be reaching their destinations with complicated, delayed, and poorly managed or poorly diagnosed conditions (Ormond, 2015).

The enthusiastic governmental and private-sector uptake of medical tourism exemplifies how market forces and the spread of biotechnological innovation combine to de-territorialize health and care from within the container of the nation-state. This de-territorialization complicates conventional notions of national citizenship, responsibility and entitlement by advancing the development of what Rose and Novas (2004, p. 132) call *biological citizenship*, in which the recognition of one's corporeality becomes increasingly central to one's individual and collective identities. The subsequent transnational re-territorialization and commoditization of health and care through frames of biological citizenship lead people, first, to see their own bodies as malleable sites of lifestyle and medical intervention (Connell, 2011); second, to see themselves as neoliberal subjects, not as passive patients but rather as proactive consumers of care and intervention (Ormond and Sothern, 2012); and, third, to see a diverse array of places around the globe as sites within which their needs and desires can be met, with scant attention to the health-equity impacts of their individual and collective pursuits on health systems either at home or abroad. Indeed, in the name of both economic and health-sector development, destination countries have come to privileging paying foreigners' medical-care needs and interests through the development of specific innovations and spaces out of reach and inappropriate to the average needs of most local people (Brown, Craddock and Ingram, 2012; Snyder, Dharamsi and Crooks, 2011).

Because of the ways in which transnational health-care seeking upsets conventional notions of citizenship rights and entitlements, it has cast in sharp relief some of the far-reaching yet often invisible effects of advancements in life-science technologies. Scholars using political economy and science, technology and society (STS) studies approaches have called attention to radical inequities in the ways in which modern medicine is accessed and used, particularly in the cases of organ transplantation and commercial surrogacy (Pande, 2010; Scheper-Hughes, 2001). Biotechnical advancements, such as immunosuppressant drugs that keep recipients' bodies from rejecting transplanted organs (Cohen, 2005) and the decoupling of sex and reproduction made possible by *in vitro* fertilization (Greenhough, 2011), for example, have enabled the number of bioavailable people (i.e., those with compatible bodily tissues that can be extracted, as in the case of organ harvesting, or temporarily borrowed in the case of surrogacy) to significantly expand beyond a small circle of close relatives and people with similar genetic backgrounds to much more distant others. As a result, the new supply-side of bioavailability looks very different, largely comprising bodies of the marginalized poor in lower-income countries commodified by those with sufficient purchasing power. Consider, for instance, surrogates repeatedly renting out their wombs in Thailand for foreigners with fertility challenges in order to provide for the needs of their own biological children, or impoverished Filipino men whose chances to get married and start families are reduced by the social stigma of having sold a kidney on the black market to foreigners seeking to circumvent their home-country waiting lists for a much-needed transplant.

Transnationalizing the pursuit of long-term care

A more recent transnational care practice produced by perceived *long-term care* deficits involves temporary, circular and permanent migration for the fulfillment of one's long-term care needs. International retirement migrants (IRMs) have generally moved abroad to maintain and maximize their health and quality of life relative to available resources. In turn, comparatively healthy, affluent, and autonomous seniors (the so-called third age), valued for their purchasing power and their non-competition with locals over jobs and other resources, have been welcomed by destination countries the world over (Toyota and Xiang, 2012). Part of this conditional welcome has hinged on an assumption that, upon becoming physically and mentally frail and economically vulnerable, IRMs return to their countries of origin for support from family and home-country health and welfare institutions instead of depending on the destination country's welfare system.

However, access to health services, resources and caregivers is increasingly recognized as both a motivation for international retirement migration and a growing need as IRMs age. Dissuaded by the prospect of burdening their families, reduced access to social benefits, dwindling savings and prohibitive institutional-care costs in their countries of origin, more IRMs have begun to either remain in their IRM destinations or relocate to such destinations upon reaching a stage of declining health and greater, costlier dependency (the so-called fourth age) (Hall and Hardill, 2016; Toyota, 2006). This permits them to outsource some of their everyday assistance and medical needs abroad and partly relieve their families and governments in their countries of origin of their care roles and costs (Ormond, 2014). Many IRMs may not officially register their presence, preferring instead to strategically circulate between their home and destination countries to circumvent tax regimes and to secure access to social benefits. Because these older migrants fall into varied economic and political-legal categories and are often precariously inserted in diverse sociocultural formations of care and support, they risk marginalization and exclusion from both their home and destination countries' health- and social-care systems (Ackers and Dwyer, 2002).

Just as the movement of care providers unsettles the relations between caring *about*, caring *for* and care*giving*, the mobility of long-term care seekers challenges the meaning of care. Physically distant from their previous homes, family members, and national health and social welfare systems, these care seekers are perceived to have special needs, desires, problems and resources, thus constituting a new subject of care. Correspondingly, a variety of transnational care spaces has emerged around long-term care, including luxurious gated

communities with advanced medical-care facilities, assisted-living facilities and nursing homes for foreigners, and live-in care arrangements enabling dependent seniors to "age (though abroad) in place" (Toyota, 2006; Ormond, 2014). Transnational long-term care has thus become intertwined with other lucrative business sectors, such as real-estate development and tourism, in ways that merit further study.

