THE WORK OF MEDICAL TRAVEL FACILITATORS: CARING FOR AND CARING ABOUT INTERNATIONAL PATIENTS IN DELHI

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fa·cil·i·tate *1. to make easier or less difficult, help forward (an action, a process etc.)*
2. to assist the progress of (a person)
(Websters' Encyclopedic Dictionary 1994, p.509)

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Summary

On the way to becoming a more sophisticated and global industry, international medical travel has undergone major shifts over the last two decades in terms of the players involved, the healthcare arrangements offered, the number of patients becoming medical travellers and its geographic scope. Medical travel offers new opportunities to patients but also poses considerable challenges from finding and selecting the right arrangement to coping with practical and emotional distress in the unfamiliar environment. This is where an economic actor comes forward to make available a remedy: medical travel facilitators offer assistance to patients throughout their medical travel endeavour and connect them to healthcare providers. The contribution of medical travel facilitators in bringing transnational healthcare into being is increasingly recognised in practice and in research. Nevertheless, medical travel facilitators are featured only marginally in academic literature. A few studies focus on facilitators, mainly on those operating in the source countries of medical travellers from the Global North. Their field of activities is sketched out and marketing strategies have been analysed. Yet there is little known about the work of medical travel facilitators located at the destination site.

The objective of this thesis is to contribute to a better understanding of the practices of medical travel facilitators located at the destination site in Delhi, India. The study is interested in the facilitators' understanding of their work, in how they perform in everyday practice and how they relate to the international patients they serve. The core finding, namely that the facilitators' work can be linked to care work, is anticipated because this outcome allows the introduction of care work as a conceptual framework to this study. Hence, this study sets out to analyse in what sense the facilitators' work comprises care work. These questions are approached by a relational and practice-oriented perspective that distinguishes three analytical dimensions of practice: perception, performance and power relations. This approach allows a thorough analysis of different aspects of the facilitators' practices and focuses on social and economic relations in which economic activities are embedded.

This study is based on qualitative data gathered in a two-month ethnographic fieldwork in Delhi. During this time thirty interviews with representatives of medical travel companies and self-employed facilitators were conducted. Deeper insights into the facilitators' daily work could be gained during several days of participant observation in corporate hospitals in Delhi. The data was coded and analysed according to the coding methods of the grounded theory approach.

This study shows that medical travel facilitators position themselves predominantly as service providers who offer assistance to international patients to successfully access healthcare in Delhi. In so doing they emphasise their competence and expertise and distance themselves from other actors in their business that pursue unethical practices such as agents and touts. This positionality is underlined by the rationales of helping and advocating that feature in the facilitators' understanding of their work. Based on the perception of international patients as helpless and vulnerable, facilitators articulate a market niche to which they respond with their extensive facilitation services. The facilitators' understanding of their work is furthermore reconfigured and extended when engaging in additional lines of business other than patient assistance such as selling medical equipment, organising training of doctors or publishing a magazine on medical travel facilitation.

The facilitation model practiced in Delhi excels in the comprehensive and highly individualised support of international patients whereby facilitators engage in a broad range of tasks that can be conceptualised as care work. This study illuminates practices carried out by medical travel facilitators at the destination site in detail (e.g. counselling, decision-making, coordination, guidance, translation, negotiation, cultural brokering, advocating, comforting). Facilitators are engaged in several dimensions of care work such as physical, mental, cognitive and emotional care work, though to a variable extent. What is especially notable about medical travel facilitators in Delhi is that they are not only caring *for* the overall well-being of the patients but also express to care *about* the patients in a particularly concerned, devoted and affectionate manner. Out of the commercial relation between the facilitator and the patient, personal relationships can develop. Induced by the close interaction and emotional aspects involved therein, facilitators and patients seem to become emotionally attached and convey a sense of friendship and familiarity in their relations. Using this as the basis, it can be argued that facilitators are engaged in care work as economic actors, but they also care *for* and care *about* international patients as social actors. In this sense, economic and social relations seem to be closely intertwined.

The establishment of links, relations and relationships is found as being essential for the facilitators' business. The main stakeholders with whom they connect are international patients, channel partners in the patients' source countries and healthcare providers at the destination site. This study focused on how facilitators relate to their patients where building trust is identified as the main challenge. To overcome mistrust and establish relationships facilitators apply certain strategies. They must prepare an ideal foundation with which to relate to their (prospective) clients by attaining specific knowledge and establishing links and channels through which patients are referred to them. Positive patient testimonials passed on by word-of-mouth are found to constitute an essential promotion channel to medical travel facilitators. To ensure referrals from former patients, facilitators employ certain tactics to satisfy and nurture their clients. Depending on the facilitators' attachment towards the patient, acting like/ being a caring and concerned companion who provides emotional support is conducive to building relationships. Making the patients feel well cared for and delighting them with their service is considered crucial for ensuring positive patient testimonials. Consequently, care work is considered not only as a practice but also as a strategy with which to win patients as ambassadors who will enhance the facilitators' future business.

This study shows that the medical travel facilitators in Delhi do more than connect international patients and healthcare providers. Their engagement in caring for and also in caring about international patients is considered to be an integral part of their work that contributes to bringing transnational healthcare into being.

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1 Introduction

Medical travel has undergone major shifts over the past two decades; more and more patients travel across national boundaries to seek treatment in medical travel destinations devoted to this endeavour. Medical travel offers vast opportunities to patients to acquire medical treatment and care abroad. Nevertheless, undertaking a medical journey is challenging for most people and the hospitals involved face difficulties in attracting international patients. At this juncture between providers and patients, medical travel facilitators have entered the market and play a crucial role in connecting and mediating these two sides. This thesis focuses explicitly on medical travel facilitators as a player that has so far been widely neglected in academic research. A thorough analysis of their practices contributes to a better understanding of how medical travel facilitators conceptualise and perform their work so as to reveal how they relate to the patients they serve. Delhi NCR (National Capital Region) was chosen as the site for the case study as it is a well-established medical travel destination that offers vast opportunities to international patients and attracts people undertaking South-South medical travel.

1.1 Transnational healthcare

Transnational healthcare is established by healthcare providers operating in an international context offering medical treatments and care to people from all over the world and patients who become mobile and travel across national boundaries to receive healthcare services (Pennings 2007; Botterill et al. 2013; Mainil et al. 2012). Today's global arena and market-based competition reshape the provision and location of healthcare, offering opportunities to the stakeholders involved but also posing challenges to them (Connell 2013; Herrick 2007).

The location of healthcare provision has undergone major changes over time. Whereas countries of the Global North were hitherto traditional sites for medical treatment, a reversal of this trend has been evident since the late twentieth century (Connell 2013, p.1). Since then, countries of the Global South and particularly Asian countries have positioned themselves as popular destinations for medical travel (Reddy & Qadeer 2010; Connell 2006). Among others, India is considered as one of the leading destinations promoting high quality care at reasonable prices (Reddy & Qadeer 2010; Connell 2006; Herrick 2007). That academic research concentrates on patients from the Global North misrepresents the actual phenomena that people seeking South-South medical travel make up the largest part of medical travellers (Connell 2001, p.113). On the supply side, a whole range of actors is involved in building up an industry that serves and caters to international medical travellers, which includes the elaboration of specific care and travel arrangements, the recruitment of trained staff and provision of the necessary infrastructure, the rendering of medical treatments and additional services, and promotional activities (Caballero-Danell & Mugomba 2006; Heung et al. 2010; Bookman & Bookman 2007; Herrick 2007).

Transnational healthcare is a complex and dynamic phenomenon evoking growing academic interest. Several studies addressing current trends in the medical travel industry elaborate on its economic potential, analyse marketing strategies of healthcare providers or focus on particular types of medical treatment or the development of medical travel destinations. Other studies are concerned with consumer issues, trace individual medical travellers and their experiences abroad, indicating opportunities and challenges alike, analyse why people seek medical care abroad and how they choose destinations, hospitals and doctors. Thereby the focus is mostly upon 'Western' medical travellers.
One actor has been neglected in academic research so far: medical travel facilitators. Little is known about the function of individual facilitators and medical travel companies mobilising patients towards the global market, connecting them with healthcare providers and assisting them throughout their medical travel endeavour. The limited knowledge is surprising, as the existence of medical travel facilitators is described as 'vital' for patients (Mohamad et al. 2012, p.362) and the function in marketing healthcare to patients (Dalstrom 2013, p.24) and mediating the transnational healthcare market (Hanefeld et al. 2015, p.362) which pass on business to healthcare providers. There are a few studies focusing on medical travel facilitators, which mainly concentrate on facilitators operating in the home countries of medical travellers from the Global North. Marketing strategies and issues feature in the literature rather than detailed analysis on the actual tasks of medical travel facilitators and their relation with other stakeholders. Some recent studies however point towards the importance of facilitators who are located at the destination site, accompany medical travellers throughout their stay and provide practical and emotional support (Ormond et al. 2014; Whittaker & Speier 2010). In a recently published special issue on medical travel, the authors point towards forms of care work involved in medical travel that have not yet gained much attention (Bell et al. 2015). Other recent studies likewise point towards the importance of linkages and networks in mediating medical travel (Bochaton 2015; Hanefeld et al. 2015). Analysing the medical travel facilitators' work and their relations with different stakeholders will contribute to a better understanding of the facilitators' contribution in bringing transnational healthcare into being.

1.2 Research objectives and questions

Given this research gap just pointed out, there are a myriad of questions yet to be analysed in this thematic field. However, the set of questions that first and foremost should be addressed as others build on their answers, are: How do medical travel facilitators understand their work? How do they carry out their work in everyday practice? How do they relate to their stakeholders? As these questions are best addressed to practitioners themselves, an empirical study was carried out applying qualitative research methods. Delhi is chosen as the site for the case study because it is one of the medical travel hubs in India attracting medical travellers from neighbouring countries and other countries in the Global South. Moreover India is one of the leading Asian medical travel destinations.
Questioning the facilitators' understanding of their work and the activities, tasks and 'doings' encompassed by their job suggests a practice-oriented research approach. Practice theory[1] as outlined by Jones and Murphy (2010) with regard to economic geography is considered as the appropriate

[1] The conceptual frameworks is presented in detail in Chapter 3

epistemological approach to obtain an in-depth understanding of the practices of medical travel facilitators. The benefit of this conceptual approach is that *practice* can be analytically divided in different dimensions. The research questions of this thesis are thus organised in accordance with the three following dimensions of practice: the practice dimension of *perception*, the practice dimension of *performance* and the practice dimension of *power relations* (Jones & Murphy 2010, p.382). The advantage of focusing on these dimensions is that the medical travel facilitators' practices can be analytically differentiated, which contributes to a thorough analysis and a more nuanced understanding of the facilitators' work. Based on the current research gap and the three dimensions of practice, the following research questions are formulated:

I) How do medical travel facilitators in Delhi understand their work?
II) How do medical travel facilitators in Delhi perform their work in daily practice?
III) How do medical travel facilitators in Delhi relate to the international patients that they serve?

As all of these research questions address the facilitators' practises and how they are closely related and interplay but focus on the different aspects of the medical travel facilitators' work.
The first research question is interested in the facilitators' conceptual understanding of their work. Their understanding is approached by looking at cognitively derived representations of the setting within which medical travel facilitators operate, the meanings associated with particular actors and their practices and by identifying prevalent rationales that constitute the facilitators' understanding of their work (Jones & Murphy 2010, p.382).
The second research question examines the practices performed in everyday work by medical travel facilitators. The focus is on the activities, tasks and duties that are performed in the facilitators' daily work. Through these performance roles, rules, intentions and identities are articulated and enacted (Jones & Murphy 2010, pp.382–383).
The third research question analyses how medical travel facilitators relate to the patients they serve in order to build a relationship. For that reason the facilitators' strategies and tactics to build trust and to mobilise patients towards the Indian healthcare market and the way in which power unfolds in these tactics are examined. Power structures that influence the way facilitators relate to their patients can likewise be examined by looking at relational geometries (Jones & Murphy 2010, pp.382–383). A relational understanding of economic geography sensitises towards the facilitators' practices to relate to social and economic actors, so as the nature, dynamics and power asymmetries of the relationships established.
Few studies indicate that the relationship between medical travel facilitators and their patients is rather personal and that international patients are in need of special emotional attention. The emphasis upon the relationship between medical travel facilitators and international patients and their particular needs suggest that the practice of relating demands personal engagement and care from the facilitators' side. Thus it is argued that facilitators engage in practices of care-giving to meet their patients' needs and make them feel comfortable throughout their medical travel endeavour. This study introduces *care work* as a concept to analyse, explain and question the work done by healthcare facilitators, which leads to a fourth research question that goes along with the other three:

IV) In what sense does the work of medical travel facilitators in Delhi comprise care work?

This fourth research question can be considered as overlaying the three others, because aspects of care work are to be crystallised in all three analytical dimensions of the facilitators' practices. This question is approached by analysing whether the facilitators' practices correspond with different conceptualisations of care work in the literature and whether particular care-work logics and issues are influential on the facilitators' work practices equally.
What is conceptualised as *work* can vary considerably depending on different scholarly orientations. This thesis applies a heterodox understanding of *work,* which is not limited to formal, paid economic labour in the public sphere but comprises other forms of work, such as domestic work or different forms of care work (Lynch & Lyons 2009; Krebs 2001). Work is conceptualised as an activity or service done for others, which is exchanged by members of society in a particular frame (Krebs 2001).

1.3 Structure of the thesis

This thesis consists of three empirical chapters (5, 6, 7) that mirror the research questions and analytical approaches outlined above and the flanking chapters of which academic work is composed. Thus, the present thesis is structured as follows:
Chapter 2 outlines the thematic field of transnational healthcare and medical travel facilitation. The state of the art in academic literature provides the knowledge and the research gap from which this thesis proceeds.
Chapter 3 unfolds the analytical approach of practice theory and relational economic geography within which this thesis is embedded and introduces the concept of care work, which is relevant to conceptualise the subject matter, namely the practices of medical travel facilitators.
Chapter 4 presents the research design and the methodology by which the data used in this thesis was generated. The chapter outlines the research process and gives insight into the different methodological steps and the reflections upon the research design and its implementation. The depiction of the sample of interviewees allows for better understanding of the source data that enrich the thesis.
Chapter 5 approaches the practices of medical travel facilitators on the analytical dimension of *perception*. The chapter is structured to analyse how facilitators conceptually understand their work and on what their understanding is based. Subchapter 5.1 looks at how facilitators frame their field of work and how they position themselves within whereby the terminology they apply is used as a starting point. Subchapter 5.2 analyses the way facilitators articulate a market niche, as this is indicative to the way they understand their work. Their line of reasoning in legitimising their work is thus studied. How facilitators understand their work is then sketched out in Subchapter 5.3 by naming relevant rationales that influence the facilitators' self-perception. The discussion in Subchapter 5.4 examines whether the idea of caring is anchored in the facilitators' understanding of their work.
Chapter 6 approaches the practices of medical travel facilitators on the analytical dimension of *performances*. The objective is to analyse how medical travel facilitators perform their daily practices that constitute their work. Subchapter 6.1 outlines how the interviewees create an operational set-up, which is necessary to work successfully as facilitators. Subchapter 6.2 gives an overview of the facilitators' practices in handling international patients. Subchapter 6.3 then zooms in on the daily performances to analyse what exactly facilitators do on site in Delhi to assist medical travellers. The

discussion in Subchapter 6.4 is two-fold: First, it relates the practices analysed in this chapter to the concept of care work. Second, the assemblage of various tasks performed by facilitators is summarised and related to existing literature.

Chapter 7 approaches the practices of medical travel facilitators on the analytical dimension of *power relations*. This chapter aims to analyse how medical travel facilitators relate to their patients, how they establish relationships and how power thereby unfolds. Subchapter 7.1 recapitulates why the facilitator-patient relationships matter for the facilitators' business. Subchapter 7.2 examines the facilitators' tactics to establish a close relationship with their patients. Subchapter 7.3 discusses how power unfolds in the relationship between facilitators and patients by analysing underlying relational geometries. In the discussion in Subchapter 7.4, the practices that realise the facilitators' strategies and tactics are linked to care work. Situating the power structures that shape the facilitator-patient relationship in the context of care work adds another layer to the analysis.

Chapter 8 constitutes the synthesis and final discussion of this thesis. The answers to the research questions are summarised, the analytical dimensions of practice are reassembled and the findings and approaches of this study are critically reviewed. In so doing some outlooks on further research are indicated.

Chapter 9 encapsulates the main findings of this thesis and indicates outlooks on further research.

2 State of the art

This chapter gives a broad overview over the state of the art regarding transnational healthcare in general (Subchapter 2.1) and regarding medical travel facilitators and companies in specific (Subchapter 2.2). To situate this thesis thematically within the discipline of geography, the contribution of medical and health geography in approaching themes related to of healthcare are briefly reviewed (Subchapter 2.3). Furthermore Delhi is introduced as a particular medical travel destination and as case study site (Subchapter 2.4). Finally, the research gaps in the current state are outlined, as they constitute the starting point for this thesis (Subchapter 2.5).

2.1 Transnational healthcare

Transnational healthcare is a broad thematic field in which medical travel is embedded. The first section (2.1.1) raises the awareness on terminological ambiguity. The second section (2.1.2) points towards geographical patterns of transnational healthcare, introduces the stakeholders involved and touches upon opportunities and issues associated with this thematic field.

2.1.1 Notes on the terminology

The healthcare industry has undergone several transformations in the last decades and has become increasingly commodified and globalised (Mainil 2012, p.14). Healthcare providers operate in an international context, offer and promote their services on a transnational healthcare market and patients become mobile in seeking treatment across national borders (Botterill et al. 2013; Mainil et al. 2012; Pennings 2007). This phenomenon has attracted and still attracts the interest of the public, the media and academics coming from several disciplines. There are different terms in use to designate this phenomenon, which leads to ambiguity about the meaning of certain notions because they show different connotations. The term ‘cross-border health care’ is often used in a European context, suggesting a consumer perspective (Botterill et al. 2013, p.2). In contrast, in Asian or American countries the terms ‘medical travel’ or ‘medical tourism’ are more frequently used and refer rather to the supply side (Botterill et al. 2013, pp.2–3). To dissolve ambiguity about such nuances of meaning, Botterill et al. (2013, p.3) suggest ‘transnational health care’ as a generic term that encompasses the before-mentioned notions.

Referring to medical tourism, the connection between the medical travel industry and the tourism industry is suggested. The alliance between the medical sector and tourism comes into effect when offers for medical treatment are complemented by touristic arrangements or vice versa, which is elaborated on in several studies (Botterill et al. 2013; Gan & Frederick 2011; Turner 2010; Caballero-Danell & Mugomba 2006; Goodrich & Goodrich 1987). Hence, some tourism agencies add medical travel as another product and healthcare suppliers and medical travel companies try to

win patients by offering well-coordinated packages combining medical treatments with place-specific amenities and leisure activities (Ackerman 2012, p.404). The term 'medical tourism' is widespread (Botterill et al. 2013, p.2) and its prevalence can be explained by "the tourism industry's early recognition of the trend and their use of the label to promote medical travel consumption" (Sobo 2009, p.331). The term was also used by the industry players themselves and the media absorbed the term, partly sensationalistic (Sobo 2009).

Critical research in the field of geography, anthropology and tourism studies though have raised several issues with the notion of tourism. Kangas (2012, p.350) sharply criticises the 'inapt' terminology as it is suggestive of "leisure and frivolity (…) that disregards the suffering that patients experience". Offering an alternative connotation, there are notions suggesting the seriousness and desperate plight of patients who seek healthcare abroad. The term 'medical refugees' for example is "suggesting individuals fleeing life-threatening conditions in their home countries" (Kangas 2012, p.353). Similarly, 'medical exile' is used by several authors (Kangas 2012; Ormond & Sothern 2012; Whittaker & Speier 2010). Ormond (2014, p.306) argues that these terms express that that "normative boundaries delimiting appropriate spaces of care and responsibility" are challenged and reconfigured. However, in academic literature, the term 'medical travel' seems to be preferred because of its neutrality and is therefore used in this thesis. Nevertheless, in the state of the art chapter, the notions used by the authors of the studies reviewed are kept.

