

# Caring across borders

The politics of belonging and transnational health

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**ABSTRACT:** Health care supply, demand and responsibility are increasingly becoming transnational. More people seek care beyond state borders, while, at the same time, most health systems are still organized nationally. Though most socio-anthropological literature on this topic focuses on “health tourism”, this article takes a different perspective: it considers migrants’ health travel at the intersection between the neoliberal framework of global health and the politics of belonging. It explores the transnational medical trajectories of family/reproductive health among Moroccans and Ecuadorians living in Italy. On one hand, migrant parents’ transnational practices are influenced by contexts of belonging – or not belonging – that they experience in Italy, including in medical encounters. On the other hand, migrants enact tactics to navigate the neoliberal framework of care. The article highlights the need for the development of a transnational framework to regulate the increasing transnational dimension of healthcare in order to mitigate (rather than increase) health, economic and social gaps between states.

**KEYWORDS:** HEALTH CARE, TRANSNATIONAL FAMILIES, MIGRATION, MEDICAL TRAVEL, HEALTH INSURANCE.

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## *Introduction*

Transnational travels in search of medical care are intensifying, and it has been estimated that a large number of transnational patients are migrants returning home for treatment (Whittaker *et al.* 2010 ; Ormond 2014)\*. Migrants' health practices are often transnational composites generated through the use of health systems and practices in both places of settlement and of origin (Elliot, Gillie 1998; Dyck, Dossa 2007). Transnational migrants rely on their personal networks and their knowledge about, and entitlement to, more than one national health system (Murphy, Mahalingam 2004; Krause 2008; Brijnath 2009; Kane 2012).

This situation complicates the questions researchers have traditionally asked in studies of migration and health, such as the cultural competence of medical personnel and of how healthcare is organized at a nation-state level. Rather, increasing attention should be paid to the complex relationships between migrants, their place(s) of origin and their place(s) of settlement. A focus on migrants and health in a transnational perspective also sheds new light on the conceptual framework used to describe medical travels, usually conceived of as "medical tourism". The term suggests leisure and rational choice, and therefore leaves unexplored other processes that sustain transnational medical trajectories (Sobo 2009), which have important ramifications for healthcare for both sending and receiving countries, at both global and local levels. What a focus on medical tourism obscures, in particular, is the political significance of the economic liberalization of healthcare services across borders (Tiilikainen, Koehn 2011). Recently, Dao and Nichter have called

for an anthropology of health care financing in low to middle income countries and for ethnographies of the social and organizational life of insurance programs that are attentive to biopolitical issues driving insurance policy decisions, program implementation and their impact on health disparities, as well as distributive justice. [...] How does current health insurance practice reflect fundamental ideas about citizen rights and state obligations? Asking this question will lead us to consider not only programs that exist, but also the politics of the possible (Dao, Nichter 2015: 14).

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This article does not focus on insurance programs *per se*, but on the biopolitics which, transnationally, fuel the implementation of neoliberal health care regimes. A focus on biopolitics is facilitated by the analysis of parenting medical practices, which are considered an integral element of “good citizenship” (Raffaetà 2015a; Umut 2011: 701). The available literature has generally adopted a narrow domestic focus: important political and economic issues in medical transnational travels have been overlooked due to a narrow political focus on national settings. However, the tendency to restrict healthcare governance to the confines of “methodological nationalism” limits the comprehension of the actual processes in healthcare because supply, demand and responsibility in health care are increasingly becoming transnational. Transnational medical travels draw a “networked topography” (Beck 2012: 362), which reconfigures space in new ways (Raffaetà *et al.* 2017). This new space has been identified as “global forms” (Knecht *et al.* 2012) or “medicoscapes”, which Hörbst and Wolf describe as

[...] a globally dispersed landscapes of individuals; national, transnational, and international organizations and institutions as well as heterogeneous practices, artifacts, and things, which are connected to different policies, power relations and regimes of medical knowledge, treatments, and healing. While concentrated in certain localities, medicoscapes connect locations, persons, and institutions via multiple and partially contradicting aims, practices, and policies (Hörbst, Wolf 2014: 184).