Conclusion

The transnationalization of health and long-term care on a global scale is a novel and fast-growing phenomenon. Its study arguably constitutes one of the most dynamic fields in health geography today. Recent scholarship has identified the multiple driving forces behind this development, particularly the demographic shifts, (bio)technological advancements and regulatory changes. The literature has also documented the experiences of a range of actors in the transnationalization of care and examined its multifaceted effects.

A strong common theme that emerges from the most recent literature is the question of inequity. In spite of dramatic economic, social and (bio)technological developments, access to and quality of health and long-term care resources within and between countries remain highly uneven. In fact, deeply entrenched inequities constitute a basis from which transnational care spaces emerge. It is in the market, state, civic, familial and individual responses to the uneven distribution of resources that diverse transnational care practices are produced. In many cases, inequities are intensified, rather than ameliorated, through transnational care practices.

The ways in which inequities are entrenched or transformed are highly complex and dynamic, and many mechanisms are not yet properly understood. The production and reproduction of inequities themselves become highly uneven processes. For instance, transnational care can work out well for those with the socioeconomic and political privilege to more easily deploy their biological citizenship (Rose and Novas, 2004): an underinsured middle-class American man in need of lifesaving heart surgery has dramatically more purchasing power in India than back home in the United States, and a middle-aged woman ineligible for fertility treatment in France because she is considered too old may undergo out-of-pocket treatment in Thailand with no questions asked by authorities. But it can also put those with more limited socioeconomic and political privilege at distinct disadvantage: a nurse born and trained in Nigeria may only be able to find poorly paid work at a residential-care home or in domestic-care services in Germany because her professional credentials go unrecognized in that country, or a Pakistani boy with the same life-threatening heart condition as the American man described above may not be able to enter India with his father for a long-awaited scheduled procedure because recent political tensions have temporarily closed border-crossings.

How can we map the distributions of costs and benefits across places and populations in ways that attend adequately to the nuanced intersections of somatic, socioeconomic and political identities involved in transnational care? We need to better understand how inequities are experienced and reflected on by different actors. Through transnational health and long-term care, many aspects of both care seekers' and care providers' individual attributes, such as gender, ethnicity, class and age, may come to acquire new significance and intersect with each other in new ways. The effects of transnational care, as suggested by such concepts as biological citizenship and bioavailability, is at once intrinsically embodied and socially far-reaching. These effects can be so physical that they cannot be properly captured by health-geography concepts, yet they can span not only space but also time, deeply transforming core understandings of social, economic and biological relationality between countries and across generations. Thus, multidisciplinary inquiries and the development of new theoretical language are urgently needed to make adequate empirical and ethical assessments about the growing range of transnational care practices.

References

Ackers, L. and Dwyer, P. (2002). *Senior citizenship? Retirement, migration and welfare in the European Union*. Bristol: The Policy Press.

Baldassar, L., Vellekoop-Baldock, C. and Wilding, R. (2007). *Families caring across borders: Migration, aging, and transnational caregiving*. New York: Palgrave Macmillan.

Bell, D., Holliday, R., Jones, M., Probyn, E. and Taylor, J. S. (2011). Bikinis and bandages: an itinerary for cosmetic surgery tourism. *Tourist Studies*, 11(2), pp. 139–155.

Bookman, M. Z. and Bookman, K. R. (2007). *Medical tourism in developing countries*. New York: Palgrave Macmillan.

Brown, T., Craddock, S. and Ingram, A. (2012). Critical interventions in global health: governmentality, risk, and assemblage. *Annals of the Association of American Geographers*, 102(5), pp. 1182–1189.

Chanda, R. (2002). Trade in health services. *Bulletin of the World Health Organization*, 80(2), pp. 158–163.

Cohen, I. G. (2014). *Patients with passports: medical tourism, law, and ethics*. Oxford: Oxford University Press.

Cohen, L. (2005). Operability, bioavailability, and exception. In: A. Ong and S. J. Collier, eds., *Global assemblages: technology, politics, and ethics as anthropological problems*. Malden and Oxford: Blackwell, pp. 79–90.

Connell, J. (2011). *Medical tourism*. Wallingford: Cabi.

Connell, J. and Walton-Roberts, M. (2016). What about the workers? The missing geographies of health care. *Progress in Human Geography*, 40(2), pp. 158–176.

Crooks, V. A., Turner, L., Snyder, J., Johnston, R. and Kingsbury, P. (2011). Promoting medical tourism to India: messages, images, and the marketing of international patient travel. *Social Science & Medicine*, 72(5), pp. 726–732.