2.1.2 Geographies, opportunities, issues and players

Apart from this healthcare-tourism nexus, the topic of transnational healthcare has been approached by various disciplines researching different aspects of the complex phenomena. As the phenomenon of transnational healthcare shows particular geographical patterns, some studies consider space and place as critical factors. From a geographic-historic perspective, the location of healthcare provision has undergone major changes over time. Whereas countries of the Global North were hitherto traditional sites to go for advanced medical treatment, a reversal of this trend has been evident since the late twentieth century (Connell 2013, p.1). Since then, countries of the Global South and particularly Asian countries have positioned themselves as popular destinations for medical travel (Reddy & Qadeer 2010; Connell 2006). India is one of the leading destinations (Reddy & Qadeer 2010; Herrick 2007; Connell 2006) emphasising "quality care, relatively cheaper services compared to the west, package deals and cheap services from tourism and hospitality sectors and the options offered by holistic medicine" (Reddy & Qadeer 2010, p.71). Moreover, the improved quality of healthcare provision by countries such as India foster 'South-South' medical travel (Ormond & Sulianti 2014, p.2) and intra-regional flows (Connell 2001, p.114). Although academic research concentrates on patients from the Global North, people from neighbouring countries are considered to make up the largest part of medical travellers (Connell 2001, p.113). Also, particular space-specific patterns and the encounters with different cultures and practices at healthcare destinations are current topics in the debate. These range from the construction of differences and similarities between healthcare facilities in different locations, the marketing of medical travel destinations to the corporeal experience of the body in space and time and the effects that affective spaces can have (Ormond 2011; Simonsen 2008; Cummins et al. 2007; Rosenberg 1998).

From an economic point of view, opportunities and risks related to transnational healthcare have been analysed (Caballero-Danell & Mugomba 2006) as well as economic rationales driving the in-

creasing commodification of healthcare and its shift towards countries of the Global South (Connell 2013; Ehrbeck et al. 2008; Connell 2006). Moreover, recent transformations in transnational healthcare provision have been associated with neoliberal economic policies (Connell 2013). Studies focusing on the economic impacts of medical travel on the supplier's destination give critical accounts (Reddy & Qadeer 2010; Pennings 2007; Ehrbeck et al. 2008). For instance, the association of medical tourism with progress and modernisation in countries of the Global South is questioned (Reddy & Qadeer 2010).

In addition, the discussion of ethical and moral issues associated with transnational healthcare nourishes critical debates. Research about the implications of medical tourism on local healthcare provision points to tensions and inequalities between the supplier and consumer society as well as between private and public healthcare providers (Reddy & Qadeer 2010; Lunt & Carrera 2010; Pennings 2007; Connell 2006). Nevertheless, to date there is little empirical research to give evidence on both the proclaimed positive and negative effects of transnational healthcare.

Another body of literature centres on international patients or medical travellers respectively. The question raised is why people travel abroad and how they choose the destination of where to travel (Hanefeld et al. 2015; Connell 2013; Yeoh et al. 2013; Cormany & Baloglu 2011). Some of the reasons given for people choosing to travel abroad are that certain treatment is not available or unaffordable in their countries or the waiting lists are too long (Hanefeld et al. 2015). Links between patients, healthcare providers and facilitators (Hanefeld et al. 2015), the patients' social networks (Bochaton 2015) and word-of-mouth (Yeoh et al. 2013) are considered as influencing the patients' choice of where to travel. Medical travellers can be understood as autonomous consumers who have the opportunity to choose from a myriad of treatment options available around the globe (Hanefeld et al. 2015; Kangas 2012; Ackerman 2012). These images are well in line with "self- empowered customers" (Sobo et al. 2011, p.129) who are "actively self-managing their care" (Sobo et al. 2011, p.129). But, this image is fostered by studies focusing on medical travellers from the Global North and may not apply to patients from the Global South which constitute the bulk of medical travellers (Ormond & Sulianti 2014; Connell 2001). In any case, this image is challenged as patients are also portrayed as vulnerable (Ormond et al. 2014; Kingsbury et al. 2012). Studies focusing on the experiences that medical travellers make point towards the difficulties of internationals in undertaking medical travel: they often face financial and logistical constraints, have limited knowledge about the healthcare provider abroad and thus find it difficult to make informed choices and to deal with socio-cultural differences, unfamiliarity, uncertainty and discomfort (Bochaton 2015; Kangas 2012; Kingsbury et al. 2012; Ormond 2011; Kearns & Collins 2010). Kingsbury et al. (2012) focus on the patients' emotional experience and show that they are exposed to considerable stress.

On the supply side, a whole range of actors is involved in building up an industry that serves international medical travellers. Primarily healthcare providers, mostly in the form of multispecialty corporate hospitals, hospital chains and private clinics, medical travel companies and facilitators but also other service providers from the hospitality and tourism sector and governments are engaged in medical travel on the supply side (Connell 2001; Heung et al. 2010; Ehrbeck et al. 2008). Governments can give impetus to the development of a medical travel destination; healthcare providers set the infrastructure to actually render medical services; and other service providers are delivering supportive services to assist, cater, transport and entertain medical travellers (Heung et al. 2010; Bookman & Bookman 2007; Herrick 2007; Caballero-Danell & Mugomba 2006). Thus, these actors are building up the necessary infrastructure and facilities and develop marketing strategies to attract

international patients (Ormond & Sothern 2012; Lunt et al. 2010; Heung et al. 2010). Connell (2013, p.7) notes that hospitals have adapted structurally and functionally to the needs and expectations of medical travellers: "the key hospitals in the medical tourism industry have come close to luxury hotels, in a transition where consumption and consumerism have been added to cure and care". Ehrbeck (2008, p.9) also addresses the efforts made by providers to cater for international patients and says: "Successful providers offer services, such as translators and airport pickups, to ease patient worries, from travel hassles to cultural disconnects". However, hospitals face difficulties in convincing international patients to come to their hospital and as outlined above, patients are also challenged by undertaking a medical travel endeavour. Yet, a particular player positioned itself at the nexus between patients and healthcare providers: medical travel facilitators. As this thesis examines the work of these facilitators, the next subchapter provides elaboration of this particular actor in more detail.

2.2 Medical travel facilitators and companies

One of the economic players that evolved along with the medical travel industry and that contribute to bringing transnational healthcare markets into being, are medical travel facilitators, either self-employed or working for medical travel companies. They seem to play a crucial role in mobilising medical travellers to certain healthcare destinations, because of their assistance in mediating between international patients and medical professionals from different countries (Turner 2012; Snyder et al. 2011; Cormany & Baloglu 2011; Spece 2010). These facilitators and companies are placed at the nexus between customers and suppliers and therefore pull important strings within the transnational healthcare market.

In line with the account on the 'medical travel' terminology in the previous subchapter, there is also confusion about the appropriate notion for healthcare facilitators and medical travel companies. Therefore some more disambiguation is required. Medical travel facilitators, healthcare facilitators or facilitators in short are also referred to as brokers, mediators, intermediaries, medical travel agents, patient navigators, case-managers or patient advocates; and medical travel companies are also termed medical tourism companies or medical tourism agencies. This 'list' is not complete and the actors themselves and researchers still come up with different terms. So, this confusing terminological diversity in practice as in academic research makes it difficult to grasp who these players are and what they do as the different notions in use often allude to a certain function or external perception. This disambiguation is taken up again in Subchapter 5.2 that outlines the use of different notions by the interviewees who took part in this study in the context of Delhi. However, it is anticipated that in this thesis, the notions 'medical travel facilitator' and 'healthcare facilitators' (facilitators in short) and 'medical travel companies' are used as they are considered to be more neutral and more inclusive than others. Thereby 'facilitator' refers both to individually working facilitators and those employed by medical travel companies; both engaged with medical travel facilitation.

2.2.1 Tasks and roles

Medical travel facilitators are considered to "play a substantial and evolving role in the practice of medical tourism" (Snyder et al. 2011, p.530) and are acknowledged as "crucial connectors between foreign patients and host countries" (Wagle 2013), which reinforces the motivation to gain more knowledge about their work. A first understanding of what facilitators do can be derived from the tasks and roles touched upon in the literature about medical travel facilitators and basically sets the starting point for this thesis.

Tasks

Dalstrom (2013, p.24) considers the main task of medical travel facilitators, consisting of both individuals and companies, as enabling patients in accessing medical treatment "through commodifying the medical experience and providing logistical support". The services and support provided by medical travel facilitators – as presented in the literature – can be categorised into the three tasks: connecting patients and healthcare providers in different countries, giving information and advice and coordinating 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). Talking about medical tourism agents, Crooks et al. (2011, p.727) contour these tasks in more detail by saying that these agents assist "with selecting hospitals, visa applications and other paperwork, making travel and tourism arrangements, and sometimes also with organizing follow-up care at home". These tasks taken over by medical travel facilitators are taken as a "one-stop solution offering integrated knowledge of medical services, tourism and travel facilitation and concierge services" by Mohamad et al. (2012, p.360). Such a concierge service is provided by a person on the medical travel destination site, a personal assistant who is available around the clock and functions as a "friend away from home" (Sobo et al. 2011, p.128). Additional tasks are introduced by Snyder et al. (2012, p.2) who say 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". Taking over such a control function is mirrored in the role of a 'patient advocate' as outlined in the coming section.

Roles

Drawing from the particular tasks taken over by medical travel facilitators, there can be found different roles ascribed to them in literature. One of these roles is the one of a patient advocate. Several studies coin the notion but what exactly a patient advocate does is rarely outlined (e.g. Hanefeld et al. 2015; Ormond et al. 2014; Dalstrom 2013; Snyder et al. 2012; Sobo et al. 2011). Snyder et al. (2012, p.2) say that being a patient advocate means doing more than coordination work, namely "playing an involved role in patient care coordination and putting forth calls for domestic health system reform". Accordingly, the authors differentiate between 'brokers' who have a rather limited role in being the middleman who connects the patient with a healthcare provider abroad and 'facilitators' whose responsibility is extended and who are getting more personally involved (Snyder et al. 2011, p.531). Nevertheless, the authors find that they cannot consistently frame the facilitator's role towards the patient (Snyder et al. 2011, p.531).

Based on the study of Casey et al. (2013) that ascribe the patients' attendants three roles, namely the one of a knowledge broker, a navigator and a companion, Ormond (2014, p.12) argues that medical travel facilitator can take on these roles as well. The author points particularly to the role as compan-

ion and says that some facilitators provide personalised support to the patients' emotional and physical needs. Elaborating further on the role of a companion, the author refers to emotional labour, which is taken up in Section 2.2.3.

Summarising different roles, Dalstrom (2013, p.25) states that facilitators "act as cultural brokers, travel agents, patient advocates, intermediaries between doctors and patients, and also as medical experts". Apart from these roles, the author differentiates between three types of facilitators. The first type is the 'full service medical facilitator' operating from the patient's home country and providing comprehensive service, facilitating logistical and cultural issues (Dalstrom 2013, p.28). If required, the patient is supported by a 'medical concierge' on site: "In some instances, this means that the patient will be picked up at the airport, driven to the hospital, and then back to the airport" (Dalstrom 2013, p.29). The second type is the 'referral service provider' who is usually based in the destination country and whose service is usually limited to building the connection between the patient and the doctor abroad (Dalstrom 2013, p.29). The third type is the 'individual service facilitator' who are "foreign medical providers who directly market their medical services to patients" (Dalstrom 2013, p.30). This typology is not useful to apply to the medical travel facilitators studied in this thesis but it raises the awareness that there are different facilitation models and that they differ in the range of services they offer.

2.2.2 Promotional strategies and issues

Looking at academic literature focusing on medical travel facilitators and companies, two issues arouse particular attention. Firstly, compared to other subjects there are many studies that focus on promotional strategies. Secondly, these studies usually draw from content analysis of medical travel companies' websites (Lee et al. 2014; Wagle 2013; Snyder et al. 2012; Cormany & Baloglu 2011; Gan & Frederick 2011; Sobo et al. 2011). Although this might also have practical reasons, it suggests that the internet is considered as important to medical travel companies. Apart from reviewing promotional strategies that indicate themes relevant to facilitators, critical accounts related to the work of medical travel facilitators are touched upon to raise the awareness of the problems that can arise.

Promotional strategies

The internet is considered a key driver for medical travel and a highly important channel for medical travel companies to distribute information and promote their services (Lunt et al. 2010; Hanefeld et al. 2015). The relevance of the internet is also directly articulated as being the most important medium for promotion: "facilitation companies in many countries have a strong web presence and rely primarily on websites (and secondarily on word-of-mouth) to advertise their services" (Snyder et al. 2012, p.1). The study of Lee et al. (2014, p.638) suggests that medical travel companies actively use their websites to increase credibility by featuring testimonial videos, links to films, podcasts, or blogs.

Several studies look at the content and images presented on the companies' webpages. A recent study conducted by Lee et al. (2014) focusing on English medical broker websites demonstrates that benefits of medical travel feature much more prominently than risks. Additionally, they note particular persuasive appeals to mobilise patients to obtain treatment abroad: "medical tourism websites typically include other appeal, such as the opportunity to travel or the benefits of recuperating from

medical procedures in a beautiful location" (Lee et al. 2014, p.638). Drawing on print material promoting India at a medical travel trade show in Canada, Crooks et al. (2011) followed a similar approach and find that against common assumption, cost benefits do not feature very prominently in sales literature. Among other explanations for this finding, the authors argue that a focus on cost savings might undermine claims for quality (Crooks et al. 2011, p.726). Suggesting a predominantly 'western' clientele, the authors argue moreover that "developing nations need to portray safe and advanced treatment facilities in order to dispel potential patients' suspicions that their medical care is inferior" (Crooks et al. 2011, p.726).

Another study conducted by Cormany and Baloglu (2011) compared the range of services offered on medical travel facilitator websites based in North America to websites of facilitators based in other countries. The authors main result is that the website content and design varies with respect to the region where the company is based. In contrary to this, another study suggests that the website is adjusted to the anticipated wishes of clients: Sobo et al. (2011) focused upon cultural factors influencing the consumers' self-perception and desires and how medical travel agencies respond to them in the messages that promote medical travel on their websites. One of the marketing strategies found by the authors is that the websites respond to "healthcare consumerism in which self-empowered customers make savvy choices, actively self-managing their care" (Sobo et al. 2011, p.129).

Equally based on an analysis of websites of medical tourism facilitators in the USA, Gan and Frederick (2011) studied domestic medical tourism facilitators' service differentiation. The main message then is, that medical tourism facilitators distinguish themselves from others in the countries and hospitals they serve, treatments they focus on, the number of medical professionals employed and additional services provided (Gan & Frederick 2011, p.165).

Issues

One of the issues is the "regulatory vacuum" (Turner 2011, p.1) within which medical travel facilitators operate; Snyder et al. (2012, p.14) refer to a "murky international arena". As the lack of regulations and guidelines can constitute a risk for international patients, Turner (2011) advocates strongly for a standardisation and accreditation schemes.

Authenticity and credibility with regard to the information displayed on the websites of medical travel companies raises another issue. Lunt et al. (2010) reflect upon the functionality and quality of such sites and their influence on the patients' decision-making process. Following a similar approach, Wagle (2013, p.28) calls for "ethical guidelines and standards" for the benefit of the patients' safety.

Another issue are conflicting rationales. Snyder et al. (2012) indicate that commission fees paid to facilitators for referring patients to hospitals might provoke unethical behaviour from the facilitators' side. They might bring their patients to the hospital paying the highest commission and not the one providing the best service. Especially with regard to the role of a patient advocate that can be taken over by facilitators, the authors point towards "the potential tension between their business interests and their role in serving as a patient advocate" (Snyder et al. 2011, p.531).

2.2.3 Relations and networks, emotions and care

Some recent studies emphasise the importance of networks and relations for international patients and medical travel facilitators. Although still marginal, emotional aspects and care are taken up in literature and seem to be promising fields of research, which is the reason for their inclusion and focus in this thesis.

Relations and networks

The study of Yeoh et al. (2013) is primarily about medical tourists and their choice of a particular medical travel destination. The authors find word-of-mouth plays a crucial role in the patients' decision-making process because "most of the tourists were influenced by friends, family, relatives and doctor's referral" (Yeoh et al. 2013, p.196). Word-of-mouth, conceptualised as an informal and personal form of communication, is thus an effective way of transmitting messages and attracting increasing attention in marketing (Yeoh et al. 2013, p.197). Although this study is not about medical travel facilitators, the finding could be of interest to them. In contrast to the strong emphasis on web-presence, personal relations and word-of-mouth could be an alternative way of reaching prospective patients. The authors even conclude that "healthcare providers may consider a paradigm shift in running their businesses; from transaction to relationship, from customers into partners, and from long-term relationship into commitments" (Yeoh et al. 2013, p.199). Thus, facilitators as operating on the provider side may also follow this shift.

In line with Yeoh et al. (2013), the research conducted by Hanefeld et al. (2015) focusing on British medical travellers supports the argument that relations and networks influence patients' choice of the medical travel destination. The authors apply a network perspective to analyse the role of "linkages – formal and informal – between individual providers, patients and facilitators to explain why and where patients travel" (Hanefeld et al. 2015, p.356). The findings put further emphasis on the importance of relations and linkages and positions facilitators within them. Yet, the authors differentiate these relations: "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). Thus, the authors consider the facilitators network as relevant and conceptualise their relations as commercial in nature.

That there are close relations between facilitators and patients is indicated by a study focusing on cross-border reproductive travel to the Czech Republic and Thailand conducted by Whittaeker and Speier (2010). The patients report that facilitators "made us feel like close friends rather than clients or customers" (Whittaker & Speier 2010, p.372). Yet, facilitators not only relate to patients but have some more network partners as Ormond et al. (2014, p.11) state: "MTFs' [medical travel facilitators] clients included not only patients but also the medical care, transport, accommodation and leisure service providers". This suggests that facilitators are engaged in networking with these providers.

Emotions and care

Kingsbury et al. (2012, p.361) make an important contribution to the literature on medical travel by illustrating "the importance of emotional geographies in medical tourists' lived experiences of travel and tourism, as well as the giving and receiving of transnational health care". Drawing from the narratives of American medical travellers, the authors argue that in the patients' experience, emotional aspects of encountering an unfamiliar environment throughout the medical journey and emotional aspects involved in the difficult situation of being ill overlay and result in an extraordinary

emotional experience: “By compounding the distance from home (a component of tourism) with isolation and a lack of spatial freedom in the hospital environment (a component of health care), MT [Medical Tourism] considerably and forcibly intensifies emotions such as loneliness, anxiety, and joy” (Kingsbury et al. 2012, p.368). Referring to the ‘components of tourism’, it is the uncertainty attached to the journey itself, the unfamiliarity with the environment set out by the medical travel destination and the encounter with the ‘other’ that challenge international patients (Kingsbury et al. 2012, p.368). Being in a hospital, suffering from a disease, making decisions and being confronted with the uncertainties associated with the treatment are ‘components of health care’ that likewise influences the emotional experience of the patient. The authors emphasis “that there is a lack of sustained theoretical and empirical research on how exactly emotions take place in MT and what types of emotions typically accompany MT spaces” (Kingsbury et al. 2012, p.363). Thus, studying emotions and emotional labour involved in the work of medical travel facilitators could bring new insights.

Ormond et al. (2014, p.12) already pointed towards such a dimension of the facilitators’ job by elaborating on their role of a companion who “may engage in formal emotional labour to provide medical travellers with companionship and support”. Similarly, Whittaker and Speier (2010, p.363) address the affective labour involved in the work of medical travel facilitators in the context of cross-border reproductive travel. The authors argue that “companies such as these reinsert the discourse of affective labor, care, and nurturing within a reproductive experience that is otherwise devoid of all familiar relationships” (Whittaker & Speier 2010, p.372). Although the medical travellers report to feel more as a friend than a client, the care provided by the facilitator is framed by a commercial relationship between the facilitator and his or her clients (Whittaker & Speier 2010, pp.372–373). Thus, the idea of care and care work is introduced via emotional and affective labour, which is a theme that seems to gain increasing interest in the context of transnational healthcare. In the introduction of a special issue published on transnational healthcare, Bell et al. (2015, p.288) call attention to the “under-examined role and dimensions of formal and informal care work involved in international medical travel”. Yet, they comment primarily on nurses as caseworkers in hospitals catering to international patients and do not relate to facilitators specifically. Nevertheless, the literature presented suggests integrating care work and emotional labour into research on the practices of medical travel facilitators.