This article examines the travels “back home” made by migrants of Moroccan and Ecuadorian origin living in Italy in search of care for their children, family or for their own reproductive health. By combining family and health visits to their place of origin, parents often supplement the care that their children and/or they received in Italy. By considering migrants’ transnational trajectories and exploring the link between the politics of belonging and health seeking behavior, this article aims to highlight the political dimensions of these medical landscapes and the urgent needs to be addressed. The article calls for the development of public health regulations within a transnational framework able to protect individual’s right to health despite mobility beyond the neoliberal grasp. A focus on belonging is crucial in highlighting the political implications of transnational medical trajectories because it is a meso level which mediates between the micro level of individual experiences and the macro level of policy and economic inequalities between governments, rampant trade liberalism and national politics of recognizing difference. A detailed analysis of the interstices between these two levels, typical of anthropology, is able to illustrate both the opportunities and challenges of the hybrid space emerging at the

interface between the state and the market (Pfeiffer, Nichter 2008; Pellecchia, Zanotelli 2010; Biehl, Petryna 2013; Maciocco, Santomauro 2014; Raffaetà, Nichter 2015). Following this approach, the article seeks to complement the scientific debate about global health beyond a simplifying economic or culturalist framework.

The first section illustrates how migrant's families take care of their children in Italy. Then follows a description of transnational flows of medications and of people, analyzed in light of the politics of belonging and an exploration of the consequences created by a free market of transnational health services. The article illustrates an unregulated transnational medical space and highlights the need for the development of policies governing transnational medical flows that mitigate (rather than increase) economic and social gaps between states.

This study derives from ethnographic research on the experiences of immigration and parenting conducted from 2011 to 2013 among 18 Ecuadorian and 21 Moroccan families living in Val Rendena, an Alpine valley in Trentino, a northern region of Italy. Parents in my study migrated to Trentino, a region which counts around 48,000 migrants, amounting to 9.2% of the provincial population (Ambrosini, Boccagni, Piovesan 2011). The focus on two quite different groups, Moroccan and Ecuadorian parents, was intentional in order to think about parenting and migration beyond ethnicity and to emphasize the findings shared by the two groups that cut across their specificities.

Recruitment, community liaison, advice and support, and dissemination of findings were assisted through the establishment and meetings of reference groups. These included representatives from local family health and social services, Val Rendena's multicultural association, and personal networks. Initial participant contact was complemented by snowball recruitment. The initial selection of the sample was based on place of residency (Val Rendena), national origin (Moroccan or Ecuadorian) and family status (participants had to have one or more children aged six years or younger). The women interviewed were aged between 23 and 45 years, they were all married except one who was divorced and a single mother, about half of them were working (mostly from the Ecuadorian sample) and had been living in Italy for several years.

A three-stage methodology was devised to analyse participants' experiences of migration and parenting. It involved in-depth interviews and participant observation. Healthcare and parenting practices are personal and intimate matters, especially when these happen transnationally. The acceptance of my role as researcher was probably facilitated by the fact that I

was a mother too. My 3-5 year old child would come with me to weekend community gatherings, various parties and she mixed with the children in the migrant community. Without participation in these activities (substantially ignored by conventional reports of population health) I would not have had the opportunity to grasp the often invisible, but yet very tangible in their outcomes, transnational medical trajectories of migrants.

### *In Italy: the biomedicalization of parenting*

The often marginal social position of migrant families within host societies and their distance – in time and space – from original models of parenting made Moroccan and Ecuadorian mothers participating in the research particularly anxious for the wellbeing of their children (Raffaetà 2013). Children's health is a catalyst for various anxieties, hopes and feelings in relation to the family's migratory experience. A great symbolic investment is made into children, who are expected to bear the fruits of parents' sacrifices and suffering (Carling *et al.* 2012; Kelley, Tseng 1992). Children are a central axis of family migration, and an important reason why families move across borders and sustain transnational ties (Orellana *et al.* 2001). Immigrant children are of great importance for receiving countries too. Family and parenting are a crucial site of negotiation in current democracies between the role of the individual and that of the state (Gillies 2005; Lee *et al.* 2010a). Children are regarded as requiring special protection, which means that parents are especially controlled by the state. In legal terms, parents have a "duty of care". Processes of control in parenting practices are increasingly at work in the global north (Faircloth *et al.* 2013; Reece 2006), but immigrant parents are a special target (Grillo 2008; Walsum 2004) because children do not only belong to them but somehow also to the state under which protection they are born. According to the legal principle of *parens patriae* the state has a legitimate power to intervene into parenting because it is legally recognized as "parent" of its citizens, children included. As Hanan, a 33 year old Moroccan with 2 children who has been living in Italy since 2001, notes:

here we have responsibilities. Here we are not in Morocco, here we have more responsibilities towards our children, we have the opportunity to access healthcare. It is also a duty. Instead of using herbs, other things, it is better to profit of the opportunity to have proper care. Given this opportunity, why not exploit it?

As Hanan observes, there is a thin line between duties and rights. The right to access healthcare also produces more responsibilities, thus tightly binding migrants in a medicalization circle.