Gatrell, A. C. (2011). *Mobilities and health*. London: Ashgate.

Greenhough, B. (2011). Citizenship, care and companionship: approaching geographies of health and bioscience. *Progress in Human Geography*, 35(2), pp. 153–171.

Hall, K. and Hardill, I. (2016). Retirement migration, the "other" story: caring for frail elderly British citizens in Spain. *Ageing & Society*, 36(3), pp. 562–585.

Hochschild, A. R. (2000). The nanny chain. *American Prospect*, 11(4), pp. 32–36.

Huang, S., Thang, L. L. and Toyota, M. (2012). Transnational mobilities for care: rethinking the dynamics of care in Asia. *Global Networks*, 12(2), pp. 129–134.

Inhorn, M. C. and Patrizio, P. (2009). Rethinking reproductive "tourism" as reproductive "exile". *Fertility & Sterility*, 92(3), pp. 904–906.

Kangas, B. (2002). Therapeutic itineraries in a global world: Yemenis and their search for biomedical treatment abroad. *Medical Anthropology*, 21(1), pp. 35–78.

McKay, D. (2016). *An archipelago of care: Filipino migrants and global networks*. Bloomington: Indiana University Press.

Milligan, C. and Wiles, J. (2010). Landscapes of care. *Progress in Human Geography*, 34(6), pp. 736–754.

Ormond, M. (2013). *Neoliberal governance and international medical travel in Malaysia*. Abingdon: Routledge.

Ormond, M. (2014). Resorting to Plan J: popular perceptions of Singaporean retirement migration to Johor, Malaysia. *Asian & Pacific Migration Journal*, 23(1), pp. 1–26.

Ormond, M. (2015). En route: transport and embodiment in international medical travel journeys between Indonesia and Malaysia. *Mobilities*, 10(2), pp. 285–303.

Ormond, M. and Sothern, M. (2012). You too, can be an international medical traveler: reading medical travel guidebooks. *Health & Place*, 18(5), pp. 935–941.

Ormond, M. and Sulianti, D. (2017). More than medical tourism: lessons from Indonesia and Malaysia on South-South intra-regional medical travel. *Current Issues in Tourism*, 20(1), pp. 94–110.

Pande, A. (2010). Commercial surrogacy in India: manufacturing a perfect mother-worker. *Signs: Journal of Women in Culture & Society*, 35(4), pp. 969–992.

Parreñas, R. (2005). Long distance intimacy: class, gender and intergenerational relations between mothers and children in Filipino transnational families. *Global Networks*, 5(4), pp. 317–336.

Pennings, G. (2002). Reproductive tourism as moral pluralism in motion. *Journal of Medical Ethics*, 28(6), pp. 337–341.

Petersen, A., Seear, K. and Munsie, M. (2014). Therapeutic journeys: the hopeful travails of stem cell tourists. *Sociology of Health & Illness*, 36(5), pp. 670–685.

Piper, N. and Roces, M. (2004). *Wife or worker? Asian women and migration*. Lanham, MD: Rowman & Littlefield Publishers.

Raghuram, P., Bornat, J. and Henry, L. (2011). The co-marking of aged bodies and migrant bodies: migrant workers' contribution to geriatric medicine in the UK. *Sociology of Health & Illness*, 33(2), pp. 321–335.

Raghuram, P., Madge, C. and Noxolo, P. (2009). Rethinking responsibility and care for a postcolonial world. *Geoforum*, 40(1), pp. 5–13.

Rose, N. and Novas, C. (2004). Biological citizenship. In: A. Ong and S. J. Collier, eds., *Global assemblages: technology, politics and ethics as anthropological problems*. London: Blackwell Publishing, pp. 439–463.

Scheper-Hughes, N. (2001). Commodity fetishism in organs trafficking. *Body & Society*, 7(2–3), pp. 31–62.

Snyder, J., Dharamsi, S. and Crooks, V. A. (2011). Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists. *Globalization & Health*, 7(6), pp. 1–14.

Sparke, M. (2009). Unpacking economism and remapping the terrain of global health. In: A. Kay and O. D. Williams, eds., *Global health governance: crisis, institutions and political economy*. London: Palgrave Macmillan, pp. 131–159.

Toyota, M. (2006). Ageing and transnational householding: Japanese retirees in Southeast Asia. *International Development Planning Review*, 28(4), pp. 515–531.

Toyota, M. and Xiang, B. (2012). The emerging transnational "retirement industry" in Southeast Asia. *International Journal of Sociology & Social Policy*, 32(11/12), pp. 708–719.

Tronto, J. C. (1993). *Moral boundaries: a political argument for an ethic of care*. London: Routledge.

Whittaker, A. and Chee, H. L. (2015). Perceptions of an "international hospital" in Thailand by medical travel patients: cross-cultural tensions in a transnational space. *Social Science & Medicine*, 124, pp. 290–297.