2.3 Medical and health geography

To situate this thesis thematically in the discipline of geography it is worth looking at how the sub-disciplines of medical and health geography approach themes related to health and healthcare and what themes have come into focus recently.

The sub-discipline ‘medical geography’ was traditionally meant to analyse “spatial patterns of health and disease” (Mayer 1984, p.2680) and to study the “complex relationships between people, place, and their health and health care” (Dyck 1999, p.243). Thus, spatial studies were the common method since the 1960s to analyse location, distribution and access to healthcare facilities, whereby space and healthcare often were conceptualised along national borders (Mayer 1982). The sub-discipline underwent major transformations in the 1990s and broadened its scope to ‘health geography’ which

"provided a more cultural and expansive recognition of health, and a more comprehensive understanding of the dynamic relationship between people, health and place" (Andrews 2002, p.221). This reconceptualization which can be linked to the impetus that social and cultural geography gained at that time, aimed to "go beyond matters of access and provision" (Parr 2003, p.212).
Consequently, different approaches and themes came into focus. Influenced by critical geography, the matter of access and provision has been taken further by raising questions of power, justice and responsibility (Kearns & Moon 2002). Patients, or consumers as they have been reconceptualised (Kearns & Moon 2002), their body and corporeal encounters or the patients' emotional experiences of healthcare places gained increasing interest (Connell 2015; Simonsen 2008; Dyck 1999). Mobility came into focus which has primarily been studied with respect to patients' mobility to access healthcare and which gained new dimensions since healthcare became a global phenomenon (Connell & Walton-Roberts 2015; Kearns & Collins 2010). But not only patients become mobile for healthcare. Connell and Walton-Roberts (2015, p.1) state that "health geography has largely neglected serious consideration of the human resources central to health care" and bring in medical professionals and care workers. Focusing more on the work itself, Kearns and Collins (2010, p.25) find that "health care work has been relatively neglected in both medical and health geography, notwithstanding limited investigations of decision-making and labor issues within health care systems". These authors thus bring "the where of care" (Kearns & Collins 2010, p.25) and the people who care into focus. Furthermore, Parr's (2003, p.213) comment that "it can hardly be claimed that geographers in this field [health geography] have as yet fully examined the multiple material and symbolic dimension to the giving and receiving of care, or thoroughly explicated care as a concept while critically assessed caring practices, roles, relations and so on" is taken as a prompt to engage with the concept of care work (see Subchapter 3.2).

2.4 India and Delhi NCR as a destination for medical travel

India is seen as one of the leading medical travel destinations in Asia that promotes its advanced technology, state of the art infrastructure, relative cost advantages and excellent doctors with proficiency in several medical disciplines (Lunt & Mannion 2014; Smith 2012; Reddy & Qadeer 2010; Herrick 2007; Connell 2006). Policy shifts in the 1980s towards commercialisation restructured the Indian healthcare sector and led to "the emergence of a corporate health sector in the 1990s" (Reddy & Qadeer 2010, p.70). Supported by governmental and corporate promotional strategies, India could establish itself as a global health destination (Reddy & Qadeer 2010; Bisht et al. 2012) under the slogan "First World treatment at Third World prices" (Singh & Gautam 2012, p.24). With treatment costs that are sometimes only 20% of treatment costs in the US or UK, India offers treatment at competitive prices (Reddy & Qadeer 2010, p.70) which seemingly do not compromise the quality: "It [India] arguably has the lowest cost and highest quality of all medical tourism destinations" (Herrick 2007, p.4). So a large number of corporate hospitals are concentrated in several medical travel hubs within India to cater for international patients (Qadeer & Reddy 2013, p.2). As one of the leading medical travel destinations in India, Delhi National Capital Region (NCR) is chosen as the site for this study and refers to the National Capital Territory and its surrounding metropolitan area that stretches out to the neighbouring states of Haryana, Uttar Pradesh and Rajasthan (Dawn & Pal

2011, p.2; Hazarika 2010, p.248; Gupta et al. 2015, p.230). That "India has the highest number of medical travel facilitators or agencies in assisting medical tourist trip" (Mohamad et al. 2012, p.360) is another reason why an Indian medical travel destination has been chosen as a site to study.

2.5 Research gaps

The state of the art shows that transnational healthcare in general and medical travel facilitators in particular offer a large variety of themes to study. Although there are some studies that focus on medical travel facilitators, there are still considerable knowledge gaps in several respects.

There are very few studies that focus thoroughly on medical travel facilitators and are based on ethnographic fieldwork: The study of Snyder et al. (2011) draw on twelve phone interviews with Canadian facilitators, Ormond (2011) interviewed seven Malaysian facilitators among other medical travel stakeholders, Dalstrom (2013) interviewed facilitators from the US and conducted participant observation in Mexico, Hanefeld et al. (2015) interviewed some facilitators from the UK though the focus is on interviews with patients, and in a more recent study Ormond et al. (2014) interviewed twelve facilitators from Malaysia, Indonesia and Australia all sending patients to Malaysia. Most of these studies and some more studies based on website analysis focus upon medical travel companies operating from countries in the Global North, serving 'Western' medical travellers. This misrepresents the actual phenomena as the majority of international patients originate from the Global South (Ormond & Sulianti 2014; Connell 2001). Thus, there is a substantial research gap firstly regarding medical travel facilitators who are based at the medical travel destination site, secondly regarding medical travel facilitators located in the Global South, thirdly facilitators assisting medical travellers undertaking South-South medical travel and fourthly studies drawing on ethnographic fieldwork. Departing from this research gap evolving around this particular economic actor, this thesis deliberately gives a voice to medical travel facilitators based in Delhi, which is a prominent and dynamic medical travel destination in the Global South, catering mostly for South-South medical travellers. To get first-hand information, an ethnographic fieldwork is carried out.

Thematically, studies focusing on medical travel facilitators raise several interesting themes but there are many aspects that are not thoroughly elaborated. Knowledge about what exactly facilitators located at the medical travel destination site do and what their work comprises seems to be basic and of essential importance for understanding their contribution to the transnational healthcare market. Still, there is almost nothing known about how medical travel facilitators themselves understand their work and how they perform it in daily practice. Departing from the knowledge gap regarding the facilitators' self-understanding and their daily practices, this thesis approaches these fundamental questions applying a practice-oriented approach. As recent studies point towards important yet under-examined dimensions of care work involved in transnational healthcare settings (Bell et al. 2015; Ormond et al. 2014; Whittaker & Speier 2010), this thesis has furthermore set out to link the concept of care work with the practices of medical travel facilitators in Delhi.

3 Conceptual framework: dis-assembling practice and introducing care

This chapter introduces the relevant conceptual frameworks in which this thesis is embedded. The first subchapter (3.1) introduces the relevant epistemological approaches that guide and structure the analysis of this thesis. The second subchapter (3.2) elaborates on the concept of care work as it is to be linked to the empirical findings of this study.

3.1 Epistemological approach: on relations and practice in economic geography

This subchapter introduces relational economic geography as a valuable perspective on the practices of medical travel facilitators (Section 3.1.1). Practice theory and its conceptual implications fro researching practices are outlines as an epistemological approach to analyse the work of medical travel facilitators (Section 3.1.2).

3.1.1 A relational economic geography perspective

Relational economic geography provides a framework to describe and explain the spatial dimensions of social and economic activities and relations (Haas & Neumair 2015). The focus is set on economic agents and "how they act and interact in space" (Bathelt & Gluckler 2003, p.128). Economic action is thereby conceptualised as "a relational process which is situated in structures of relations" (Bathelt & Gluckler 2003, p.128). In this case, a relational perspective highlights firstly the social and economic relations in which economic activities and processes are embedded. Thereby the multiplicity of such relations can be conceptualised as networks. From this point of view, "the global economy is thus made up of social actors engaged in relational networks within a variety of 'spaces'" (Dicken et al. 2001, p.97). Secondly, the sociocultural embeddedness of economic activities is highlighted, whereby space is taken as an analytical lens to contextualise economic action geographically (Bathelt & Gluckler 2003, p.125). Thirdly, the actors' learning are highlighted as "any analysis in relational economic geography is based on an understanding of the intentions and strategies of economic actors and ensembles of actors and the patterns of how they behave" (Bathelt & Gluckler 2003, p.125). Yeung (2005) uses the framework of relational economic geography further to address power relations. He introduces the notion of 'relational geometries' which refers to "the spatial configurations of heterogeneous relations among actors and structures through which power and identities are played out and become efficacious" (Yeung 2005, p.38). Thus, a relational perspective can also contribute to analyse the ways in which power relations unfold in economic relations.

A relational economic geographic perspective is valuable for this thesis as it draws attention to structures of relations in which social and economic action is embedded. These relations can be contextualised and situated in time and space. With this perspective, the complex ways in which medical travel facilitators' economic activities are embedded in social and economic relations can be approached. Furthermore, the perspective raises the awareness of how power unfolds in these relations.

3.1.2 Practice theory in economic geography

As this thesis sets out to analyse the medical travel facilitators' practices, practice theory which is a type of cultural theory (Reckwitz 2002) provides the appropriate framework to do so. Thereby, the epistemological framework of Jones and Murphy (2010) to conceptualise and examine *practice* in economic geography guides the analysis of this thesis.

The concept of 'cultural economic geography', which looks at the spatiality of a "culturally infused" economy (Gregory et al. 2009, p.129) focuses on the ways in which fluid economic entities are brought into being by economic activities, rather than analysing the functioning and effects of given economic entities (Berndt & Boeckler 2007, pp.215–216). In this sense, markets are considered to be brought into being through the interwoven practices of several actors (Berndt & Boeckler 2007). Markets are not fixed entities but the outcome of on-going processes (Kjellberg & Helgesson 2006, p.840). To foster a better understanding about how markets like the transnational healthcare market are brought into being by economic actors, it makes sense to examine their practices.

The opinions about how to conceptualise 'practice' diverge respective to different disciplines and epistemological theories. Jones and Murphy (2010) define socioeconomic practices as:

> "the stabilized, routinized, or improvised social actions that constitute and reproduce economic space, and through and within which diverse actors (eg, entrepreneurs, workers, caregivers, consumers, firms) and communities (eg, industries, places, markets, cultural groups) organize materials, produce, consume, and/or derive meaning from the economic world" (Jones & Murphy 2010, p.367)

The authors then sketch out different strands of approaching practice within economic geography. One of these strands follows a relational and communitarian approach to practice whereby practices are understood as "everyday relational processes that constitute economic action and hold communities or firms together within, and in relation to, particular geographic contexts, networks, institutional structures, power hierarchies, and/or spatial scales" (Jones & Murphy 2010, p.357). This approach is well in line with the relational perspective on economic geography outlined in Section 3.1.1. However, to make use of practice as an analytical category, the authors elaborate on a methodology that isolates different analytical dimensions of practice. Jones and Murphy (2010, p.382) distinguish four dimensions of practice: perceptions, performances, patterns and power relations. According to the research question of this thesis, three of these four dimensions are specifically addressed and therefore outlined here.

The first analytical dimension of practice is *perception*. Grasping this dimension is challenging as perceptions are influenced by thought processes that cannot be easily disclosed. Jones and Murphy (2010, p.382) argue that perceptions can be approached by "cognitively derived representational and constitutive elements":

> "Representations include the linguistic symbols, identities, discourses, and basic meanings or ideas ('truths') associated with particular communities and practices. Constitutive elements are derived from an individual's ego or socially constructed self. These include the motivations, desires, and objectives that create intentions as well as the rights, choices, and capacities that empower (or disempower) an individual in relation to a particular practice. Context, and an understanding of the self and its role in social relations, matter in determining how perceptions are socially constructed and, consequently, how human agency is enacted in relational settings." (Jones & Murphy 2010, p.382)

In the context of the thesis, the practice dimension of perception is considered as a useful analytical tool to approach the facilitators' understanding of their work. This dimension is about cognition, thought processes and the ways of making sense of the world. Knowledge about the perception dimension of practice is derived from the interviews where facilitators verbalise their perception of their context and their self-understanding[2]. In contrast to the performance dimension, here the focus is not on descriptive narratives about the facilitators work performances. Perception is about the *meaning* attached to things and practices. Therefore the facilitators' lines of reasoning, the way they (deliberately) construct their field and position themselves within, so as the rationales that they ascribe their work are of interest.

The second analytical dimension of practice is *social performances*. The authors explain that "through social performances, agents articulate representations, identities, power asymmetries, roles rules, and intentions" (Jones & Murphy 2010, p.383). In contrast to the former dimension, which was about understandings and meanings, this dimension explicitly centres the performances, the doings and everyday activities carried out. The dimension of performance is suitable to addresses the facilitators' daily practices as they are articulated in their narratives or as they can be observed in the field.

The third analytical dimension of practice is *power relations*. Power relations are considered to influence "the dynamics of practical action and determine how actors are positioned within the context of a practice" (Jones & Murphy 2010, p.383). With regard to how such power relations become evident, the authors distinguish two ways. First, in relational geometries that "shape or limit the opportunities available to actors" (Jones & Murphy 2010, p.383) or secondly, "as power is embodied in or produced by actors themselves, and is manifest in the strategies and tactics they use to control, build trust, and/or mobilize others in relation to their desires or intentions" (Jones & Murphy 2010, p.383). Thus, this third dimension is helpful in examining power structures that underlay the facilitators' economic and social relations by analysing their strategies and tactics to build them.

[2] The act of talking is a social performance in itself but the focus is on the perceptions expresses by means of language

3.2 Theoretical approach: Care work

Care and care work as a conceptual framework increasingly gained interest in academic research since the 1980s when feminist scholars reconceptualised 'work' and criticised that care work has been widely neglected as a meaningful dimension of work in traditional economic understandings (Lynch & Lyons 2009, pp.54–55). Since then, care work was set on the agendas of several research disciplines that contributed to a rich debate about how to conceptualise care work, its dimensions, logics and implications. This subchapter outlines theoretical accounts that serve as a base for the later discussion of the fourth research question of this thesis, namely in what sense the facilitators' work comprises care work.
The first section (3.2.1) examines different ways of conceptualising care work drawing on its aspects and discussing logics and issues related to it. The second section (3.2.2) elaborates on the commodification of care work and the third section (3.2.3) looks at how these concepts are taken up in geography. The last section (3.2.4) summarises the key points of the conceptual approaches.

3.2.1 Conceptualising care work

Care work is a "multilayered and complex concept" (Anttonen & Zecher 2011, p.15), which cannot easily be pinned down. It is difficult to find clear-cut definitions in academic literature, where multiple disciplines elaborate on a broad variety of aspects related to care and care work. Instead of having encompassing definitions, the concept is rather approached either by looking at different aspects of care work (Subsection 3.2.1.1) or by discussing logics and critical issues related to care work (Subsection 3.2.1.2). Drawing on these approximations, different ways to conceptualise care work are discussed. This serves the purpose of being able to approach the fourth research question, which asks about *the sense in which* the work of medical travel facilitators comprises care work.

3.2.1.1 Aspects of caring and care work

It seems that care work can be approximated best by looking at the purposes that drive caring and care work and by elaborating on the dimensions that care work can take.

Purposes of caring and care work
Several approaches take the purpose of the activity as an approximation to analytically grasp what care or care work is. Here, four such approximations that point towards particular aspects – and neglect others – are presented to give an idea about the varying conceptualisations of care work.
For Engster (2005) the central aims and virtues of caring are considered as the relevant aspects:

> "Caring may be said to include everything we do directly to help others to meet their basic needs, develop or sustain their basic capabilities, and alleviate or avoid pain or suffering, *in an attentive, responsive and respectful manner*." (Engster 2005, p.55; italics in original)

According to this understanding, the purpose of helping others is central. Furthermore, the author specifies that this help is meant to support and enable others in looking after themselves. Consequently, caring encompasses all practices that directly serve this purpose and which are carried out in a typical caring manner. The statement, however, does not explain how caring is related to work.
England and Folbre (1999), who have a similar approach, make the link to work more explicit:

> "caring work includes any occupation in which the worker provides a service to someone with whom he or she is in personal contact. The work is called 'caring' on the assumption that the worker responds to a need or desire that is directly expressed by the recipient" (England & Folbre 1999, p.40)

Apart from considering caring as work they make another interesting point. The criteria to consider the work carried out as caring requires that it is a response to the needs and desires expressed by the care-receiver. Thus, the way in which the needs and desires are expressed by the care-receiver and how they are interpreted by the care-giver respectively are determining the scope of caring.
Razavi (2007, p.iii) starts by saying that "care is crucial to human well-being" and then turns explicitly towards care work to which she assigns two purposes and differentiates between two sets of activities:

> „Care work involves direct care of persons; it can be paid or unpaid. (…) Direct care of persons (bathing them, feeding them, accompanying them to the doctor, taking them for walks, talking to them and so on) is often seen as separate from the other necessary activities that provide the preconditions for personal caregiving such as preparing meals, shopping and cleaning sheets and clothes. But such boundaries are arbitrary, especially since the persons needing intensive care are often also unable to do such tasks themselves." (Razavi 2007, p.6)

The way Razavi (2007, p.6) presents these two sets of activities suggests that she is differentiating between direct care work that serves the purpose of direct personal care and indirect care work that serves the purpose of "provide[ing] the preconditions for personal caregiving". This differentiation is useful as it raises the awareness that care work is not only practiced on and with the care-receiver directly but also encompasses supportive activities carried out that indirectly contribute to the well-being of a person. This division is also made by Stingelin et al. (2012, p.10) who further introduce a third form of care work referred to 'care responsibility' (Betreuungsverantwortung), which consists in the necessity of a care-giver's presence to look after the well-being of a person and assists if necessary. However, as the activities comprised by indirect care are not specified apart from their purpose, the category of indirect care work can be criticised for being all-encompassing and thus not meaningful because "virtually all activities can be construed as providing support for direct care" (Folbre 2006, p.187).
Jochimsen (2003, p.3) chooses to approach care and caring activities on a relational level stating "to care is to relate". She further elaborates and says:

> "To care is to consciously situate oneself in relation to the world, to the outer social and natural environment. The performance of a caring activity presupposes and involves the conscious establishment of relationships" (Jochimsen 2003, p.11)

Although the previous two approaches also presuppose a relationship between the care-giver and the care-receiver, Jochimsen emphasises much more on the relational aspect of caring. According to her, caring is fundamentally intertwined with deliberately establishing relationships. This is interesting when analysing the relationships and the ways in which they are established. The author describes how consciousness alludes to strategies and logics that drive this activity of relationship building and which decisively shape care work (see Subsection 3.2.1.2). Although this approach revolves

around a central aspect of care, it can be argued that building relationships is not the only task of caring.

Dimensions of care work

Care work can also be approached by looking at the dimensions it can take regarding different forms and features involved in the tasks that constitute care work. Firstly, a list of features that indicate different dimensions of care work is presented and then one of the dimensions is picked to elaborate further.

Lynch and Walsh (2009) provide a practice-oriented approach towards care work by enlisting different dimensions of care work:

> "Care work generally involves not only *emotional work* and *moral commitment*, but also *mental work* (including a considerable amount of planning), *physical work* (doing practical tasks including body work such as lifting, touching and massaging) and *cognitive work* (using the skills of knowing how to care)" (Lynch & Walsh 2009, p.42, italics in original)

These five dimensions show that a versatile assemblage of tasks that demand the involvement of the caregiver's body and mind constitutes care work. The authors complement these dimensions by enlisting some additional features that shape the practices of carrying out care work: responsibility, trust, intensity, mutuality, sense of belongingness, time and scope (Lynch & Walsh 2009, p.43). These additional features refer to qualities, requirements and framings of care work practices.

Drawing on these dimensions of care work, some distinctions that find linguistic expression are made. The expression 'caring *for'* refers to "catering for the material and other general well-being of the one receiving care" (Lynch & McLaughlin 1995, p.256). In contrast 'caring *about'* refers to "having affection and concern for the other and working on the relationship between the self and the other to ensure the development of the bond" (Lynch & McLaughlin 1995, pp.256–257). Another differentiation is made by Brückner (2010, p.43) who distinguishes between 'taking care *of*' that refers to the active aspect of caring and 'caring *about'* that refers to the emotional aspect of caring. Thus, depending on whether it is about caring *for* or caring *about* and the extent to which the other dimensions and features of care work manifest themselves, the bond or the relationship between the care-giver and the care-receiver varies in intimacy, intensity and emotional depth (Lynch & Walsh 2009, pp.43–48). As this differentiation shows, there are different ways to conceptualise emotional aspects of care work. This emotional dimension of care work features prominently in academic literature as it is looked upon as one of the peculiarities of care work. To gain a better understanding of how this dimension of care work is approached, Hochschild's (1979) conceptualisation of 'emotion work' or 'emotional labour' and 'love labour' as discussed by Lynch and Walsh (1995) are looked upon in more detail.