Moreover, biomedicine is not only considered credible and authoritative, but substantially “part of the very package of improved life circumstances that women hoped to access when they migrated in the first place” (Gálvez 2011: 12; see also Wailoo *et al.* 2006). Even if healthcare systems are quickly changing towards increased privatization (Frisina Doetter, Götze 2011), in 2000 WHO ranked Italy second best in the world<sup>1</sup>. The current national health service (Servizio Sanitario Nazionale – SSN) was established in 1978, with universal coverage and tax funding. Family doctors and hospitalization is entirely covered by the SSN. Specialist visits or diagnostic tests require a copayment when prescribed by the family doctor with the exception of protected groups. In comparison, the Moroccan and Ecuadorian health systems present difficulties in meeting the population’s health needs. The Moroccan health system, reformed in 2005 in order to expand health insurance coverage (only 16% of the population has medical coverage), does not have a universal or compulsory health insurance system. Even though on paper residents/citizens/local have free access to needed health care, the quality of care these facilities provide is generally considered low and it may depend on incentives on the supply side to require “extra charges” for services (Prah Ruger, Kress 2007). The situation in Ecuador is different (given its emphasis on preventive care and community health) but, like the moroccan migrants, the Ecuadorians partecipating in the research considered medical infrastructure at home poorly supplied and of a lower standard than in Italy. Roberts (2013) observes that public health in Ecuador had a role in a whitening project, aiming at transforming the poor and indigenous population into national citizens. However, this project was undertaken through the neglect of public medicine, encouraging people towards private medical care: “Given that state services in the early 2000s were generally devalued and the recourse only of poor, indigenous, or Afro-Ecuadorians, people across class and race went into debt to afford private medical care so they wouldn’t be treated ‘like Indians’” (2013: 568).

For a number of migrants, the opportunity to easily access biomedical treatments is among the planned advantages of the decision to migrate. Sometimes, their enthusiastic embrace of biomedicine might produce paradoxes, as in the case of Alloui, a Moroccan woman of 34 years with two children and one to come, who tells me she has done amniocentesis even though she had never thought about having an abortion. As she explains, the procedure “was prescribed by the gynecologist. And it is anyway a medical

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1. WHO Health system attainment and performance in all member states, ranked by eight measures, estimates for 1997, [www.who.int/whr/2000/en/annex01\\_en.pdf](http://www.who.int/whr/2000/en/annex01_en.pdf), accessed on 25/05/2019.

examination. It can be useful for the mother's health, maybe they [*the doctors*] can see something wrong, you never know, it can be useful". At the same time, Alloui affirms that in case the amniocentesis would prescribe an abortion, she would not undergo it because forbidden by Islam. Hughes Rinker (2015: 238), suggests that in the case of Morocco, adherence to medical programs which are expression of a neoliberal development agenda is in part due to the desire to offer their children a better life by taking advantage "of the tools offered by the state to improve their lives and to become financially secure". At the same time, she notes how the neoliberal logic of self-regulation and responsibility is not the same everywhere: in Morocco it interweaves with Islamic beliefs.

While some women used traditional remedies in the form of herbs, most of the research participants discarded them, perceived as inseparable from their legacy to poverty and to what they considered a "backwarded mentality". As Nadia – a Moroccan woman of 40 years, with curly and colored blond hair, living in Italy since 2002 with two children:

Old people treat themselves with herbs, but we do not go back, it can be dangerous. My father uses herbs, I don't. My mother uses all those things [Nadia makes a disgusted face]. She treated us that way [she laughs]. She performed black and white magic. But we don't, we do not go back. Otherwise, why would we be here?!

In her argument, Nadia blends the use of herbs with magic, both expression of outdated treatments. She underlines her determination not to go back, and this intention is mirrored both in her migratory path and medical treatments.

Most of the mothers, however, found their expectations of medicalization frustrated. Mothers often lamented the "soft" approach of Italian pediatricians who, according to them, did not prescribe enough medicaments and diagnostic tests. Sara, who arrived with 2 children from Morocco in 2007, expresses clearly her dissatisfaction: "The pediatrician examines my child only by looking, without prescribing any test. 'Can you prescribe me some analysis? Some X-rays to see if it is all right or not?! Tell me why X-rays and tests exist if the eye is enough?!" In Sara's narrative, technological devices have priority with regard to the "eye" and experience of the doctor. Perceived under treatment is one of the reasons for many families to directly go to the emergency room (ER) and sidestep the pediatrician (Raffaetà 2013). The ER is described as a reassuring place "because there you can find all doctors you wish, all the specialists, they are more competent and it is a safer place. There are all the machines, all the exams" (Ibnissam, Morocco). This attitude grounds on the comparison, here only implicit, with the care received at home.

Maria, 44 years, two children and lives in Italy since 2001 observes:

Sometimes he [*the Italian pediatrician*] is good because he prescribes me some strong drugs, when it is needed. But in general, they are too hasty. The pediatrician, in Ecuador, explores the child from the tip of his toes until the tip of his hair.