Emotion work is theorised by Hochschild who understands it as "the act of trying to change in degree or quality an emotion or feeling" (1979, p.561) which can be done "by the self upon the self, by the self upon others, and by others upon oneself" (1979, p.562). The author distinguishes cognitive, bodily and expressive emotion work and contrasts 'deep acting' that refers to the management of emotions and 'surface acting' that refers to the (bodily) display of emotions (Hochschild 1979, pp.562–568). Based on this differentiation, Hochschild (1979, p.572) brings in the idea of commodification. She states that emotion work can be commodified and exchanged on the marketplace. She

coins the notion of 'emotional labor' to refer to the "management of feeling to create a publicly observable facial and bodily display" (Hochschild 1983, p.7). However, the extent and quality to which emotional labour is performed depends upon the individual worker, the job and related expectations and the contextual situation (Hochschild 1983, pp.147–153). A study that focused on emotional labour of nurses found that this dimension of work is perceived ambivalently by the carers: it is causing both stress and job satisfaction (Bolton 2000, p.584). With a critical undertone, Hochschild (Hochschild 1983, p.153) states that emotional labour is "a dimension of work that is seldom recognized, rarely honored, and almost never taken into account by employers as a source of on-the-job stress".

Love labour is considered as a particular form of care work by Lynch and Walsh (2009). They argue that in contrast to general care work, love labour is more than a set of tasks. It is about:

> "a set of perspectives and orientations integrated with tasks. It is a feeling and a way of regarding another while relating to them. While it involves respect for the other like all forms of care, it involves more demanding forms of attentiveness and responsiveness than would apply to other forms of care" (Lynch & Walsh 2009, p.44).

The authors emphasise that features like commitment, trust, and sense of belongingness, intensity or mutuality are present to a higher extent in love labour than in general care work. Furthermore, the relations in which love labour is embedded are more intense, intimate and profound. Because of that, the authors conclude that in contrast to some tasks of general care work, love labour is non-commodifiable in nature (Lynch & Walsh 2009, p.51). The repeatedly raised issue of commodification is further elaborated in Section 3.2.2.

3.2.1.2 Logics and issues of care work

Some authors approach care work by discussing logics and issues that they find peculiar. Madörin (2009a) elaborates on three particular logics that condition care work. The first logic that can be derived from the constellation of people involved in care work is that there is always a relation between the care worker and the recipient, irrespective of the quality of this relationship (Madörin 2009a, p.67). The service is bound to the personal exchange between the care-giver and the care-receiver and the interpersonal relationship is inherently part of the transaction, thus the time spent thereby is part of the service.

The second logic that is inherent to care work is that there is an imbalance in power between the care worker and the recipient, which is marked by a sense of dependency and responsibility (Madörin 2009a, p.67). Power and power relations are central themes in the context of care work. Several studies examine the logic of power inherent to care relations or take power rather as an issue because the context of care work seems to hold peculiar and complex power structures, which can affect the work and well-being of the care-giver and care-receiver alike. Jochimsen (2003, p.7) states that "situations of caring for dependents, however, are characterized by relatedness of the individuals involved, by asymmetric starting positions, by varying degrees of dependency of the individuals, and by a certain asymmetric power structure underlying the provision of caring services for dependents". The author differentiates different kinds of power that are constituted, for example, by physical capabilities, skills, resources and moral values (Jochimsen 2003, p.21). She furthermore distinguishes between asymmetries in capabilities, in resource control and in motivation that frame caring activi-

ties (Jochimsen 2003, p.19). Orme (2002, p.804) also analyses power relations, "or more accurately the competing needs of care givers and care receivers" as she says, and addresses issues like the creation of dilemmas, impeded agencies, vulnerability and narcissism. This excursus made power as inextricable and crucial issue of care work explicit though it is implicitly already entrenched into the articulation of the purposes of care work and the dimensions specified.

The third logic addressed by Madörin (2009a, p.67) is that care work is usually processual in nature whereby performance and effect are usually too complex to quantify. These characteristics, the author argues, are inconsistent with the common rationalities of the market (Madörin 2009a, p.68). Section 3.2.1 will have a closer look at the interplay between economic logics and care work.

Stingeling et al (2012, p.8) bring up some more logics that condition care work and which are resulting from the logics that have just been outlined. In accordance with Madörin (2009a), the authors state that care work always entails a relationship between the care-giver and the care-receiver. Owing to this relationship, which is based on mutual trust and often results in a personal bond, the possibilities to replace the care-giver are limited (Stingelin et al. 2012, p.8). Another logic that Stingeling et al (2012, p.8) find indicative for care work is its particular temporal structure. The authors state that the temporal predictability of care work is limited, which is why care work is difficult to plan and requires flexibility from the people involved. Furthermore and consequent of these logics, the possibilities to rationalise and speed up care work are limited.

An issue that is related to the issue of power outlined before is the gendered nature of care work. Gendered rationales underlying care work featured prominently on the agendas of feminist scholars. One of the main points of criticism is that care work has been and still is traditionally assigned to be of women's responsibility (Anttonen & Zecher 2011; Knobloch 2009; Madörin 2009b; Lynch & Walsh 2009; Hochschild 1979). Scholars originating from different disciplines thus made substantial contributions in raising the awareness for the gendered nature of care work and its consequences. However, Anttonen and Zecher (2011) also address critical issues related to the existing body of gender-sensitive research. They state that care work carried out by men should not be neglected. Although the perception and attitude towards care work vary between men and women, the authors relativise some of the gender-specific differences made respective to care-giving qualities: "studies of informal care work show that the dimension of care, such as commitment, duty and devotion, are a part of both men's and women's care experiences" (Anttonen & Zecher 2011, p.23).

Another issue brought up by Anttonen and Zecher (2011, p.26) is that "the people needing care, their experiences, needs, agency and wishes" have been neglected up to now. This is the result of the research focus upon the care-giver's perspective and women's care agency, the authors argue. They question the portrayal of the care-receivers as "a helpless, passive and dependent person" (Anttonen & Zecher 2011, p.27). Based on this critique, the authors furthermore spot the relationships that are established between the care-giver and the care-receiver as being of particular interest and worth studying from the perspectives of both parties involved: "new approaches are needed in studying the daily practices of care and the partners of the care relationship" (Anttonen & Zecher 2011, p.28).

The working conditions of care workers is another issue that comes into focus. Greuter (2013) emphasises that doing care work is demanding regarding the scope of activities, responsibility taken over or long and scattered working hours which is neither rewarded in terms of the salary or appreciation. Also Schwiter et al. (2014) review the working conditions of round-the-clock carers are critical. Common characteristics of care work like the requirement of being permanently on call and the temporal and spatial dissolution of the boundaries between work and leisure are addressed.

3.2.2 Commodification of care work

There is a rich debate evolving around the commodification of care work. One of the questions that is discussed critically is if or to what extent care work is commodifiable: "There is a sharp division of views about whether markets, caring feelings, and caring activities are at odds with each other." (Folbre & Nelson 2000, p.129). Care work has long been associated with unpaid work carried out in the realm of the family but is actually carried out in variable settings and arrangements and thus can be paid or unpaid, formal or informal, in the private or the public (Madörin 2009a, p.68; Razavi 2007, p.6). Some of the logics underlying care work contradict common logics of the market, for example the limited ability to quantify care work or to rationalise the process (Madörin 2009a, p.68). Nevertheless, care work is being increasingly commodified (Schwiter 2013, p.504).

Some care work tasks are commodifiable but not all, as several authors argue (Lynch 2007; Folbre & Nelson 2000; Hochschild 1983). Care work has a practical and an emotional component which are commodifiable to different extents (Folbre & Nelson 2000, p.129). Lynch (2007, p.565) states that "what makes commodification of care work problematic is the attempt to commodify the non-commodifiable dimensions of it". Then, because of some constitutive features like the other-centred character, mutuality, commitment and deep intimate feelings, Lynch and Walsh (2009, p.51) consider love labour as being of a non-commodifiable nature. Therefore the authors distinguish love labour from general care work that is partly commodifiable. Another example is Hochschild's (1979, p.572) elaboration on the "commoditization of emotion work". She introduces 'emotional labour' as a commodified form of emotion work that is "sold for a wage and therefore has exchange value" (Hochschild 2003, p.7).

Another debate discusses the implications and consequences of the commodification of care work. Lynch's (2007, p.563) main line of reasoning that because care, love and solidarity relations have "an other-centred dimension to their character, they cannot be entirely marketised without undermining their care or solidarity purposes" (Lynch 2007, p.563). That for-profit care work can undermine its character is meant in the sense that the care relationship for example The author points towards the apprehensions that the time and efforts invested by the care-giver and his or her personal involvement might be reduced in for-profit care work arrangements (Lynch 2007, p.563).

Another line of reasoning have Folbre and Nelson (2000, p.138) discussing the dichotomy of "self-interest vs. altruism or money vs. love" that depart form the premise that work is either done for money or for love. Similarly to Lynch (2007), the authors raise the concern that the marketization of care might compromise the feeling component of care work: "motivation by money may lead to caring activities being performed to minimum standards, mechanically and impersonally, unaccompanied by the personal love and attention" (Folbre & Nelson 2000, p.130). The authors argument though goes in a different direction. They dissolve the dichotomy between love and money by arguing that they are not exclusive. Someone who takes money for doing care work does not necessarily invest less caring feeling than someone who does not get paid for doing care work. Thus, their main message is that there should not be an "a priori judgment that markets must severely degrade caring work by replacing motivations of altruism with self-interest" (Folbre & Nelson 2000, p.124).

3.2.3 A geographic perspective on care and emotions

As this thesis is set in economic geography, to see how care and emotions are taken up by a geographic scholars gives a new twist to the concept of care work as the concept is aligned with a spatial dimension (cf. Conradson 2003; Parr 2003; Silk 1998; Raghuram et al. 2009; Barnett 2005).
Conradson brings in a spatial component to care by arguing that care work and emotional labour occur in a particular spaces and argues that these spaces are not just the setting where care work takes place but that these places are shaped by the activity of caring or care relations. Thus, focusing on "the spaces, practices and experiences that emerge through and within relations of care" (Conradson 2003, p.452) is insightful.
Emotion as a conceptual framework also found its way into the focus of geographers (Wright 2012; Anderson 2009; Lipman 2006; Bondi 2005). Along with an 'emotional turn' in geography, "the spatiality and temporality of emotions, with the way they coalesce around and within certain places" (Bondi et al. 2005, p.3) comes into focus. From a geographic perspective, Bondi et al. (2005, p.3) understand emotions "in terms of socio-spatial mediation" and conceptualised as "relational flows, fluxes or currents, in-between people and places". Drawing on the 'new mobilities paradigm' by Sheller and Urry (2006), emotions as non-human entities are subjects to mobility and immobility (Hannam et al. 2006). The idea of the mobility of emotions feature also in the works of Ahmed (2004; 2012) that elaborate on the circulation, movement and stickiness of emotions that broadens a spatial understanding of emotions. Thinking about people being mobile, Urry (2005, p.77) raises the question about "what emotions are provoked by being in a relatively unfamiliar place". This indicates to understand emotions as being evoked by the experience of spatiality. This brief review shows that there are multiple ways of thinking about emotions in space.
A phenomenon in which geography, care work and emotional labour unfold in a very explicit way are global care chains that Hochschild (2000, p.131) defines as "series of personal links between people across the globe based on the paid or unpaid work of caring". Usually such care chains are established as people in 'poor' countries who are looking for jobs become mobile to meet the demand for domestic care workers in 'rich' countries whereby some more people get involved to replace the care work done by the worker who becomes mobile (Hochschild 2000, p.131). The phenomenon of a transnational provision of care raises several themes. These may include mobility patterns of care workers, the (spatial) distribution of care and relations of dependency and exploitation (Yeates 2004, pp.373–375).

3.2.4 The essence to be taken further in this thesis

The concept of care work is complex and can be framed in multiple ways. This is taken as an asset for this thesis as its aim is to reveal *in what sense* the work of medical travel facilitators compromises care work. The key points to be taken further in the analysis of the data are the following:
Generally it can be said that care work is about helping other people to meet their needs and wants. This can be done in direct face-to-face interaction with these people or it can be done in a rather indirect way by providing supportive practices that enable direct forms of caring. Care work involves several dimensions (e.g. emotional, mental, cognitive and physical work), which can be assembled in multiple ways and carried out with variable vigour. Consequently, the extent of care and care work carried out depends on the needs and wants expressed by the recipient, the interpretation and attitude of the care-giver, his or her engagement in the multiple dimensions of care work and the

meaning ascribed to values that are relevant for care-giving (e.g. commitment, trust, attentiveness, mutuality, respect).

The extent to which care work is carried out, the emotional quality of caring and in the strength and intimacy of the relationship established between the care-giver and the care-receiver can vary depending on the framing of the care work, the people involved and the rationales to engage in care work. In this sense it can be differentiated between 'caring *for*' that refers to the actions that enhance the care-receivers' general well-being and 'caring *about*' that refers being attached and thus caring for someone in a concerned, devoted and affectionate manner whereby the establishment of a close relationship is central.

Attention should be paid to the power structures that underlay care relations, the ways they are produced and counteract and the consequences resulting from negotiations of power. Furthermore, care work is not only embedded in (power) relations but also framed by the organisational (e.g. private or public sphere, formal or informal, paid or unpaid) and spatial settings.

4 Research design and methodology

This master's thesis is based on qualitative data gathered in a two-month fieldwork in Delhi from December 2014 to February 2015. Ethnographic methods such as in-depth interviews with representatives of medical travel companies and self-employed facilitators and participant observation in several corporate hospitals in Delhi provided interesting insights into the work and daily practices of the interviewees. The data was analysed according to the coding methods of the grounded theory approach. The research design (Subchapter 4.1), the different steps of data collection (Subchapter 4.2) and data analysis (Subchapter 4.3) are explained in detail in this chapter. Finally, the research design is critically reviewed and some personal reflections about the fieldwork are enclosed (Subchapter 4.4).

4.1 Research design

Before examining the different steps of the research project in more detail, some preliminary accounts about the study's methodological framework help to understand the overall research design and its implications in the different phases of the project.
This study is based on empirical fieldwork applying a qualitative research methodology as it best fits the research questions outlined in Chapter 1. Qualitative research is interested in how "humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, social roles, and so forth" (Berg 2001, pp.6–7). This study is about how medical travel facilitators perceive and perform their work, as well as their business strategies and the evolving relationships. An ethnographic research methodology is in accordance with such a relational and practice-oriented approach as it allows "an examination of the qualitative nature of relations among actors as well as an assessment of the spatial, temporal, and institutional contexts in which these relations are embedded" (Rantisi & Boggs 2009, p.318). With respect to the research questions and the conceptual framework, interviews and observations are considered the most useful methods for data collection.
Furthermore, the thesis is embedded in a 'grounded theory' inspired methodological approach, which is taken up especially in the section about data analysis in this chapter. Anselm Strauss, one of the first founders and Juliet Corbin who made significant contributions emphasise that 'grounded theory' as "a set of methods for building theory" implicates also "a way of thinking" (Strauss & Corbin 1998, p.4). A quick overview over their approach and way of thinking shall foster a better understanding of the overall research design. By "Grounded Theory" the authors mean:

> "theory that was derived from data, systematically gathered and analyzed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another. A researcher does not begin a pro-

> ject with a preconceived theory in mind (unless his or her purpose is to elaborate and extend existing theory). Rather, the researcher begins with an area of study and allows the theory to emerge from the data. Theory derived from data is more likely to resemble the "reality" than is theory derived by putting together a series of concepts based on experience or solely through speculation" (Strauss & Corbin 1998, p.12)

According to them, the two crucial points are, firstly, not to approach the data with preconceived ideas and concepts but to develop a theory out of the data, and secondly, to ground the theory by going back into the data and testing the theory.
A grounded theory approach, which is designed particularly as an exploratory approach, is considered to be a useful starting point for this thesis for the following reasons: First, up to now there are only limited empirical findings available about the work of medical travel facilitators; second, the literature is often descriptive in nature and not yet conceptually strong; third, empirical fieldwork goes along with a full range of uncertainties. Because of the limited base of literature and these uncertainties it was difficult to narrow down the scope of research and to anticipate possible outcomes of the study. Considering this vast field to explore, a grounded theory inspired approach is regarded as a useful methodological approach due to its openness to new insights and interest in looking at what is there in the field, in working closely with the data and in building theories based on these insights. Given a vague conceptual frame guiding the empirical interest, Charmaz (2013, p.17) says: "We may begin our studies from these vantage points but need to remain as open as possible to whatever we see and sense in the early stages of the research". Similarly, Silvermann (2004, p.11) underlines that openness is the key for "revealing the unexpected elements that come to light as a study progresses". However, given the limited scope of a master's thesis, it is not possible to go through all the different and repeating stages that Strauss and Corbin recommend, nor is the main target to come up with an elaborate, new framework of theory. However, the leitmotif of grounded theory and the coding methods were taken up in the phases of data gathering and data analysis.
Apart from this conceptual-methodological framework, the research project can be considered as a case study conducted in Delhi NCR, India. Narrowing down the research to a particular geographical setting is important to realise the project with the given resources and to draw conclusions on this particular site. This location is chosen because Delhi NCR is one of the leading Asian medical travel destinations as explained in the introduction in Subchapter 2.4. The chosen site for the fieldwork involves a complex assemblage of political, economic, social and cultural layers. This implies site-specific particularities, which are outlined in Chapter 5.

4.2 Data collection

The two-month ethnographic fieldwork of this study took place in Delhi from December 2014 to February 2015. To pursue the fieldwork some decisions about the subject to study and the concrete methodology had to be made.

4.2.1 Sampling

Drawing a sample of interview partners was the first step in the phase of data collection. Following a nonprobability sampling (Berg 2001, p.31), the interviewees had to meet two basic criteria: Firstly, the interviewee is working as a self-employed medical travel facilitator or is employed by a medical travel company located in Delhi NCR and is operating from there. Secondly, the interviewee is engaged in medical travel bringing international patients to Delhi (and other Indian locations). Moreover, the sampling was guided by theoretical sampling as designed in grounded theory. Theoretical sampling is a conceptual development of sample categories, which involves "starting with data, constructing tentative ideas about the data, and then examining these ideas through further empirical inquiry" (Charmaz 2013, p.102). After conducting a few interviews, some more criteria were found to specify the two basic criteria during the research process. From a first review of the data it became apparent that the size of medical travel companies, the number of patients facilitators handle and the interviewees experience in the job are relevant for building categories. Additional, criteria like nationality, the number of target countries, gender, engagement in additional lines of business, company internal organisation or work ethics were identified as being relevant. Although such theoretical sampling was applied, due to the given time span in the field it could not be done in an extensive way as foreseen in grounded theory.

The sampling started with extended online research from which a list of twenty-seven medical travel companies or facilitators was compiled. Out of these, eleven could be converted into an interview. Consequently, the sampling was repeated in several cycles during the fieldwork, which allowed taking up some more criteria that appeared to be relevant during the fieldwork. Additional to research on the internet though to a limited extent, the contacts established in the field were used for snowball sampling. Thanks to the interviews and field observations, the researcher could detect central figures, also referred to as 'stars' in ethnographic literature (Berg 2001, p.157). To get in touch with them, interviewees and other people in the field were asked for contact details.

The sample size was planned to consist at least in twelve to fifteen interviewees. Being in the field the time and opportunities were exhausted best possible: Thirty interviews with medical travel facilitators could be conducted whereby eight interviewees were self-employed and twenty-two were in the management of medical travel companies. Another ten interviews were conducted with employees of medical travel companies apart from the management team. Additionally, ten more interviews could be conducted with hospital employees, consisting of people from the international marketing department and medical staff, and with an international patient. Although all the interviews provide valuable insights and contribute to the researcher's understanding of the field, not all could be included in the analysis of this thesis. For the benefit of a more thorough and in depth analysis the sample chosen to be taken into account in this thesis consists in the thirty interviews conducted with self-employed facilitators and facilitators in the management of the medical travel companies. The interviews with people from the management of medical travel companies give insight into a broader spectrum of activities and considerations and were thus preferred to those with other employees.