Again, the negative judgment of Italian medical professionals is made on the backdrop of the comparison with home. The difference between the care received at home and that received in Italy has the effect to jeopardize the trust in Italian medical interventions. In the next sections I will illustrate the various ways through which migrants access care transnationally and their motivations.

### *Transnational flows of medicaments*

As highlighted by previous studies (Beijers, de Freitas 2008; Krause 2008; Thomas 2010), it is common for migrants to exchange medicines and treatments that flow back and forth between the home and the host country. In line with these findings, research participants told how, when coming back from home, they travelled with bags filled with essential oils, soap and creams, used for the treatment of skin and hair problems. They also evaluated the disparity in costs for drugs and medical interventions and bought medicines where the prices were most reasonable. Both Moroccans and Ecuadorians bought generic drugs (such as pain-killers or anti-inflammatory medicines) in their home country and brought them to Italy, or asked relatives and friends to bring such drugs when traveling to Italy. A common explanation for justifying the transnational movement of drugs, irrespective of their origin, is that they are identified as “more powerful”. This explanation is provided even when the active ingredient in the medication is exactly the same in the sending and receiving countries and the drug differs only in name, packaging, or shape (pills, drops, powder). The assumed difference in efficacy is often related to the national or cultural context in which a drug is produced<sup>2</sup>. Some research participants sent drugs from Italy to relatives back home with the assumption that biomedicine from Europe is more powerful than locally available drugs. The reverse was also true, some people asking relatives and friends to send medicines from home because these “are stronger” than the ones available in Italy. These ambiguities and contradictions in medicaments’ perceptions reveal the

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2. On the relation between assumed efficacy and meaning see Van der Geest, Whyte 1989; Van der Geest, Whyte, Hardon 1996.

tensions between the imaginary of modernity contained in Italian drugs, based on the assumption that biomedicine from Europe is more powerful, and the emotional attachment to medicine representing the home context, also called “the social efficacy of traveling medicines” (Pribilsky 2008). Thus, these contradictions are not only about modernity and tradition, but they also reveal what is “home”, what emotions and ideas are attached to it and how its concept is dispersed in multiple scales and times.

Beyond social efficacy, practical considerations also matter. Jenny, an Ecuadorian mother, explains that some drugs are available in Italy too, but she and her Ecuadorian friends usually do not know the Italian name. Thus, they should go to the GP (general practitioner) to have a prescription. GPs, however, are often unwilling to cooperate. Therefore, the solution is to ask a friend or relative to carry with him/her the drug during next trip to Italy. It is not possible to send drugs by post from Ecuador to Italy: one needs someone to carry drugs and show the medical prescription to customs authority at the airport, even for drugs available over-the-counter. According to Jenny, this is a common habit and Ecuadorian doctors are used to perform this kind of prescriptions for expatriates. Among research participants, the readiness to carry someone else’s drugs from or to Ecuador was an important social issue, bonding migrants in ties of reciprocity or creating motive for conflicts in case of denied help. This is telling of the social value assigned to transnational drugs and the charged meanings of these exchanges.

### *Transnational flows of people*

Not only drugs travel, people travel too. Research participants did not primarily travel for seeking care, but their medical encounters were part of their visit to relatives. This is the case of Sara (whose dissatisfaction with Italian pediatricians has already been illustrated above):

When I go back to Morocco I take advantage of being there to have medical consultations, most of all for the children. In Morocco doctors make a proper check of all the body and then they prescribe many exams, X-rays... they make all, they are more precise [*than in Italy*]. They explain well, with calm, not as here [*Italy*] where doctors have a quick look at you and that's all. They [*Moroccan doctors*] understand better our problems. And they are also cheap; a visit to a private doctor costs me around 10 Euros. And they are very competent, you know they have studied in France, Great Britain... they are very good.

For these visits, Sara usually goes to a hospital in Casablanca, a big and modern medical structure where, as she highlights, “Western medicine” is practiced. Quite interestingly, the better judgment of Moroccan doctors in

comparison with their Italian colleagues is granted by their European education. This seems to instill drops of “modernity” into a comforting and traditional background. As Sara observes, the relationship with Moroccan pediatricians is easier, but this is not simply a matter of speaking the same language. By saying “they understand better our problems” Sara points to the sharing of common cultural references and knowledge of “local biologies” (Lock 1993). This common background shapes attitudes and expectations of both doctors and patients, facilitating the medical encounter. For example, as most other Moroccans, Sara had her two sons circumcised in Morocco. The Italian health system does not take into proper account such specific medical needs, characteristic of certain groups. Given that this practice is rather rare among Italians, migrants wishing to circumcise their children may have to wait up to a year before being called in for the medical procedure. As a result, many decide to circumcise their children while visiting the home country, thereby adding the advantage of a short waiting list to the mutual implicit understanding of gender and body conventions that the home context brings with it.

This is particularly important one people have to deal with parenting and reproduction, these being issues heavily laden with political meanings. In Ecuador, for example, giving birth to new babies is emphasized as a desirable personal goal and social duty to be supported by all means despite the crumbling public health care infrastructure (Lind 2012). Despite in Italy making a family is seen favourably too, in the experience of Jenny, Ecuadorian doctors were better at welcoming her desire to become a mother. Jenny is 38 years and is in Italy since 2001. She and her husband were trying unsuccessfully to have a child for 9 years. While a sperm test confirmed her husband’s capacity to procreate, Jenny suffered from poor and sporadic menstruation. She consulted 3-4 Italian gynecologists who performed ultrasound; all agreed that everything was right with her. The last doctor booked her a visit at the local centre for assisted reproduction without explaining much. The day of the visit Jenny and her husband discovered what assisted reproduction was. They were a bit puzzled and offended: “I do not know what he [*the gynecologist who booked the visit*] understood. Probably he still thinks I am not fertile...”. They also discovered that the first real visit was planned 12 months later. Jenny’s husband, quite upset, said to the doctor “within a year my daughter will be already at school!” Few months later, during a travel to Ecuador the couple decided to consult a local gynecologist. They showed him the exams performed in Italy and the doctor identified an ovarian cyst, to be removed, which was preventing Jenny to

become pregnant. Jenny recalls that the doctor added “I assure you at 100% that in 3 months after surgery you will be pregnant”. She had the surgery within few days and exactly 3 months later she happily found herself to be pregnant: “It was like a miracle, you can find this kind of stories only in fairy tales! If I relied on Italian doctors I would be still there waiting, they understood nothing of my condition!”.

As a result of this almost magical experience, in Jenny’s narrative, the competency of the Ecuadorian gynecologist goes hand in hand with the fact that in Ecuador her desire to become a mother has been better supported in comparison to Italy. Even if Jenny did not think to be discriminated as being an ecuadorian migrant in Italy, still she felt that in Italy reproduction is not taken seriously. This made her proud for her homeland, a place where one can find good standards of biomedical care, even superior to European ones.

Higher trust in homeland doctors may bring to the creation of transnational “therapy networks” (Krause 2008): doctors based in various national contexts might constitute a transnational team, as advisors and facilitators in therapeutic decisions or in prescription made in one national context. This is the case told by Maria, 44 years, two children, living in Italy since 2001. When Maria’s son was 2, he had to undergo a difficult surgery for a serious problem with his gut. She did not totally trust the Italian medical personnel. During the time spent in hospital she called every day her aunt in Ecuador who was working as a nurse in hospital. Maria was asking her opinion with regard to the medical choices taken by the Italian doctors and about the exams and the drugs prescribed. The aunt related to Maria by consulting the Ecuadorian doctors working with her. Fortunately, the opinions of the Ecuadorian doctors were consistent with those of the Italian doctors, reassuring Maria and preventing medical controversies which would have been difficult to handle.

Other causes – at the juncture of national economies and neoliberal processes– should be considered beyond the “cultural competency” of doctors in sustaining transnational medical travels. Both in Morocco and Ecuador, only the poorest access the public health system, described by research participants as of low quality. The norm is to consult private doctors. This is particularly true for migrants who enjoy a “status paradox” (Nieswand 2011) when back home, by gaining a higher status through the income they gain with low-status work in the country of emigration. This allows them to access more easily private medical care. Laila, from Morocco, 34 years, in Italy since 1998 and with 2 children observes:

*Laila:* We were in Morocco, K had fever, even if I gave him Tachipirina [*Italian drug*] the temperature did not decrease. We went to the pediatrician and he examined K for a long time, very differently from my [*Italian*] pediatrician...

*Roberta:* Was he more competent?

*Laila:* Mmm...same, they are both good. But pediatricians in Morocco are private, therefore they have to gain the visit [*she laughs*]...probably also this is the reason. And also because it was the first time that the [*Moroccan*] pediatrician saw K. In Italy I go to the pediatrician every month...

Laila points to the fact that performing more accurate visits might be a role played by private doctors, somehow compelled to perform a more careful visit in order to justify their fees and to be competitive within a wide offer of private medical care. Linked to these economic considerations, she also alludes to organizational factors, such as the accidental access performed by transnational patients, that might motivate a more in-depth visit.