4.2.2 Portray of the sample

The sample of the thirty interviewees taken into account is quite heterogeneous but four main groups of people could be formed according to the form of employment and the size of the medical travel company, see Table 1: The people working as self-employed medical travel facilitators form the first

group. The people working in the management of medical travel companies can be distinguished into three groups according to the size of the company categorised as 'small', 'medium' and 'large' in terms of the number of employees. However, the numbers of employees and the number of patients per month are subject to uncertainty and range within the groups, so the table can offer only some rough figures to give an idea. That the interviewees did not give very precise numbers can be attributed to the fact that their business is affected by seasonal fluctuations, wherefore the number of patients handled per month and also the number of employees varies. The samples represents a broad range of actors working as facilitators in Delhi, ranging from individual facilitators assisting only around three patients per month up to companies with over forty employees handling more than hundred patients per month. But also some medium sized companies cater to a considerable patient flow of up to two hundred fifty patients. From the companies in the sample, only two are operating internationally. The others are based in India only though a few of them have a branch office in another Indian cities than Delhi.

Facilitators working	Number of employees	Number of patients per month	Number of interviews per category	Number of Indian interviewees
as self-employed facilitators	1	3 to 20	8	2
for a 'small' company	2 to 10	3 to 60	11	10
for a 'medium' company	11 to 25	20 to 80 and 250	7	7
for a 'large' company	26 to 45	50 to 100	4	3

Table 1: Overview and categorisation of sample according to the facilitators' form of employment and the size of the medical travel company

Out of the thirty interviewees, twenty-five were men and five were women, of which three are in management. The interviews were mostly conducted with someone from the management team of medical travel companies and it could be assumed that women are underrepresented in this hierarchy level. But actually the women interviewed do take management positions. So it does not seem to be biased with the sample as such. The observations in the field rather support the impression that there are generally few women working as facilitators, irrespective to their position. The branch seems to be men-dominated which might have to do with some features of the job (eg. strong personal contact, long and unpredictable working hours) or with cultural or hierarchical structures in the society.
From the thirty interviewees, twenty-two are Indians, which is not surprising drawing from the geographic scope of the study and some implications regarding the legality of founding a company in India. Of the non-Indian interviewees five are from Iraq, two are from Afghanistan and one is from Congo. These people have lived in Delhi for three to eight years; two of them are working in the management of medical travel companies and the other five are represented in the group of self-employed facilitators.
The sample is complemented with some additional information about the facilitators' backgrounds and their relation to their work. Their educational background can be said to give insight into their knowledge and skills. Almost all directors of medical travel companies interviewed hold a university degree. Yet the range of subjects varies from marketing, to commerce, IT, banking, tourism, engineering and language studies. Although their studies were not specifically aligned towards a job in healthcare, most of the interviewees worked for a hospital before they started their medical travel companies. Many worked in the marketing department, especially the international marketing section or as an interpreter employed by the hospital. Through their work they gained knowledge of

international patients travelling to Delhi and the difficulties they faced, which gave them the idea to start a medical travel company. Being familiar with the process in the hospital and having good network connections is an advantage for them. Similarly to the founders of medical travel companies, many individual facilitators were first employed by different hospitals and then decided to quit their job and work on an individual basis. They report that they had heard about the job as hospital translator or facilitator from friends and family members. Some even experienced medical travel themselves, either as a patient or as an attendant.

Many of these self-employed facilitators are students. Muslim Indians who study the Arabic language at Islamic schools can easily enter the medical travel business because of their language skills. They can cater to Arabic speaking international patients, which make up a substantial share. Some of these self-employed facilitators still study part-time; others turn completely towards the job as facilitator and intend to complete their studies at a later time. Some of the non-Indian facilitators actually came to Delhi specifically to study or as refugees. Facilitators with migratory backgrounds have the advantage that they can translate between English or Hindi and their mother tongue.

Working as a facilitator seems to be a lucrative job for self-employed facilitators and directors of medical travel companies as well. What this means in numbers is difficult to say. But to give an idea: derived from the data, the treatments that international patients need often cost around $10'000. The business models that most of the facilitators report is that they get commission paid by the hospitals for referring international patients. The commission they get consists of a percentage share of the patients' treatment, which is said to be around 20% of the treatment cost. Depending on the number of patients that facilitators assist, they can 'make good money' – to put it in the words of the interviewees – compared to the average monthly wage in India which is around 300$ per month (Bureau of Labor Statistics 2012; adjusted to purchasing power).

4.2.3 Access to the field

Preparing the fieldwork in Switzerland, it was difficult to get a first access to the field in India. Starting from the list with the contact details of twenty-seven medical travel companies and facilitators located in Delhi, five of them were contacted via email but only one of them answered.

Being actually in Delhi, the access to the field was much easier. The mobile phone was the essential gadget to contact possible interview partners. Via phone, meetings could be arranged with short notice, which was conducive to accelerating the fieldwork. Sometimes the meetings had to be rescheduled spontaneously as the interviewee could not make it to the time and place agreed upon. Being on call is part of the facilitators work; and consequently also of the researcher. As already mentioned only eleven out of the twenty-seven initially listed medical travel companies could actually be interviewed. The other companies and facilitators were no longer active, did not respond to the phone calls or email or were not available for a meeting.

The access to self-employed facilitators and agents (although they would not necessarily identify themselves as such) was much more difficult. Medical travel facilitation in Delhi proved to be a contact-based business which means that some of the facilitators do not have a webpage nor an office but rely completely on their phone and word-of-mouth. Some of the interview partners from the category of self-employed facilitators were met when being present in different corporate hospitals and getting into conversation with them by chance or mediated via another contact. Through a per-

sonal contact, the head of the international marketing department of a corporate hospital in Delhi was helpful in organising interviews with five individual facilitators or agents.
Gaining access to the field for participant observation was more difficult than arranging interviews. The researcher asked the interview partners if she could accompany them one day to see the operation of their daily business. Some of them agreed to call to arrange such a field observation day. However, most of them did not call and sometimes it was logistically difficult because of the spontaneous nature of the facilitator's job, which made it difficult to join them at short notice. Several facilitators agreed to take the researcher to the airport when they picked up patients. Unfortunately it never worked out because they forgot to call, the travel itinerary changed unexpectedly or the flights were delayed. However, by coming back to the interview partners, calling them again and making concrete suggestions, the researcher could spend ten days doing field observations with different facilitators and in different hospitals in Delhi. The researcher gained valuable insights during these days as the access to the different localities and people the facilitators usually interact with were not restricted. The facilitators accompanied seemed to act naturally from what could be said from general field observations. They were helpful in answering questions and explaining what was going on in the field. All in all, the access to the field was pleasing, thanks to the openness and flexibility of the people contacted.

4.2.4 Semi-structured interviews

The interviews were conducted mainly with directors of medical travel companies and self-employed healthcare facilitators. These people can be considered as experts, because they have specialised expertise in negotiating medical travel because of their daily business (Bogner et al. 2002, p.7). The type of interview considered most appropriate is the semi-structured interview with an interview guide that helps the interviewer to cover the stated thematic field (Dunn 2000, p.61).
The interview guide is composed of a set of formulated questions and associated keywords and helps the interviewer particularly in the beginning to cover the main points. The interview guide used for this study consisted of questions assigned to three superordinate topics, see Appendix 11.2. The first set of questions was designed for acquiring knowledge about the interviewees' work and focused strongly on the field of activities and working routines, but also asked about the interviewees' network of people, the business model and employees. The second set of questions was devoted to the interviewees' perception of the clients they serve and asked about the patients' home countries, the reasons to seek treatment abroad and in Delhi specifically and about their needs. The third set of questions evolved around the facilitators' perception of their intermediary role and their strategies of patient mobilisation. The interviewer was sensitive to the terminology used by the interviewees and adjusted the questions accordingly.
After the first three to four interviews the questions were known by heart and the guide was consulted only in the end to check if the main themes were addressed. The advantage of a semi-structured interview guide is its flexibility to adjust to the interview situation (Dunn 2000, p.61). Thanks to this flexibility of the interview guide, the focus could be set on particular themes that either the interviewee brought up unexpectedly or the interviewer felt particularly interesting. Although the interviews were recorded, the interviewer noted the key points in a journal. This helped to stay focused and allowed taking up particular notions and themes that the interviewees introduced during the interview.

The interviews all took place during an intense phase of two months. Due to the distance to the research site, the researcher could not go back to the field repeatedly as anticipated in an ideal research cycle. Nonetheless, the transcription and a first analysis of some interviews during the phase of data gathering allowed for the adjustment of the interview guide. Some questions were reformulated, certain notions replaced and new themes included. These adjustments were an advantage in the sense that themes relevant to the interviewees are included to see if and how other interviewees frame them. Though, such a modified interview guide results in some topics being addressed with some interviewees, but not necessarily with all. For the purpose of this study, giving the interviewees room to express their views was valued.

Out of the thirty interviews, ten were conducted in the interviewee's office, eight in hospital cafeterias, six in other venues of the hospital like meeting rooms or waiting areas, five in public cafes, and one in a guesthouse. Usually the interviewee chose the location to meet. The interviewer therefore assumed that the person felt comfortable to do the interview there as this was agreed upon before the meeting.

4.2.5 Participant observation

In addition to the semi-structured interviews, participant-observation offers unique insights into the daily business of healthcare facilitators. Observation is a common ethnographic method in social science which "involves spending time being, living or working with people or communities in order to understand them" (Laurier 2010, p.116) and draws on taking field notes as an instrument to gather data. Ethnography implies a range of research methods and "usually involves the researcher participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts" (Atkinson & Hammersley 2007, p.3). Observations can take multiple forms and do not have a prescribed 'template' (Laurier 2010, p.118). In the observation undertaken in this study, the researcher's role resembled the role of a 'participant-as-observer' (Atkinson & Hammersley 2007, p.82). In agreement with facilitators, the researcher could accompany them as they assisted their patients in Delhi inside and sometimes outside hospitals. The researcher participated in the sense of being involved in some activities with the facilitator and the patients, sometimes even taking the facilitator's role and participating in conversations with people in the field including asking question to foster a better understanding. As the facilitators being accompanied were informed about the research method, handwritten notes were jotted down during observation and data entered on the computer in a manner as detailed as possible immediately following being in the field (Berg 2001, p.158). Because the "actual words people use can be of considerable analytic importance" (Atkinson & Hammersley 2007, p.145), 'situated vocabularies' and statements were captured whenever possible.

Observation is about exploring multiple dimensions of the field and of concrete activities carried out by the people observed (Charmaz 2013; Atkinson & Hammersley 1994). Getting an inside view of the studied field helps to detect actions, interactions and context specific reactions, underlying rationales and mechanisms and taken-for-granted assumptions (Atkinson & Hammersley 2007; Kearns 2000). As this thesis focuses explicitly on the everyday activities and practices of facilitators that are difficult to express because they are often taken for granted and accrue little reflection, observation is an integral part of this study's methodology. It is the key to bodily enacted, non-verbal dimensions

of labour and any other activity. Field notes taken from participant observation are thus particularly insightful. Some original field note episodes are presented in Subchapter 6.4 as they give a lively impression of the field and provide a basis for further analysis and interpretation.

4.3 Data analysis

The next sections present the data gathered in the fieldwork and explain how the data was processed (4.3.1) and then coded and analysed applying grounded theory principles (4.3.2).

4.3.1 Data and data processing

The data gathered consists of interview transcripts and field notes from participant observation. Out of the thirty interviews taken into account in this thesis twenty-five were tape-recorded. Detailed notes were taken during the other five interviews that were conducted with self-employed facilitators. These interviews were not recorded, as it would have been too critical for them; they did not want to be detected, partly due to their immigration status. The notes taken were integrated in a written text after the interview. The twenty-five interviews that were recorded are between forty minutes and one hour fifty minutes in length with an average duration of sixty minutes. Twenty of the twenty-five interviews were transcribed word for word with the program 'f5'. The other five interviews were partially transcribed; some sections were not included if considered irrelevant to the research focus.
This data material originating from the interviews is complemented by ten days of participant observation in the field in the form of field notes, which are already in the form of written documents and thus these data do not need further processing.

4.3.2 Data coding and analysis

In the research design, the approach of grounded theory has already been introduced. To recall, the main principle is to draw theories on the basis of the existing data rather than approaching the data with preconceived theories (Strauss & Corbin 1998, p.12) and combining inductive and deductive methods (Breuer 2010, p.52). A solely and tailored coding structure, developed from the data, helps to categorise and interpret the data qualitatively (Cope 2010, p.445; Strauss & Corbin 1998, p.105). Regarding the data analysis, Strauss and Corbin (1998) find:

> "Analysis is the interplay between researchers and data. It is both science and art. It is science in the sense of maintaining a certain degree of rigor and by grounding analysis in data. Creativity manifests itself in the ability of researchers to aptly name categories, ask stimulating questions, make comparisons, and extract an innovative, integrated, realistic scheme from masses of unorganized raw data." (Strauss & Corbin 1998, p.13)

What does this scientific-creative act of data analysis mean in practice? The data analysis begins 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). Such an 'open coding' supports "the analytic pro-

cess through which concepts are identified and their properties and dimensions are discovered in data" (Strauss & Corbin 2008, p.101). Phenomena that become apparent in the data and that can consist of a single word or even a text passage are labelled with the most appropriate term, respectively a code (analytical or in vivo). Through techniques of attentive reading, questioning and comparing, phenomena inherently anchored in the data can be detected.

During this first phase of coding, a group of eight transcribed interviews, presumably giving the most contrasting information, were coded word-by-word, line-by-line or incident-by-incident according to the most useful unit with the program MAXQDA. As provided in the coding principles, the researcher stayed close to the data, put simple but specific codes – if possible such reflecting action – and was sensitive to tacit assumptions, relations and processes (Charmaz 2013, pp.47–54). The process of giving these items names helped to break up, conceptualise, and abstract the data.

Codes, categories and concepts detected throughout this process were then further reworked and redefined, analysed and integrated in a more hierarchical structure of categories, sub-categories and codes according to the principles of axial coding (Flick 2005, pp.265–267; Breuer 2010, pp.84–91). Axial coding is: "The process of relating categories to their subcategories, termed "axial" because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (Strauss & Corbin 2008, p.123). Axial coding helps to "synthesize, and organize large amounts of data and reassemble them in new ways" (Charmaz 2013, p.60). After organising the codes that resulted from the coding session of the first eight interviews, the other twenty-two interviews and ten filed note documents were coded. During this phase the codes and coding structure was reworked, specified and altered. Thereby memo-writing was an important method to capture ideas and consolidate analytical insights (Charmaz 2013, p.72). Although the different steps of coding in grounded theory are presented here in a consecutive way, they actually blend into one another and are repeated in multiple cycles. Going through such cycles, the researcher found it appropriate to build three slightly different sets of codes – in addition to the main set of codes – for the interviews with individual facilitators, representatives of medical travel companies and for the field note documents, because codes were generated that only apply to these specific data sets.

On a more sophisticated and abstract level, 'selective coding' is about the actual theory building process (Strauss & Corbin 2008, pp.143–148). The coding is selective in the sense that a central category is selected. As this thesis is designed to analyse the facilitators' practices and the relationship with the international patient, these two key categories were selected. Then other categories and concepts were organised around these themes and built up a framework in which more and more codes and concepts could be integrated. Integrating, recognising relationships and linkages between the concepts is crucial because the "findings should be presented as a set of interrelated concepts, not just a listing of themes" (Strauss & Corbin 2008, p.145).

Given the scope of a master's thesis, the coding and theory building principles of grounded theory could only be followed to a limited extent. Actually the phases of data gathering and initial coding should be passed through multiple times. Because of the researchers' limited presence in the field for a two-month period, the focus was on data gathering and a first review of the data could only take place in a limited way. It was not possible and the intent was not to build a very comprehensive and sophisticated theory, but rather to focus on a limited number of specific findings in the data.

4.4 Reflection upon the research process

The first section (4.4.1) of this subchapter provides a critical appraisal of the research design. The second section (4.4.2) is devoted to some of the researcher's personal reflections upon the fieldwork with a focus on positionality.

4.4.1 Critical appraisal of the research design

As the choices, advantages and drawbacks of the respective methodological approaches and implementation have already been elaborated in the relevant methodology-chapters, this section reflects upon the research design as the set chosen to approach the questions and objectives of this thesis as a whole.

The choice of Delhi NCR as the location for this study is considered as bringing valuable insights that are contrasting with a large part of the state of the art literature. Delhi was anticipated as being a medical travel hub, which is catering in large part to international patients originating from countries of the Global South. This was confirmed and thus throws light on a different clientele than the one that is often conjured in the media but also in academic literature. The interviewees' sensitivity towards some locational peculiarities of Delhi as a medical travel destination indicates that this study gives insights into a particular setting that might show features that cannot be found in many other places. It would be interesting though to compare the findings of this study with other studies focusing on healthcare facilitators operating in medical travel destinations in the Global South.

The choice to combine interviews and participant observation as data collection methods is considered most appropriate to approach the research questions considering the scope of a master's thesis. As the research questions go in two directions by asking about the facilitators' perception and their practical performances, such a two-sided methodological approach is well designed to grasp different analytical levels. In the interviews the ways in which facilitators understand themselves and the field in which they operate can be approached (though not fully grasped). Participant observation allowed additional dimensions of the facilitators' practices to become visible; fore example the bodily enactment of activities, the relational setting within which facilitators operate and interpersonal encounters. Thus the combination was also valuable in order to approach the third and fourth research questions about relations and care work.

A drawback of the methodological approach using interviews and participant observation is a social-desirability bias. This means that in the situation given in the interview or participant observation, participants try to "present themselves in socially acceptable terms in order to gain the approval of others" (King & Bruner 2000, p.81). Such a social-desirability bias is considered as unfolding in two ways in this study that touches upon sensitive issues related to the practices of the interviewees. Firstly, so-called agents and touts that pursue practices that are not compatible with common understandings of social desirability are unlikely to participate in a research study like this. Hence, the sample of this study covers a particular type of facilitators that does not reach people overtly engaging in dubious and unethical practices. Secondly, the people participating are expected to present themselves in a favourable light. Actually, the self-representation of the facilitators is positive throughout the study. Although they do emphasise that there are other actors pursuing unethical practices, they clearly distance themselves from socially inacceptable practices.

The field observations could have been extended when having more time for data collection. The observations for this study predominantly took place in the hospitals and to a lesser extent the area close to hospitals or en route. It would be interesting to see facilitators in other spatial settings, for example when picking up patients at the airport (several attempts to accompany them were made but unfortunately not realised), when visiting them in guesthouses or hotels or undertaking some activities outside the hospitals. Accompanying the facilitator and a particular patient over a longer period of time, ideally from the beginning of the patient's stay until the end, would bring interesting insights. Also the business-development practices could not be observed directly and were ascertained only in the interview situation. Extending the location and scope of observation to the geographical reach in which facilitators operate would be useful when focusing on the facilitators' networking practices with channel partners.

A qualitative and ethnographic methodological approach goes along with certain epistemological limitations. The facilitators' practices, their social reality and especially their feelings and emotions can only be approximated and reconstructed but can never be fully disclosed by the researcher nor by the facilitators themselves (Mattissek et al. 2013, p.138). The methods applied provide an instrument to approach the subject matter though the data should always be critically reviewed. Combining different methods like interviewing and observation makes it possible to contrast the statements given in the interviews with observation made in the field. This is highly valuable to gain more consolidated and nuanced insights. Another effect that should be kept in mind is the "reflexive character of social research" (Atkinson & Hammersley 2007, p.14). As researchers themselves are part of the world studied, bring along particular socialised mind-sets, are involved in the process of creating a research design, in data collection, analysis and interpretation, the researchers have effects on the field of research, the participants, the data gathered and the knowledge produced (Atkinson & Hammersley 2007, p.14).