Laila observations jeopardize the romantic vision many migrants expressed about the quality of care received in their homeland. Given the structural fallacies of the homeland health system, both in Ecuador and Morocco, migrants might even arrange for their relatives to be cared by an Italian doctor in person when they come for visits. Depending on the trust between the Italian doctor and the migrant, this caring relationship can extend through time and space. Some Italian doctors continue to provide drug prescriptions for returned relatives that are then sent to Ecuador or Morocco, as in the case of Carla's mother. When Carla, originally from Ecuador, living in Italy since 15 years and married to an Italian man with whom she has a child, gave birth for the first time, her mother came to Italy. Carla's mother has had a problem with a varicose vein in her leg for many years, but never thought to seriously take care of it. Once, while accompanying Carla to the GP for a regular visit, the GP also had a look at her leg. Carla's GP prescribed a visit to a specialist for the mother, who, one year later, had surgery on that leg in the local hospital in Italy. Even if Carla's mother came to visit her daughter in Italy only time to time, she received a regular permit to stay for family reunification, thereby gaining the right to have free access to Italian healthcare. So, the surgery did not incur any costs to Carla's mother, while in Ecuador it would have been an expensive endeavour. After recovery Carla's mother went back to Ecuador and followed up the surgery by taking a specific kind of drug prescribed by Carla's GP. Carla buys it in Italy and then sends it to her mother in Ecuador. Although this case does not deal with children's health or reproductive health, it reveals the crucial role of family in health-related matters and the fact that not always migrants search care in the home country, but the flow is sometimes reversed in light of economic considerations.

The case presented – from Sara to Carla – reveals forms of caring which are graded according to graded forms of citizenship<sup>3</sup>. While common understanding of gender and body (Sara) and of reproduction and parenting (Jenny) are important in engendering trust and compliance (Maria) and therefore addressing migrants' preference for the care provided in the homeland, the case of Laila and Carla point to complementary processes and forces which somehow elusively transform migrants' medical choices and trajectories. These are not simple economic considerations (e.g., which doctor cost less?) but are tactics undertaken at the juncture of national economies and neoliberal processes. Ong (2006) argues that an interactive mode of citizenship with alleged social rights and entitlements is emerging. This is linked to personal affordances in a global market more than to membership within nation-states: "Articulations between citizenship elements, entrepreneurial traits, and global circuits fragment what we long assumed to be a homogeneous collectivity and a unified space of citizenship" (2006: 16).

### *Politics of belonging and healthcare trajectories*

A rich literature has shown how Mexicans living in the US cross the border into Mexico to circumvent a lack of insurance and the high cost of medical care in the US, so taking advantage of the disparity between the costs of private health care in Mexico and the US (Chavez 1984; Seid *et al.* 2003; Wallace *et al.* 2009). The nexus of neoliberal regimes of care and economic disparities among states is, however, not enough to determine transnational medical trajectories. A growing number of studies in different parts of the world has illustrated (Horton, Cole 2011; Lee *et al.* 2010b; Ormond 2014) that healthcare cost is not the main or only trigger for migrants to search healthcare "back home". Italy is a good case study to appreciate this because the Italian health system includes free and unlimited access for primary, needed and urgent care of standard. More than economic considerations, health seeking tactics of Ecuadorian and Moroccan are influenced by the politics of belonging (Geddes, Favell 1999; Yuval-Davis 2011) enacted in therapeutic encounters and resulting in positive and negative experiences of inclusion or exclusion.

The impact of medical visits and travels to the homeland varied greatly according to migrants' feelings of belonging, which refers to rights and duties, but also to the emotions that membership evokes (Hage 2003). Belonging refers to the past (origins, heritage) but also to the future in terms

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3. I thank one Anuac reviewer for having suggested this concept.

of feelings of hope and imagination of what will be the future (Raffaetà 2015b). Tellingly, Carla and Laila (the first developing tactics to receive care for her mother in Italy and the second putting the care received in Morocco into a global perspective) were, among the women participating in the research, the one who felt most attached to Italy. A politics of belonging is salient in medical encounters because they concern questions of participation and recognition. The encounter between a doctor and a patient is not just a matter of health or a medical visit; rather, it is a political situation in which patients are (or are not) acknowledged as citizens and parents, through their role as patients (Gálvez 2011). Medical situations are not only about the relationships between therapeutic professionals and patients, but also about the interface between a person and the state, the private and public spheres, involving both therapeutic regimes and the politics of entitlements.

The concept of belonging is a vital node within the recent debate concerning the character of transnational migration (Yuval-Davis 2004). Since the 1990s (Glick Schiller *et al.* 1992), transnational studies of migration have extended the reach of traditional study of migration by exploring which are the relationship between home and host countries and how they affect migrants daily life. The focus has been on interconnections people between places rather than the lives they make in one or other places. Migrants which often travel home, or for whom home is important in any way, often feel to belong to more than a country. A rich literature has defined this process as the development of mixed, hybrid or multiple identities (Hall, Du Gay 1996), deploying particular identities in specific contexts depending on which are more strategic (Banks 1996) and occupying a “third space” (Bhabha 1990), a space distinctive from either the home- or host-land cultures (Waters 1990).