The choice of an explorative, grounded theory inspired approach to analyse the data is considered particularly appropriate because the field to study is vast and underexplored. This approach strongly encourages openness to new insights and indeed such insights have been gained from the data. Consequently, the initial research questions were partly abandoned and partly modified and some new questions rose from the data. To focus on relations and care work was induced by the data and incorporated in the research objectives during the analysis of the data. However, the outer fieldwork conditions did not allow making full use of the gains that an extensive circular research and data analysis process according to grounded theory offers. The data analysis according to the coding principle of grounded theory made it possible to move from a 'close-up' of data fragments to analytical categories by reworking and reorganising the data in several steps and iterations. Therefore it should be acknowledged that the analysis relies on the researcher's engagement and interaction with the data from which interpretations result (Charmaz 2013, p.179).

4.4.2 Reflections on positionality in the field

This last section is dedicated to some reflections of the researcher on positionality in the field. Two cases are looked upon: First, the negotiation of positionalities between the researcher and the research partners and second the positionality of the researcher towards the field as such. As it is about the researcher's and author's personal reflection, and to better explain, this section applies a first person account which is otherwise not present in this thesis.

The fieldwork was a very interesting, surprising, enjoyable and intense phase full of unique moments experienced. As it was my first fieldwork on this scale, critical questioning of 'adequate' behaviour in the field and doing everything 'right' in the interview situation accompanied this phase. Immersing myself into the field, I was aware that doing fieldwork is not only about conducting research by applying certain methods. I knew about positionality and power relations in ethnographic research and the constant negotiation upon them, about the researcher being in a strong position wanting information from the interviewee. Furthermore, I was about to conduct 'international fieldwork' which "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). Keeping this in mind, I was sensitive to the interview situation and tried to make the interviewees feel comfortable. However being actually in the field, I learned about more dimensions infusing fieldwork and my own perception and entanglement with them.

On a personal level, doing fieldwork also means negotiating presuppositions suggested by my own sociocultural background and feelings evoked by the unfamiliar setting and the encounters with various people within. I tried to overcome the latent discomfort of navigating as a woman alone through the hustle and bustle of Delhi's streets to meet with my interview partners by focusing on my research aims and cherishing the great opportunity of researching such a fascinating subject. When I arrived at the interview location, it was usually the interviewee who recognised me first and not the other way around – because I called attention as a light-skinned, blue-eyed, young European woman. That is when I started thinking about intersection of identity categories, about how my own person, my physical appearance, embodied gestures and the way of speaking and thinking might influence the interview situation and the power relations inherent to all interpersonal encounters. I became more aware of my positionality and the underlying intersectionality when some of my predominantly male interview-partners started to relate to me on a personal level. How to react when an interviewee suggests going to the cinema together? What to answer when an interviewee texts in the middle of the night, just to ask what you are doing? What to say when the person guiding you in the field observation asks if you are married? And: how to feel about that?

There is a sudden confusion about the presupposed setting given by the interview or fieldwork situation, the declared and, apparently, subliminal intentions. The position between the researcher and the research participants is not clear-cut. As a researcher I have an interest in their lives but they also are interested in my life and maybe me as a person. How to assess such situations? Is going out for dinner just a well-meant proposition born out of the interest to get to know someone from another country perhaps. But why does an interviewee try to socialise at 'unsocial hours? Is it an attempt of flirting? Is it legitimate to play the flirting game, if it is one at all, induced by the interviewee (or unconscious signals from my part?), being-out-for information and further access to the field? Am I then exploiting the interviewee for research purposes? Or is the interviewee exploiting my dependence on his information and facilitated access to the field? Defining the dimensions of life that are shared and others that are private is a process of negotiation.

The confusion evoked by an unexpected turn in the research encounter and the changing power relations can be approached by the mentioned concepts of positionality and intersectionality. The article of Kaspar and Landolt (Kaspar & Landolt 2014, p.9) gives particularly interesting insights into different ways such "sexualised research encounters" can be perceived and managed. The authors show how flirtation can unfold unexpectedly in the field encounters, evoking ambivalent feelings and shifting positionalities (Kaspar & Landolt 2014, p.2). Thereby, the researcher is exposed to "con-

flicts of interest and emotion between the ethnographer as authentic, related person (i.e. participant), and as exploiting researcher (i.e. observer)" (Stacey 1988, p.23). Negotiating shifting positionalities, conflicting rationales and subliminal feelings turn the field into a "complex and contradictory social landscape" (Chattopadhyay 2013, p.137). However, this landscape did not only unfold in the interpersonal field encounters itself but was transferred on a virtual level beyond the fieldwork.

The ways in which my positionality in the field impacts my knowledge and understanding of the field is another issue to reflect. It was the operational and tacit knowledge gained throughout the fieldwork that caught my attention – retrospectively, because the learning happened rather unconsciously and its effect was grasped only after being away from the field. In a way, I was practically in training when accompanying facilitators on their daily missions. After repeatedly navigating in some hospitals, I became more and more familiar with the locality. But not only familiarity with the locality, I repeatedly came across facilitators, doctors and staff from the international marketing, recognised them or they recognised me. We said hello, stopped for a chat or went to have a coffee. From this I established a network of people in Delhi through which I could access information, other people and localities. I picked up names of influential people and a specific terminology; learned what OPD[3] stands for, where to go for the billing, what a referral fee is, why to avoid touts, not to use the term agent for a facilitator, how to complete a patient admission form or a that translator, interpreter and facilitator can be one and the same person. Surprisingly – or rather not – I also got to know what investigations to do with an epileptic, the risks involved in a knee replacement surgery and could even recommend a neurosurgeon specialising in spinal cases. Before I spent time with facilitators in Delhi, I could hardly imagine how they can discuss treatment plans with doctors and explain medical procedures to their patients without any medical background. But then I realised that I picked up some of the medical terminology and associated procedures myself. Unconsciously, I built up knowledge and learned some unwritten rules that apply in the field. I immersed myself so heavily in my research that I was even mistaken by some people for somebody who had just begun to work as a facilitator. Such learning-by-observing or rather learning-by-experiencing substantially fostered an in-depth understanding of the facilitator's role and realm. This experience can be understood as a cautionary approach "to 'going native' by actively taking part in the systems of knowledge being studied" (Tresch 2001, p.303). However, this is still far from experiencing "the world in the same terms" (Tresch 2001, p.303) as the people being studied. Unless you are an active and long-term participant in this 'world' you can only study and not truly experience the system.

[3] OPD stands for outpatient department

5 Perception: approaching the facilitators' understanding of their work

This chapter approaches the practices of medical travel facilitators on the analytical dimension of *perception* (Jones & Murphy 2010) and is dedicated to generate knowledge about the facilitators' understanding of their work. As this understanding is a complex cognitive construct evolving from the facilitators' self-perception and the perception of their surroundings, it is approached in three steps:

The first subchapter (5.1) describes how facilitators frame the field within which they operate and how they position themselves with respect to other medical travel intermediaries. Firstly, this provides an insight into the circumstances on which the facilitators' work is based. Secondly, the terminology, which the interviewees use to refer to themselves and to others, and the positionalities displayed are introduced. The second subchapter (5.2) enters more deeply into the facilitators' perception of the medical travellers that they serve and the challenges that these patients face when navigating the medical travel market in Delhi. Based on these perceptions, the interviewees articulate a market niche and legitimise their work. Finally, the third subchapter (5.3) explores the prevalent ways in which medical travel facilitators understand their work.

5.1 Framing the field and the actors of medical travel facilitation

Framing a phenomenon is a cognitive task that expresses representations constructed by the person who is doing the framing and the meanings associated with particular phenomena (Jones & Murphy 2010, p.382). Thus, the ways facilitators frame the context within which they operate (Section 5.1.1) and the actors involved (Section 5.1.2) have explanatory weight and indicate the social construct on which their self-perception is based.

5.1.1 Framing the field – or knowing the setting

In the interviews, explaining what healthcare facilitators do was coupled with outlining particular characteristics of the field in which they operate. Thus, a portrayal of Delhi as a medical travel destination by the interviewees provides valuable insights into the perception of their work environment.

Healthcare facilitators engage in medical travel, which the interviewees see as generally a large-scale enterprise in Delhi and India compared to other medical travel destinations. They see potential in medical travel and expect the business to expand in the coming years. But to develop further and compete with other destinations, many interviewees call for a joint effort of the government, the corporate hospitals and facilitator associations. A myriad of reasons are presented by the interviewees explaining why international patients are coming to Delhi: excellent doctors, medically advanced

technologies and facilities, high success rates, cost savings, little to no waiting time, English language, cultural similarities, and closeness and connectivity to their main target markets. In comparison to other Indian cities, Delhi is considered to be one of the principal hubs for medical travel, largely due to the particularly good flight connectivity, the geographic location, and because Delhi is the capital city, where the headquarters of the major hospital chains are also located. International patients often undergo complex and invasive medical procedures in Delhi. The need for cardiac, neurologic, orthopaedic, paediatric, and cancer treatment seem to be the most prevalent according to the interviewees.

They report that most of the international patients coming to Delhi are from the Middle East (particularly from Iraq and Oman), from SAARC-countries (South Asian Association for Regional Cooperation, with a stronghold in Afghan patients), CIS-countries (Commonwealth of Independent States, especially Uzbekistan) and African countries (mainly Nigeria and Kenya). Interviewees also mention the United States of America, Canada, many European countries, and Australia among others. Some of the interviewees are specialised in serving patients coming from particular regions. However, focusing on a particular region seems to be the outcome of the facilitators' network connections (see Section 6.1.2) rather than an explicit business strategy. The interviewees signify openness and readiness to assist medical travellers from all over the world instead of limiting their scope to a particular geographical region. Furthermore, the interviewees outline the common reasons why people coming to Delhi as medical travellers seek medical treatment abroad. Most of them struggled to find good quality diagnosis and treatment in their home countries, which often lack state of the art medical equipment and whose doctors are not very well trained. Due to these deficiencies, diagnoses are often inaccurate, long waiting times apply, and the treatment success rates are significantly lower. Cost savings are also mentioned, but the unavailability of good medical care seems to be the main reason that Delhi's international patients seek treatment abroad.

From the way facilitators present the field in which they operate, some deductions can be made. The interviewees see their work as a contribution to an expanding medical travel market in which India is competing with other destinations. They know about the advantages of Indian healthcare providers and Delhi as a strategically well-located destination. Furthermore they know where the international patients they assist are likely to come from and the reasons that cause them to seek healthcare abroad. With this framing, the interviewees demonstrate and share their knowledge and perceptions of the field in which they operate.

5.1.2 Framing the actors – or how positionality unfolds in terminology

Studying the labels healthcare facilitators use to describe themselves and other intermediaries and how they define these titles, indicate their perceptions of themselves in relation to others. Induced by terminological disambiguation, "linguistic symbols, identities, discourses, and basic meanings or ideas ('truths') associated with particular communities and practices" (Jones & Murphy 2010, p.382) are revealed in this section.

Medical travel company / medical tourism company

The terms 'medical travel company' or 'medical tourism company' are used to designate an organised and registered firm facilitating patients seeking healthcare abroad; the extent to which tourism packages are offered differs, but the number of these packages is generally rather low in Delhi. The

notion is associated with "having a lot of people and a proper set-up," (I.4, 414)[4] which suggests a high level of organisation and ethical practices as the following quote shows:

> "We would call ourselves as a medical tourism company, because we are ethical. (...) We are full organization to back it up. And we are multiple, we are across different cities in India, and we are working on a marketing plan on how we gonna move forward. And we don't, you know, we don't do unethical practices, like what others do." (I.1, 63)

The company can vary in size according to the number of employees and the number of patients served per month[5].

Medical travel facilitator / healthcare facilitator:
The terms 'medical travel facilitator' or 'healthcare facilitator' are used interchangeably. If the medical travel context is obvious, 'facilitator' for short is the notion mostly used. The terms refer to individual self-employed facilitators and to people employed by medical travel companies (sometimes the term 'case-manager' is used to refer to those employees that are in direct contact with patients on site). They assist international patients throughout different steps in their medical travel endeavours. The interviewees describe healthcare facilitators as actors who are thought to assist medical travellers before, during and after their stay in Delhi. Unlike other terms such as 'agent' or 'tout', the terms 'medical travel facilitator' or 'healthcare facilitator' are associated with people who are experts in medical travel facilitation and pursuing ethical practices.

The interviewees typically refer to themselves by using these two positively connoted terms. They call themselves medical travel / healthcare facilitators if they work on an individual basis or for a medical travel or tourism company. This gives some indication about how facilitators see and position themselves, namely as organised, knowledgeable, competent, and as pursuing ethical practices. Working for a company, having a business plan and an organisational set-up are seen as qualifications. Contrary to academic literature, the interviewees do not seem to be sensitive about whether the company is one for medical travel or medical tourism. But as Subchapter 5.3 will show, this applies only to the terminology and not necessarily to the deeper understanding of the facilitators' work. Distancing themselves from other actors and assigning them a term seems to be a prominent strategy of the interviewees to effectively circumscribe their relative position.

Agent:
Similar to a facilitator, an agent is a person functioning as a middleman assisting international patients. An interviewee who calls himself a facilitator says: "People can say agent also. But it doesn't sound very good." (I.4, 16). In contrast to the previous terms, this notion mostly but not always has negative connotations, as it is often associated with people working in a disorganised way and without expertise, who are primarily interested in making money and who therefore do not shy away from unethical practices:

[4] This abbreviation refers to the interviewee who is assigned a number and the line number of the quote in the interview transcript

[5] See chapter 4.2.1 for the sample characteristics

> "You just bring the patient (…) you get the percentage [commission fee] and your role is over. Then hospital will provide each and everything (…) You're just agent. And you are only, you can say that you are doing nothing but getting money. Ethically this is not good." (I.6, 29-33)

The Indian interviewees often use the term 'agent' to refer to people working in Delhi with migratory backgrounds, mostly refugees and students entering the business as a side job because they have the necessary language skills and a network in their home country that sends patients. This nationality-based 'othering' of 'good Indian facilitators' and 'bad non-Indian touts' is challenged as facilitators with migratory backgrounds practice the same line of reasoning. According to their perceptions, Indian actors are considered a danger to their fellow citizens.

Tout:
The image the interviewees assign to 'touts', which is already a derogatory term, is one of people pursuing unethical practices, cheating and overcharging patients, and bringing them to obscure healthcare providers, driven by the prospect of making money:

> "These touts, they erode your base. They're like termites. Okay. So they don't openly fight with you. (…) But these touts, they use all possible evil instruments, (…) They do whatever." (I.7, 157)

Although some characteristics presented for agents and touts overlap, the interviewees perceive 'touts' as people who are worse than agents, and who are described as (nearly) criminal.

The distancing from agents or touts is expressed differently ranging from subtle nuances to explicit differences. While facilitators are presented as assisting patients throughout their medical journey, agents are described as middlemen bringing patients to hospitals, which indicates a different scope of activities. Pursuing ethical practices in contrast seems to be a more obvious criterion to position an actor. By distancing themselves from other actors to clarify their positionality, the interviewees ensure that the 'right' associations are evoked. This practice of othering is based on the principle that "the Other is that which is excluded from the Self and through this exclusion comes to constitute the boundaries of the Self" (Gregory et al. 2009, p.515). This strategy of self-demarcation should be critically evaluated as it mirrors the interviewees' perception and arguments. Such a self-demarcation can thus be strategically used. The interviewees' self-perception is based more on the idea of being different – or rather, better – than agents or touts. That the facilitators' position is constructed relative to other actors indicates a relational economic space within which positionality is negotiated. The efforts made to clarify their position relative to other players active in international patient assistance show that facilitators are aware of ambiguous images evoked around them. For example it can be assumed that healthcare facilitators like intermediaries or brokers in other branches apart from the medical branch are sometimes perceived as making money out of someone's weak position (Kern & Müller-Böker 2015, p.164). Clarifying their positionality thus seeks to correct such perceived misconceptions, and provides an advantageous image. This strategy is also widespread in interview situations where the interviewees have the chance to create an image that is further biased by a certain social control. Therefore, this study's scope is limited, as the sample comprise – according to the interviewees self-representation – organised industry players pursuing ethical practices.

The interview situation evokes a social-desirability bias (see Section 4.4.1) wherein it is unlikely to hear interviewees talking about unethical practices, which they pursue themselves.
The listing of terms, which are important when referring to different actors working in medical travel facilitation in Delhi, shows that terminological differences are powerful: The symbolic meaning of a word reveals the understanding and conceptualisation of a phenomenon. Thus, the distinctive terms for actors facilitating international patients allude to different levels of organisation, variable fields of duties such as subjective and common connotations. The terminological vagueness was addressed during the interviews to capture this conceptual ambiguity and to synthesise the most appropriate terms that are applied by the actors themselves. The terminological findings are directly adopted in this study as the notion 'medical travel facilitator / healthcare facilitator' (facilitator in short) is used to refer to both self-employed facilitators and people employed by medical travel companies, because the term is more neutral and inclusive than other terms and appropriate in the interviewees perception.
Nevertheless it is important to say that these terminological designations and the corresponding perceptions and understandings were sometimes contradictory and the boundaries between the different players are fluid and subject to personal interpretation. This shows that the interviewees do not uniformly agree on a consolidated terminology. To make such nuances in word usage and meaning visible, it is important to give the practitioners the opportunity to express their understandings in their own words. These findings reinforce the importance of the *perceptional* dimension to study the practices of economic actors.

5.2 Articulating a market niche

The healthcare facilitators' articulation of a market niche gives insights into their perception of the market and the way they legitimize their work. This subchapter shows how a market niche is articulated out of the facilitators' perception of international patients (Section 5.2.1) and the evaluation of difficulties posed to them when navigating the medical travel market (Section 5.2.2).

5.2.1 Representing international patients as vulnerable and helpless

The way that the interviewees perceive and represent international patients can be traced back to two states: a weakened health state and the lack of knowledge. How facilitators articulate these two states and the conclusion they draw from them are illustrated in this section.
First the facilitators' perception of the health state of international patients is to be analysed. The terminology indicates that medical travellers are primarily referred to as 'patients'; the use of this term by the interviewees is consistent. Being a patient indicates that the person is not in good health and the interviewees are aware of the patients' fragile condition. Although the state of health in a medical context is often first and foremost considered as a physical and bodily phenomenon, also the mental state of medical travellers attracts attention:

> "So, the patient comes from other country with many diseases and hopeless."
> (I.15, 16)

The interviewees seem to be aware that poor health affects both the physical and mental state of a patient. The quote shows that suffering from a disease and the unavailability or inaccessibility of the treatment needed in their country are recognised as considerable physical and psychical stressors. Many describe the patients as being "emotional and nervous down" (I.29, 360). Because of this particular perception of the bodily and emotional state of patients, they are described as physically weakened, suffering pain, stressed, worried and under psychological pressure. Thus, medical travellers are articulated as vulnerable and helpless patients.

A second line of articulating international patients as vulnerable and helpless draws on their lacking knowledge and the resulting inability to manage their medical travel endeavour successfully. The interviewees point towards considerable difficulties in evaluating the different actors operating in transnational healthcare. Thus international patients seem to be overstrained with finding and choosing a – or rather the best – doctor or hospital for the treatment. Although there exists national and international accreditation for hospitals, the interviewees stress the difficulties that international patients face despite this point of reference. The interviewees make clear that given the huge number of healthcare suppliers in Delhi, it is difficult for a layperson to differentiate between the specialisation of various medical centres and to form an opinion:

> "Because they don't know. They can't make differentiation, this hospital and that hospital, this doctor and that doctor" (I.18, 36)

It seems that most of them are overwhelmed by the options they can choose from and do not know what to focus on. The interviewee points directly to the lacking knowledge of international patients; they are perceived as ignorant, uninformed and unfamiliar with choosing medical providers generally and especially in another country. Geographical distance seems to matter. That international patients have to find the right hospital and doctor over distance, by mere means of an extended internet research, is compounding the problem of choosing the right provider:

> "Some hospitals are good for onco [oncology] some are good for cardio [cardiology] some are good for ortho [orthopaedics] and neuro [neurology]. Because it not depends on the huge building, it depends on the doctor's specialization. When you are finding on the internet, you find every hospital (…) all claim that we are the best in our specialization. So the patient gets confused. Where does he go? Because he just only find information on the internet and all are saying we are the best." (I.6, 126)

Providers making false claims further compromise the patients' ability to assess the offers presented by the internet. The interviewee experienced many times that the decision making process of foreign patients is influenced by misleading images and claims on some hospitals' webpages and warns about being misguided. Given these difficulties, the interviewees argue that people abroad would better trust a local facilitator who is familiar with the hospital landscape at the destination site, who knows the hospitals' standards and the doctors' specialisations and can advise them accordingly:

> "Because sometimes the patient need the support, guide the right way for treatment. So one person cannot do this. So this is my job to facilitate and to give the right doctor and expert, and right treatment for the patient. So that is the reason we are doing this service." (I.15, 14)

The articulation of the international patients' drawbacks serves as a source for the legitimacy of the facilitators' work. The interviewee argues that facilitators are more competent and compensate the patients' lack of knowledge and experience. But like other actors on the provider side, facilitators too can make false claims and mislead international patients. The interviewees acknowledge that the evaluation of a facilitator's proficiency is challenging for international patients. In contrast to assessing hospitals, there is no official platform or accreditation for healthcare facilitators to guide their choice. Because of the lack of knowledge about medical travel intermediaries, international patients run the risk of falling into the wrong hands:

> "Because you have many, many hospitals in Delhi NCR, small hospitals, bad people who want to earn easy money in short span of time. They want to become billionaire. So patient is *erhm* on the danger some time, if he is not getting the right person to handle that [a medical travel endeavour]. Because, you [as a patient] are totally new in India, you don't know how to rely on the people, because *erhm* informed people is little in number." (I.18, 34)

This quote shows three interesting things: First, such 'bad' and money-minded people, often referred to as agents and touts in the interviewees' terminology, mix in the medical travel market in Delhi and are perceived as a danger to the patients. Second, the interviewee stresses that it is important that patients are assisted by a reliable healthcare facilitator to handle their medical journey and protect them from malpractices of other players. Third, the reason why patients need someone to prevent them from this danger is because they are new in this country and do not know whom to trust. This last point is further elaborated in the coming section (5.2.2) that focuses on problems related to the medical travel market in Delhi.

The facilitators' image of international patients is considerably influenced by their state of health and their lack of knowledge. Their fragile physical and mental health and their difficulties in evaluating the actors' proficiency offering medical and facilitation services lead to an understanding of international patients as vulnerable, helpless and unable to cope. Following this line of reasoning, international patients need support to navigate more easily and successfully the transnational healthcare market. Thus, healthcare facilitators articulate the assistance of international patients as market niche, which is to be covered by their services.

5.2.2 Representing Delhi as an unregulated and difficult to navigate medical travel destination

The articulation of a market niche is based on a demand that is not yet met. Delhi as a medical travel destination seems to create a demand for navigation help. Then, its depiction by the interviewees point towards three consecutive issues: an unregulated market, unqualified actors operating within, and the deployment of unethical work practice like misguidance and overcharging.
Many interviewees, especially the ones working for medical travel companies, agree on an unregulated market as a major challenge for their industry:

> "India does not have any regulation as of now in medical tourism. That's the biggest problem." (I.9, 168)

Although lacking regulations was repeatedly brought up as a general statement to explain issues related to the medical travel business in Delhi, the further elaboration on particular regulations varies. Some address regulations that concern the industry as a whole, but regulations that directly concern the facilitators' work were more frequent.
That there is no qualification scheme regulating the facilitators' market entry seems to be one of the main issues according to the interviewees:

> "There is no regulation for it, like I told you. Anybody can begin as medical tourism agent out here." (I.1, 193)

The lack of industry-wide regulations setting requirements and obstacles that restrict the access to become a player in the medical travel market in Delhi is perceived as a problem because unqualified people can easily enter this business. According to the interviewees, basically anyone can start working as a healthcare facilitator and tie-up with hospitals as there is no need for a specific qualification record or a registered company. Language skills seem to be an essential qualification, though. One of the interviewees puts it simply: "You know the language, you are working" (I.4 98). Especially the co-presence of so-called touts and agents that mix up the medical travel market because of the low market entry requirements is put forward as a major challenge by almost all the interviewees; yet for different reasons.
The most prevalent reason to perceive unqualified facilitators as a problem consists in the malpractices that are ascribed to them. Misguidance and overcharging of international patients are considered the most prevalent malpractices that put a risk on gullible patients. As most of the medical travellers are not familiar with the price schemes – generally and particularly not in Delhi hospitals – they can easily become a victim to overcharging. However, landing into the wrong hands can have worse consequences than being overcharged; it can literally be life-threatening. According to the stories told by the interviewees, some touts even misinform patients about their medical evidence, tell them to undergo a treatment that they do not necessarily need and thus expose them to considerable risks. Whereby malpractices can be harmful to the patients' well-being, they can also compromise the facilitators business. India's reputation as a medical travel destination is challenged by stories circulating about malpractice of some players that raise the apprehensions of international patients to travel abroad.
A second reason why some of the interviewees perceive the co-presence of touts and agents as an issue is that they regard them as serious competitors. It seems that this has to do with the huge number of such perceived unqualified actors that challenge the interviewees' position:

> "Their [individual agents] numbers are numerous, huge quantity of such people available, everyone who has a patient, a relative, sometimes they even bring their own parents and take it on facilitators. Yes, they do. Nigerians especially, Iraqis and Afghanis. These are people in dire need of money." (I.7, 1-3)

The quantity of such agents competing against the interviewees for international patients seems to be a threat to their business. However their strategies and especially their strengths seem to be a serious cause for concern. As the quote shows, some of the interviewees refer particularly to non-Indian facilitators when talking about agents and touts. Indeed there is a considerable group of immigrants in Delhi engaging in medical travel and it seems that working as an individual facilitator without a proper set up offers a business opportunity to them. They do have language skills and connections to

prospective patients in their home country. They can use these assets to earn money. Hence, earning good money is considered the prevalent motivation for touts and agents to work in medical travel. In addition to their network and the language skills, touts and agents with migratory backgrounds are considered to have another advantage over Indian facilitators:

> "A patient who is coming to a new country will trust a fellow country man more than a stranger from that country. No? And Arab will trust an Arab; a Nigerian will trust more a Nigerian." (I.9, 124)

The quote states that patients trust their fellow citizens more than those from the host country. Based on this principle, non-Indian touts and agents are perceived as serious competitors by Indian facilitators. For them it is difficult to redeem the advantage and trust-building factor that these other intermediaries have for being the same nationality as the patient. However, the interviewees warn their patients from being misguided by fellow citizens. The intuition to find familiarity and trustworthiness in the foreign country allegedly impersonated by the fellow citizen guide can fatally mislead, they say.

Another example of an issue posed by an unregulated medical travel market – apart from the lacking qualification regulation and the consequent troubles – evolves around the commission fee model according to which most healthcare facilitators are rewarded for their work. Some of the interviewees criticise the power that is assigned to corporate hospitals because they can set the percentage share of the commission paid to healthcare facilitators themselves. That there is no regulation for this is considered as an issue of the medical travel business in Delhi. The interviewees explain that this aspect of an unregulated market can have serious consequences for international patients. They might be referred to a hospital that does not meet high standards but pays high commission for every patient referred. According to the interviewees' line of arguing, touts and agents in need of money are tempted to bring their patents to the hospital paying the highest commission and not the hospital that offers the best treatment:

> "So what happened, a patient is coming, now this person [an agent or tout] is saying, okay fine, I will help you, I know the country better, come with me. They take them to the cheapest hospital where the commission is more, where they get the maximum money." (I.9, 124)

The facilitators' integrity towards the patients is challenged and the competition of corporate hospitals is distorted because of the commission fee model. That the height of commission is set by the hospitals themselves is considered as an issue by the interviewees for several reasons. Firstly, confusion arises and transparency is limited because the commission varies from one corporate hospital to another. Secondly, the quality of treatment for international patients may be compromised by the height of the commission fee paid to the facilitator. Thirdly, facilitators find themselves in a conflict of interests between the best option for their patients and the highest reward for their pocket.

Apart from the issues directly related to the medical travel business, the interviewees also acknowledge that India in general poses a challenge for many foreign traveller. The city of Delhi is huge and for foreigners it is difficult to find their way; furthermore there is always confusion about prices, be it for cabs, food, clothes or other commodities. Stereotypes of untrustworthy money exchanger and corrupt policemen are furthermore reproduced in the interviews and mentioned as apprehension for foreigners to come to Delhi. They would not know how to deal with them – unless

they have a respectable and honest facilitator on their side – so the argumentation of the interviewees. So, the image of the country as being chaotic, populated by frauds and hence barely navigable for foreigners is advantageous to facilitators for gaining clients.

The two sections of Subchapter 5.2 traced down the articulation of a market niche by healthcare facilitators. Thereby the portrayal of the conditions given by the medical travel destination Delhi and a particular depiction of international patients as vulnerable and helpless in the former section are suggestive for a certain argumentation. The dominant line of reasoning is that international patients cannot cope with the challenges posed by the medical journey, firstly because of their health condition and lacking knowledge about the local situation, and secondly, because of the issues and intransparent logics present on the medical travel market in Delhi. Satisfying the international patients' need for medical travel facilitation is seen as the market niche. Filling this niche by providing a solution to encounter the patients' difficulties legitimises the healthcare facilitators work. The understanding of this fundamental base is important to comprehend the dimensions of the facilitators' ideational understanding of their work outlined in the next subchapter.

5.3 The ways in which facilitators' understand their work

As expected, there could not be found a consolidate understanding of the facilitators work. Rather, different ways in which they understand their work overlap and can be derived from the articulation of motivations, objectives and desires (Jones & Murphy 2010, p.382).
The first section (5.3.1) illustrates in what sense facilitators understand their work as service provision including mediation of patients as a particular type service. The second section (5.3.2) evolves around the rationale of advocating for patients and helping people in need. The third section (5.3.3) elaborates on the distancing of the facilitators' work from the tourism industry and an alternative understanding of their contribution.

5.3.1 Providing a commercial service including the mediation of patients

The most prevalent way in which facilitators' understand their work is as commercial service provision. That providing a service features prominently in the statements of the interviewees is not surprising because facilitators themselves articulate and promote their work as such and they are also seen as commercial service providers by outside parties. The following quote shows that service provision is considered as the facilitators' asset:

> "Because, you [as a facilitator] are not a doctor, you are not a hospital, your basis is on the services. Good services." (I.18, 167)

Providing good services to the international patients as well as to the hospitals they work with is considered to be crucial to gain a good reputation and sustainability in the market. However, what good services are leaves room to interpretation. One of the interviewees defines facilitation service in its most limited scope:

> "You just coordinate between the patient and the hospital. Patient contacts to you and you just forward the patient to the hospital, that is called facilitation." (I.6, 27)

This understanding points to the most basic form of facilitation service that is usually referred to as mediation. The position of healthcare facilitators within the transnational healthcare market, namely as being in the middle between patients and healthcare providers, advises them to function as an intermediary, which is a term that is often used in the literature. In this arrangement, the relational situatedness of facilitators becomes obvious and their role in mediating economic activity is made explicit. Their intermediary position and the relations that facilitators have with both parties enable them to mediate between the stakeholders. One of the interviewees sees his company as being 'the wire-media' and explains that his medical travel company is "the one point of contact between all this people put together" (I.1, 22). Another interviewee uses the word 'platform' to describe the function of a medical travel company. Thus, the intermediary position seems to lay the foundation for the facilitators' conceptualisation of their work. However, this understanding resonate some sort of passivity, which does not apply the interviewees' attitude. They argue that such a basic interpretation of facilitation service might work in some countries but not in the Indian medical travel market. To them, mediating patients and healthcare providers is just one specification of the commercial services they provide.

The Indian facilitator model - or at least from what can be said from the fieldwork in Delhi – is said to excel in a comprehensive approach towards service provision. The interviewees emphasise the importance of face-to-face contact and the services they provide throughout the patients' stay in Delhi that requires their attendance and assistance. To contrast the quote above and to illustrate how encompassing the service of the facilitators in Delhi is:

> "And all the thing we will do. Also in the hospital, suppose that patient need fruits, need clothes, need anything. Any need in life, because the patient is a foreigner, okay? He does not know where his need is available. (…) So this kind, e-v-r-y-t-h-i-n-g [knocks on the table] is agent's duty." (I.15, 114)

That the interviewee refers to himself as an agent is exceptional as outlined already. Against the negative image that is usually attached to agents, the interviewee seems to be likewise concerned to provide the international patient with a comprehensive service as other facilitators say they would. This comprehensive understanding of service provision is further explicated in detail in Section 6.3.2 where the focus is on how these services are performed in everyday practice. However, the quote shows that the service that the interviewees render to their patients exceed the function of an intermediary by far.

One of the reasons why the facilitators' service takes such an all-encompassing form has already been touched upon. The interviewees perceive the international patients as vulnerable and helpless and thus in need of such a comprehensive assistance service. This need seems to be widely acknowledged by healthcare facilitators and most of them implement such a comprehensive service. Consequently, this facilitation model seems to be naturalised by the market practices of the actors in the context of Delhi and becomes quasi the standard practice. To be competitive, facilitators express that they can hardly limit the range of services they provide. Responding to the question if there is a service he would not provide, one of the interviewees says:

> "No, no, no. If you are doing this, this is inhuman, first thing, and nobody will come to you." (I.18, 168)

This reaction shows that the facilitator is under pressure by his competitors. Limiting the range of services is directly associated with the loss of clients. Furthermore, the interviewee states that it is 'inhuman' to not provide a certain service. Apparently, facilitators seem to place particular demands on their own services and work ethics.

The prevalent understanding of the facilitators' work is one of comprehensive commercial service provision, which exceeds the functions commonly associated with an intermediary. The underlying rationale seems to be to create a service that best meets the needs and wants of international patients coming to Delhi. According to the prevalent facilitation model, facilitators take their patients by the hand, guide and assist them throughout the whole process. However, additional dimensions of understanding their work layer and specify this first and fundamental understanding of what facilitators do.

5.3.2 Advocating and helping people in need

The idea of 'helping people' seems to be a driving rational for many interviewees and thus is part of their work understanding. This is not surprising given the image of the helpless, desperate, uninformed and vulnerable patient presented in the interviewees' narratives (see Section 5.2.1). One of the facilitators outlines the scope in which his help is required explicit by saying:

> "They [the patients] need help in each and every task!" (I.24.4)

Responding to this demand, the interviewees understand themselves as the person providing help but also as 'a friend in need'. All interviewees express their disposition to help though the motives for helping vary. Three cases are outlined here:
The first case revolves around the motive of a particular group of facilitators to help. It became apparent that especially facilitators with migratory backgrounds articulate an understanding of the facilitators' work as helping people in need. A certain feeling of being responsible for their fellow citizens, who are staying back home and those who are seeking medical care in Delhi, seems to be the driving motive for these facilitators help. They feel particularly attached to fellow citizens and can sympathise with the difficulties they face:

> "There are a lot of patients coming from my country but you know they cannot speak English very well. So I'm there to translate. I help them." (I.30, 11)

Lacking language skills is a hindrance for patients in making themselves understood which is crucial when talking about a sensitive issue like health. Foreign patients who do not speak English or Hindi find remedy in the person of a healthcare facilitator who speaks their language, preferably a fellow citizen. This preference seems to be enacted by some facilitators who hold the opinion that the assistance provided by a fellow citizen facilitator is best. One of the interviewees, a young Iraqi woman who came to Delhi to study, says that there were only Indian facilitators at the airport who "just catch them [fellow citizen patients]" (I.30 43). Helping their fellow countrymen motivated her and her brother to work as facilitators. Another interviewee declares:

> "Because we are Iraqi nationality. So we need to give the service to my country. And we need to help our people there." (I.14, 4)

It seems that especially those who came to Delhi as refugees, leaving behind their (war-torn) country, feel a certain obligation to help their fellow citizens. Some of the interviewees with migratory backgrounds are engaging in the assistance of patients coming from their countries in Delhi but are also involved in projects to improve the healthcare system in their home country. Thus, helping people can take different dimensions that are further elaborated in the next section (5.3.3).
The second case presents personal fulfilment as a motive for helping international patients. Helping people in need is considered as good work, beneficial to the needy and satisfying to the person who is helping. One of the interviewees explains:

> "Before I was a student, I was in university. After that I see this job is very useful and beneficent to my life and maybe I will do service for the patient. So, the patient comes from other country with many diseases and hopeless. So if any patient becomes happy and disease released so I think this is a good job. It means that I am giving the life, new life to the patient." (I.15, 16)

The interviewee explains that 'giving new life to the patient' is a great benefit for the patient but also for himself. Helping people in accessing (life-saving) treatment motivates the interviewee to help whenever he can. Giving hope and a new life to the patient seems to be his mission. Compared to his former occupation as a student, the interviewee considers helping patients as meaningful and personally fulfilling.
The third case is closely related to the second one but challenges the motive of doing something good by bringing in earning money as another rationale. The following quote (it talks about the facilitator in 3rd person because an interpreter assisted during the interview as the facilitator was not fluent in English) illustrates the field of tension:

> "He [the facilitator] sees his role as helping the people as a human being. He's helping some unknown people, helping them to get whatever treatment or whatever. He says his role is the central role, as a human being he's helping. (…) So he's helping along with a purpose that is why he is also helping. What is the purpose? He's getting good money for the work and the other thing is he's also at the same time he's helping people. So the purpose is combined with this helping; a dual role. That's what he's looking at himself. Along with his helping he's getting paid. Because obviously nobody, there is no free lunches. Right? Nobody will help you for free. (…) Helping the unknown people in the right direction, getting them the right advice for which he's getting paid, that is right but he's telling them the right thing to get the treatment." (I.29, 464)

This quote mirrors a very interesting aspect of the facilitator's work. The interviewee starts with his mission to help unknown people. He helps them not only to get medical treatment but to get 'whatever', which refers to the loose concept of what the facilitators work and the task of helping in particular includes and what it does not include. Furthermore, it is stressed that he helps 'as a human being' which suggests that helping other people is a human duty. But then, money as the purpose of work is brought in. Interestingly, considering earning money as the purpose of the facilitators' work or helping people in need is first presented as conflicting. The interviewee clearly says that nothing

is for free and that earning money is a purpose to work. However, in the end the interviewee presents earning money and helping people as two parallel rationales.
Another dimension of conceptualising the work of facilitators is to understand them as patient advocates. Advocating for people can be considered as a particular form of help. The notion of an advocate and the idea conjure a novel bias to the understanding of the facilitators' work. The conceptualisation refers to a commitment towards the patients; guaranteeing to stand with them at all times and fighting for their rights. The fact that the notion of a patient advocate is often used in combination with 'fighting' points towards an active defence of the patients' rights and interests. The term indicates a different scope of activities ascribed to the facilitators' work. One of the interviewees explains:

> "And we don't just provide and coordinate and interpret to the patient. We also are the safeguards against the misbehaved corporate also. Sometimes you know, hospitals agree on a particular package, on a particular amount, you know. And on the day of discharge, patient is shocked to know that his bill is so high. (…) We always fight; we always stand with the patient. And we don't allow this to be with the patient." (I.18, 52)

In other words, if something goes wrong, either with the treatment or the bill, the patient advocate would intervene on the patients' behalf, even against the hospital that actually pays the facilitators' wage. In additional, when there are some issues outside the hospital, the facilitator would stand up and become active on the patients' behalf, articulating their needs and wants and supervising the situation. The understanding of being a patient advocate refers to a particular ideational conceptualisation of work that goes along with a distinct work ethic.

The idea of helping and advocating for patients is anchored in the facilitators' understanding of their work. They articulate help as being a human obligation that draws on the feeling of being concerned about someone's wellbeing or the persons' capability to manage a situation. Some of the interviewees understand help as a form of caring for someone out of a personal motivation. Also the understanding of being a patient advocate is backed up by a particular idea of helping patients that seems to be coupled with particular work ethics. Nevertheless, helping people and advocating on the patients' behalf as practiced by medical travel facilitators is situated in commercial context. Thus, the facilitators' understanding of their work as helping and also advocating can be seen as a specification of the service provided by facilitators.