In Italy there is a profound absence of discourses and practices to recognize citizenship to mixed or hyphenated identity forms, at least at an overt level, and where legal and public discourse reinforce a conceptualization of identities as fixed – and not even multiple (Andall 2002; Baldassar, Raffaetà 2018). In Italy immigration is a fairly new and problematic phenomenon (Pastore 2001; Zincone 2006) and lacks a well-developed politics of recognizing difference which entails a legitimate space for the public discourse about the recognition and management of difference (Grillo, Pratt 2002; Salih 2003; Riccio, Russo 2011; Ambrosini 2013). Historically, the process of nation building demanded the marginalisation and subordination of internal differences (north/south), and was predicated on a denial of (local, regional and provincial) “otherness” and on the need to remove the memory of the short Italian colonial experience, given the

humiliating failure of its aspirations (Dal Lago 2009 [1997]; Mellino 2006; Tabet, 1997). These elements provide the context of incorporating the immigrant other, both as an abstract category of otherness and as bodies (Pizza 2012). This situation mirrors on the encountering of migrants with institutions which address parenting practices of care (Taliani 2015).

As a consequence of this situation, normal facts, such as a quick visit for clear absence of alarming symptoms, appears to migrants as a deliberately discriminatory act. As Sara, among many others, notes:

I have the impression that here [*in Italy*] doctors turn a bit nasty with foreigners [*sic, common terms to define migrants in Italy*], a bit racist. I can notice this on the road too, the glimpses I receive because of my clothing. They are scared, they think I am a kamikaze [*she laughs*]. They always fear us. The point is not that the pediatrician himself is scared, but...but at the end this is the result. I do not think that he is so quick also with Italians...probably they are well cared for, they are provided with drugs and exams.

During my fieldwork I recorded very few instances of overtly racist behavior from the part of medical professionals. The perception to be discriminated against, as Sara points out, does not have to do with individual cases of racism: “The point is not that the pediatrician himself is scared but...but at the end this is the result”. rather, this perception of being discriminated depends from the wider social and political climate, a kind of “structural vulnerability” (Cartwright, Manderson 2011; Quesada *et al.* 2011).

For migrants in Italy the recognition of their identities as fixed impacts on how to make sense of their multiple identities. Belonging in Italy, therefore, is more a set of dynamic practices of belonging than identification strategies<sup>4</sup>. Migrants’ transnational medical travels are practices and processes of belonging which take place at the levels and the spaces where people have the greatest capacity to act.

### *The neoliberalization of unregulated transnational medical space*

Migrants, by navigating among alternating feelings of belonging, make use of the interstices created by inequalities between countries and take advantage of gaps between different health policies and neoliberal governance regimes. The term “transnational therapeutic opportunity spaces” (Raffaetà *et al.* 2017) emphasizes the advantages of this situation. A range of negative consequences or risky ambiguities, however, are not excluded and are discussed in this section.

4. In this dynamic identification is not excluded though. Identification may, at times, play a role and people can experience at times their identity as fixed, mixed and “in-between”, even concurrently, see Raffaetà, Baldassar, Harris 2016.

In Europe and worldwide a series of projects have been launched to build an electronic service infrastructure for the management of cross-border health through the development of a digital identities integrated in different networks<sup>5</sup>. The European Commission funded (2008-2014) the project epSOS (Smart Open Services for European Patients)<sup>6</sup>, promoted by 25 national ministries of health (22 EU member states and 3 non-EU member states) and a consortium of e-industry, aims to improve the quality and safety of healthcare for citizens when travelling to another European country by providing quick access to documentation as well as by increasing accessibility of prescribed drugs abroad through cross-border use of electronic prescriptions (“ePrescription” or “eMedication” systems). EpSOS is a pilot study, further to be used for extension between EU-US. As a pilot study, “it follows EU regulatory framework, and as such will not require changes to national legislation governing the provision of health services.” Even while recognizing that “epSOS focuses on electronic patient record systems and operates within a complex policy environment”, the project focuses on technical and clinical aspects (e.g., the development of a common terminology for the smooth functioning of electronic data sets) and leaves basically untouched the political and legislative void of cross-border health. A truly political issue is so turned into a technical and technological problem.

The mentioned EU regulatory framework is the “Directive of the European Parliament and of the Council on the application of patients’ rights in cross-border healthcare”, issued on 2011, after modifications (1998) of the already existent Regulation (EEC) No 1408/71 from 1971. The Directive states that patients treated during their stay in another Member State should be entitled to the same benefits as patients insured in the host Member State. The major limit of this directive, beyond being restricted to the EU territory, is the lack of any political effort to build a legislative transnational framework of healthcare. As Commissioner of Health, Androulla Vassiliou, emphasised in her presentation of the directive, it does not aim to constitute a unified health care system, but rather to allow European patients to move and seek treatments within EU territory by respecting the variety of national health care systems which “remain fully responsible for organising and

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5. See Szpuzsta 2009; Gemalto, Health cards and electronic healthcare solutions, [www.gemalto.com/govt/health](http://www.gemalto.com/govt/health), accessed on 24/07/2015.

6. Cross-border health project epSOS: What has it achieved? <https://ec.europa.eu/digital-single-market/en/news/cross-border-health-project-epsos-what-has-it-achieved>, accessed on 10/06/2019.

financing their home system in accordance with their traditions and their needs”<sup>7</sup>. This statement reveals the difficulty inherent in any attempt to transnationally regulate a sphere so dominated by national interests.

In the interstices of this legislative and political void and within a global context of public expenditures for health cuts and increasingly shifted responsibility for financing health care onto individuals and the private sector (Pfeiffer, Chapman 2010; Raffaetà, Nicther 2015) there is opportunity for market-based initiatives to develop (Chanda 2002; Cortez 2008). This is especially true for low and mid income countries (Janes *et al.* 2006; McIntyre *et al.* 2008; Wu, Ramesh 2009), which are also countries of origin of many migrants, where private medical care facilities are developing (Ormond 2014). These are especially targeted for two kinds of patients-clients: 1. returning (even occasionally) migrants and their family; 2. the domestic elite wishing to travel abroad for healthcare. Companies take advantage of the structural and socio-political inequalities and the lack of regulation of the global medical space, which cause people to shuffle between home and host country for care. Ormond (2014: 153) reports the case of the US-based medical travel facilitator, Planet Hospital, which launched a “medical tourism-based” insurance called “Diaspora”. It offers accident coverage within US and full healthcare coverage in selected medical clinics in the country of origin for non-emergency care. Returning migrants, even if they have citizenship rights in their country of origin, see themselves downgraded from citizens-patients to customers. For example, Ellison (2014) has described the development of “first-class ward” in Tanzania’s hospital, which treat patients according to their wealth. These new kinds of insurance products allow for further disengagement of national governments from staffing and financing public health systems, making entitlement to healthcare for both returning migrants and locals an increasingly hazy horizon.

### *Governing transnational health: A matter of money, technology or politics?*

The article has described how transnational medical trajectories of migrants are not just motivated by “cultural” adherence of medical concepts or by cost but also by politics of belonging. Belonging deploys as practices of belonging, of which migrants’ transnational medical travels are significant examples because they take place at the levels and the spaces where people have the greatest capacity to act. Nevertheless, in the context of neoliberal

7. Videos laud benefits of cross-border healthcare, <https://expathealth.org/healthcare-video-cross-border-healthcare-eu/>, accessed on 10/06/2019.

organization of medical care, migrants' agency is guaranteed by the existence of an unregulated transnational medical space. At a micro level, this might be beneficial for singular migrants in mitigating global inequalities but at a macro level there is a rising trend to capitalize on these legislative and political gaps, so creating even more disparities. Migrants exercise strategically their citizenship rights in a transnational medical space but, at the same time, their agency is constrained by various factors as economic inequalities and politics of belonging<sup>8</sup>. In order to address the inequalities and ambiguities of this situation (see also Vineis 2014), Ottonelli and Torresi (2010) propose the development of new policies: for example, to grant returning migrants the right to use pension gains accumulated in the host country to be entirely or partly used at home.

The aim of this article has been twofold. First, it described the nexus between politics of belonging and transnational health governance. Discourse on family and children's health enables a new focus on politics and practices of belonging in the context of the biopolitical processes at play in the current economic globalization process with consequent risks of neoliberal exploitation of an unregulated transnational medical space. Second, this article argued for the need to develop, within a transnational framework, healthcare policy and social security laws regulating transnational medical spaces. These, ideally, should ease national health, economic and social disparities while, at the same time, protecting the rights of individuals to pursue health care across national borders. As Whittaker (2010: 409) observes, "regulation of forms of the trade requires cooperation across sectors, state, and non-state actors [...] The challenge is to determine both the mechanisms for regulating the trade and deciding on what basis global regulation is undertaken". In other words, this is first and foremost a political decision, and it should not be left to the market or technology to resolve it.

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8. Baldassar (2014) has shown how visa regulations might be another important constraint.

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