5.3.3 Assisting development rather than tourism

Tourism is an industry that is repeatedly represented as being closely intertwined with the medical travel sector. Thus, engaging in tourism could be expected as being relevant for the facilitators' self-understanding. The data, however, show that this is not actually the case. Associating medical travel facilitators with tourism providers is considered as inappropriate by most of the interviewees. Inconsistently, the notion 'medical tourism' is still widely used even by the practitioners themselves. The majority of the interviewees report that tourism aspects of medical travel can be widely neglected in the case of Delhi:

> "Basically, very frankly, medical tourists 90% don't care what the places is there. 90-95%. If there is a hospital in the Taj Mahal, they do not come if there is not a good care. Because they are spending not for seeing the places." (I.6, 86)

Getting access to good quality care seems to be the driving rational for patients to travel abroad. According to the interviewees most of the patients choosing Delhi as a destination are suffering from a serious disease, which is usually incompatible with leisure tourism. Furthermore, a considerable number of patients are coming from a weak financial background and do not have spare money to spend on leisure. Thus the notion 'medical tourism' is misleading:

> "Doing medical tourism does not mean that patients coming to India just for treatments and going for a sightseeing and that's all. So our responsibility becomes more when talk about medical tourism, rather I would say it is not medical tourism, it is medical assistance." (I.28, 50)

The director of a well-established company is an advocate for the notion ‚medical assistance' which is emphasising the assistance service rather than tourism promotion. Medical assistance as he and his company implements however means even more than providing comprehensive assistance to the patients on site in Delhi. The interviewee actively works with organisations concerned with healthcare provision abroad. His company and non-governmental organisations act jointly on different projects including health check-up camps in various countries, purchasing diagnostic equipment and the training of doctors.

The rationale to contribute to the improvement of medical care in the patients' home countries is a recurring theme in the interviews. Several facilitators get involved in the development of healthcare in the source countries. The director of a medical travel company shares his grand ambitions:

> "I would like to build my hospital in Iraq, with very modern technology, with very famous doctor from all over the world. So that I will help people not to suffer." (I.14, 245)

The director of this medical travel company with migratory background wants to build a hospital in his home country to improve the healthcare provision of his fellow citizens. They can be conceptualised as medical refugees who cannot access good quality healthcare in their country and are forced to seek medical treatment abroad. Supporting the local people by pushing the development of healthcare services in their countries can be considered as a distinct dimension of the facilitators' work.

Entering such additional lines of business thus influences the facilitators' conceptualisation of their work considerably. Some of the interviewees perceive themselves as a kind of 'development aid worker' contributing to a more sustainable development of healthcare provision also in the patients' source countries. Thereby, some of them are volunteering, some others are earning money with their engagement. However, the quote further exemplifies that usually multiple dimensions of understanding the facilitators' work overlap: The idea of helping people and pushing development are articulated simultaneously.

Another group of facilitators motivated by the idea of development is moving for uniform codes of conduct in medical travel facilitation. The reason why they want to contribute is that they are frustrated with unethical work practices of other players, especially of touts and agents, because they poach their patients and thereby can spoil India's reputation as a medical travel destination. Most of

the interviewees feel powerless and do not know how to deal with them. An interviewee expresses the opinion that some facilitators do unofficially blacklist people with harmful work ethics, touts, doctors and other hospital employees as well. In contrast to this attempt to control the situation in this area, there are also some more sophisticated attempts to advocate for regulations in the medical travel market:

> "We have started a medic trend in the first medical tourism magazine, our group has it started, and we have formed also an NGO to work on these things. On guidelines, on ethics." (I.18, 40)

A group of facilitators decided to join together and form an association that works on establishing universal standards and guidelines for healthcare facilitators. They hold regular meetings to discuss the issues they face in the medical travel business:

> "Group of small number of people. We called a meeting. Because we want to improve the quality of medical tourism in India and want to attract medical tourists from all over the world." (I.18, 20)

Another company that developed a training program for medical travel facilitators makes another advance in this direction. They offer a course to obtain a certification in medical tourism services.

Although the terminology still refers to a tourism component in medical travel, the interviewees distance themselves from understanding tourism as a significant dimension of their work. That healthcare facilitators and medical travel companies are pursuing other lines of business than assisting patients throughout their medical journey is a new finding. Being engaged medical travel in a wider sense reconfigures the interviewees' understanding of their work in the sense that their conceptualisation is shaped by the idea of contributing to improvements and developments in transnational healthcare.

5.4 Discussion: (care) work in the perception dimension of practice

Chapter 5 approached the facilitators' understanding of their work that mirrors "the overarching objectives driving or underlying one's participation in a practice" (Jones & Murphy 2010, p.382). Thereby the research gap articulated by Snyder et al. (2012, p.20) arguing that there is a knowledge gap about "how patients, facilitators, and other industry stakeholders, including physicians, perceive the facilitators' roles and responsibilities" is at least partly addressed. This last section discusses the contribution of the data on existing literature and analyses how care work is anchored in the facilitators' understanding of their work.

The first finding to be discussed is the terminology applied by the practitioners themselves and the negotiation of their positionality. The notion 'facilitator' that seems to be increasingly prevalent in academic literature (Ormond et al. 2014; Dalstrom 2013; Wagle 2013) is also widely used by practitioners in Delhi. Although the dominant use, connotations and differentiation of the terms 'facilitator', 'agent' or 'tout' could be crystallised there remain inconsistencies. Following Jones and Murphy's (2010) analytical approach, the interviewees position in a relational economic space could be derived from the linguistic symbols they use and the identities they define within the community of

medical travel intermediaries. Different positions were articulated, but generally the facilitators presented themselves knowledgably, competent, employing ethical practices and acting in favour of the patients. Emphasising the co-presence of 'bad' actors in the field can be considered as a strategic move to articulate positionalities. The interviewees' reasoning behind this rational is to demonstrate knowledge, showing themselves in a better light relative to others and demonstrating the necessity of a reliable facilitator when undertaking a medical travel endeavour.

The second finding is the interviewees' representation of international patients as vulnerable and helpless. Jones and Murphy (2010) point towards the explanatory weight of the ways in which identities and 'truths' are constructed. Thus the interviewees' articulations of the patients' 'identities' were studied thoroughly. One line of reasoning draws on the patients' lacking knowledge and their enfeebled health-state that compromise their agency and result in vulnerability and helplessness. This framing of international patients does not correspond with the construction of a well-informed, self-empowered and agency-holding patient-client depicted in other studies (Ormond & Sothern 2012; Sobo et al. 2011; Crooks et al. 2011; Cormany & Baloglu 2011). The patients are considered as clients but not as empowered ones. The reason why international patients are perceived differently in the existing literature and in the data seems to be that the patients come from different countries. Patients who travel to Delhi are mainly coming from the Middle East, SAARC-, CIS- and African countries, and are obviously perceived differently from the image of the 'Western' medical traveller that dominates the literature. The clients served by facilitators in Delhi are predominantly articulated as medical refugees in the sense that they are in dire need of treatment, which they cannot access in their countries due to unavailability or poor quality, which is why they are forced to go abroad. The region may be indicative for the healthcare needs of a certain clientele, but the agency of these people may vary according to their socio-economic status. This finding goes in line with Ormond and Sulianti's (2014, p.15) call for "more cross-sectional studies that reflect and consider international medical travellers' diverse geographic, socio-economic and political situations". Through the facilitators' narratives, this study gives insight into the situation of particular 'types' of medical travellers, undertaking mainly South-South medical travel, which has not yet featured greatly in academic literature. Hence, based on this finding, one could think about different degrees of vulnerability and dependency upon facilitators' assistance relative to the patient's socio-economic status and the situation in their home countries.

The other line of reasoning for the vulnerability and helplessness of international patients emphasises the challenges posed when navigating the medical travel market in Delhi. The interviewees' depiction of the Indian medical travel market as being unregulated is well in line with observations made in other studies that acknowledge that the conditions of the transnational healthcare market pose certain challenges to international patients (Padiya & Goradara 2014; Burkett 2014; Connell 2013; Reddy & Qadeer 2010; Snyder et al. 2011). The Indian market though is considered as being particularly difficult to navigate by international patients.

A third finding is the logic behind the articulation of a market niche, which basically makes use of the representations of the patients and the context presented before. Drawing on the logics discussed above, the facilitators argue that international patients are incapable of successfully navigating their medical travel endeavour on their own. They will be confronted with serious difficulties and expose themselves to risks when undertaking medical travel. According to this logic, international patients act in a responsible manner and make a prudent decision when choosing to enlist the assistance of a

competent healthcare facilitator. Providing a service that matches the patients need for assistance, help, and also care appears necessary and thus legitimises the facilitators' work.

The fourth finding is that the interviewees show multiple and overlapping understandings of their work, which seem to be indicative of the scope of tasks they associate with their job. Different rationales are driving the facilitators to engage in particular forms of medical travel facilitation while ascribing meaning to their work. The understanding that featured most prominently in the interviews is providing a commercial facilitation service with mediating patients and healthcare providers as one of the basic tasks. Service provision can be further specified into helping people and advocating for patients. These forms of service however can be provided on a commercial basis but can also take place in informal arrangements in the sense of supporting a friend or relative. Another rational that influences the facilitators' understanding of their work is contributing to improvements of the medical travel business in Delhi and healthcare in the patients' source countries. The degree to which these rationales form the facilitators' self-understanding varies.

It is argued that people who primarily understand their work as commercial service provision have a different attitude towards their work than people who primarily understand their work as helping people. Expressly the helping rational seems to respond to a different scope of the patients' needs and the facilitators' motives. The ways in which the interviewees articulate the understanding of their work as helping people refer to an inner motivation and personal commitment, responding to a feeling of responsibility or obligation. It can be argued that the service provided to international patients by someone who is strongly motivated by the idea of helping people in need thus might exhibit more personal involvement and commitment than someone for whom helping is not the guiding principle.

The fifth finding is that the dimensions of how the facilitators' work can be conceptualised correspond with actual literature but that the data deepens the existing knowledge. Firstly, that providing a service is the most prevalent conception of the facilitators' work is in accordance with several other studies (Spece 2010; Herrick 2007; Caballero-Danell & Mugomba 2006). What service provision means though is seldom specified in this literature. In this regard, this study gives relevant insights as it points towards the wide range of tasks that facilitators in Delhi perceive as being in their scope of responsibility. What this means for the practical performance of the facilitators' work in everyday practice is elaborated in Chapter 6. Secondly, the facilitators' self-understanding as patient advocate corresponds with the findings of other studies that coin the notion (eg. Ormond et al. 2014; Dalstrom 2013; Snyder et al. 2012; Sobo et al. 2011). Thirdly, that the interviewees distance themselves from engaging in tourism is another example that shows that their conceptualisation is in line with relevant literature but contributes to new insights. With regard to Delhi as a medical travel destination, the interviewees agree that medical treatment is the main and foremost goal of the patients they serve; tourism becomes secondary – if it is relevant at all. Recent studies support this shift away from the belief that tourism as leisure and relaxation are rarely central in medical travel (Turner 2012; Ormond & Sulianti 2014). The facilitators' involvement in other areas of business – some more, some less related to healthcare – provides new insights. A respectable portion of the interviewees seem to directly engage in projects improving the situation on the medical travel market in Delhi and in projects that foster the development of healthcare in the patients' source countries. This dimension of the facilitators' work is considered to present a novel role, where further research could bring interesting insights.

The sixth and last finding to feature in this discussion is that the idea of caring for people and a disposition to provide care work is definitely articulated in the facilitators' understanding of their work, although it is not directly verbalised. This finding becomes apparent in the facilitators' perception of the patients they serve. The interviewees depict them as in need of care. For example, the attention paid to the patients' physical and mental state indicates that these people have specific care needs. They are in need of medical care, which is the reason why they became medical travellers, but they are also in need of emotional care, which are two relevant dimensions of care work (Lynch & Walsh 2009). Thus, facilitators have a double role. They facilitate medical care and care personally for the patients' overall well-being before, during and after the actual medical treatment. Care work is furthermore implicated in the facilitators' understanding of their work as providing a service and to help people in need, which are main purposes of care work (Anttonen & Zecher 2011; Engster 2005; Pellegrino 1999). Helping someone presupposes to be concerned about a person's well-being and demands sensitivity, empathy, sympathy, personal and emotional involvement as a commitment, which are all qualities of care work (Larsson & Wilde-Larsson 2010; Bolton 2000; Lynch & Walsh 2009; Pellegrino 1999). Being concerned and showing personal attachment towards the patients even indicates that facilitators care about their patients' well-being in a rather intrinsically motivated manner. Furthermore, the perception of doing decent and meaningful work that results in personal fulfilment are commonly articulated motivations for the carrying out of care work (Bolton 2000). The scope of tasks outlined in the facilitators' understanding of service indicates several components of care work as described by Razai (2007) or Lynch and Walsh (2009). Thus, concepts of caring and care work are anchored in the articulation of the patients' needs and in the rationales that constitute the facilitators' understanding of their work. Hence, it is worth considering how care work is realised in the facilitators' everyday performances, which is the subject of the next chapter (Chapter 6).

6 Performance: insights into the facilitators' daily work practices

Now that the facilitators' self-understanding of their work has been clarified, the question of how their work is enacted and performed is addressed. Thus, this chapter aims to investigate thoroughly the everyday practices of medical travel facilitators who are based and operating in Delhi. The analytical dimension of practice is the one of *social performances* (Jones & Murphy 2010).
The first two subchapters frame the facilitators' main duties, namely building an operational set-up in the background (Subchapter 6.1) and assisting patients before, during, and after their stay in Delhi (Subchapter 6.2). Departing from this overview, the daily practices performed by healthcare facilitators are scrutinised (Subchapter 6.3). The field notes reporting the exemplary experience of Tariq[6], an Indian facilitator, who goes through the check-up marathon with two international patients, offers unique insights into the facilitators' routines. The discussion (Subchapter 6.4) is twofold. Firstly the ways in which care work is entangled in the facilitators' job performance is unfold and secondly the assemblage of the main practices analysed in this chapter are consolidated.

6.1 Building an operational set-up

So far, the basic tenor has been that basically everyone can start working as a facilitator as long as you have a patient to serve and know the language to communicate. Thus, knowledge and people are the critical factors. But to enter and sustain a successful position in the medical travel facilitation business, more than language skills and having a patient is required. In the interviews it became apparent that those who take their job seriously and for whom it is not a side-line or a temporary solution to generate income, extensive knowledge and a well-established network of people is crucial. This demands effort and resources. Before entering the business, one of the interviewees invested three years to understand what medical travel and patient facilitation is about and to create a set-up in the background:

> "So after two years, when I started to research and get to know how it's working [medical travel and facilitation], maybe another year it took me just to you know get those contacts." (I.9, 26)

The kind of knowledge that is required (Section 6.1.1) and the contacts that are needed (Section 6.1.2) to enter and succeed in healthcare facilitation are analysed in this chapter.

[6] All the names have been changed for anonymity reasons, the names are fictitious

6.1.1 Attaining knowledge in several fields

Knowledge is considered as a key asset of facilitators and consequently, gaining knowledge is an integral practice of their work. The following paragraphs are structured into fields and categories of knowledge and address how knowledge is attained and the merit acquired.

Knowledge about the patients' home countries

The first kind of knowledge comprises some general information about the countries where the bulk of patients travelling to Delhi come from. It seems to be a prerequisite that facilitators obtain some basic knowledge about the geographical location, the languages spoken, the currency used, cultural peculiarities, and religions as well as the economic and political developments. Apart from this, some additional information related to medical travel is needed; for example information about the healthcare system and country specific travel regulations.

The strategies required to gain such knowledge differ. As many of the interviewees were employed by hospitals and were involved in marketing, finance, or as interpreters before they entered medical travel facilitation, they had acquired an idea of the international patients that come to Delhi. Some others learned about the nationalities of the patients coming to Delhi by talking to the international marketing staff in different Delhi hospitals or from friends and relatives who have experience with medical travel. In order to get information about these particular countries, researching the internet seems to be a good starting point. Nevertheless, the most effective way to obtain knowledge about the countries peculiarities according to the interviewees is to talk to people from the relevant countries. As the facilitators usually accompany their patients throughout the day, there are plenty occasions for the facilitator to ask questions or to listen to their patients' narratives about their home country. Facilitators with migratory backgrounds who assist mainly patients from their home countries have an advantage as they do not need to attain this knowledge but are already familiar with peculiarities of their countries.

The merit of such general knowledge for the facilitators is primarily that they can present themselves as knowledgeable and competent which helps to build trust with the patients. Talking about the patients' home countries is a common topic of conversation for breaking the ice. Furthermore, the interviewees emphasise that it is important to relate to them personally and gain their favour by showing interest in their countries and respecting their cultures. One of the interviewee states:

> "For example, if you are talking to a Nigerian, he loves to talk about governments. So unless you know the name of their president, you cannot start the conversation" (I.7, 101)

This quote presents some common knowledge as indispensable to facilitators for relating to patients. Furthermore, it suggests that people from different nationalities have different preferences; not only with regard to conversation topics.

Thus, the second kind of knowledge is about the particular preferences of the patients. The interviewees were quite specific on the peculiarities of handling patients from different countries, which are related to particular expectations and preferences. Depending on their nationality, patients demand different food, prefer to stay in a hotel or a guesthouse, decide on a particular hospital, respect for prayer times or appreciate particular social manners. The interviewees draw stereotypical portraits of different nationalities, which is critical as it is a simplification and the portrayals are also not

consolidated as the perceptions differ widely. Nevertheless, according to the interviewees there are substantial differences. To illustrate:

> "So Nigerians love to eat beef, in India it is not easily available because cow is very sacred for us. But we have found out places where you can actually get beef. (…) If people are coming from Middle East, they don't take very rich food. Their food tastes very bad. People coming from CIS countries, they don't like the sound of horns. So their guesthouses have to be in a place where it is very less noisy." (I.7, 89)

The interviewees report that they learned about their patients' country-specific preferences only in practice by repeatedly working with patients from the same home country and by talking to them. Some admit that in the beginning they did not know about such peculiarities and only found out when their patients were not satisfied. But they learned that it is worth paying attention to the patients' preferences and took it as feedback.

Knowing the patients preferences is important to facilitators as it helps them to adapt and tailor their services according to their wishes. Being informed about the patients' accommodation or food preferences, they can select suitable options. Knowing about preferred social manners prevents facilitators from appearing rude or intrusive to them and knowing about prayer times makes it possible to schedule the appointments accordingly. Thus, this knowledge helps to make the patients feel more at home and comfortable far from home.

The third kind of knowledge in this field is knowledge about the reasons why patients seek healthcare abroad. Thus, facilitators need knowledge about the lack of healthcare provisions in particular countries. This means that facilitators should be knowledgeable about the missing medical facilities, limited treatment options, low success rates, waiting times or poor diagnosis quality. Resulting from these drawbacks of the healthcare provisions and other factors, the spread of some diseases or the need for certain treatments respectively seems to show geographical patterns.

One way to gain such knowledge that demands time and financial efforts but seems to be effective is travelling to the patients' home countries:

> "Experience, experience. And when you start traveling so much, I travel almost every month one of the destination that we deal, so my team members travel a lot. So they gain inside from within." (I.7, 94)

Travelling thus proves to give valuable insights and foster a better understanding of the situation in the patients' home countries. Usually facilitators meet with so-called channel partners who are located in the patients' countries (see Section 6.1.2) who can show them around and give insights into the countries' healthcare situation. Furthermore, facilitators gain such knowledge also in direct encounters with the patients on site in Delhi:

> "And I think the major learning comes from the patients itself; because we get a lot of time talking to patients. (…) A 15 minutes coffee chat or a lunch chat gives us a lot of things about their things and they tell us, okay this is a problem in our country, this is what is not available." (I.5, 68)

Taking the time to talk to their patients and listen to the healthcare needs in their country can give valuable information. Some other facilitators are researching the reasons why people from certain countries travel abroad for medical treatment on the internet. The director of another medical travel

company has a team who is doing market research and creating a database by analysing the search requests on Google. They compare the healthcare needs of certain countries with strengths that Delhi offers as a healthcare destination:

> "So if we know that they [a nationality] have a problem and the success rate in that country is decreased and we are one of the best in kidney transplant in India, which we can do almost, hospitals like [name of hospital] are almost doing three or four a day. Right? So that's a country to focus." (I.5, 134)

This quote further points out the merit of such knowledge, namely that it indicates what to focus on. In the case illustrated, the company uses the knowledge to decide upon target countries as well as upon a specific treatment that they want to promote there. Thus, thanks to this kind of knowledge, facilitators can also adapt their promotional strategies. One of the interviewees further explains that such site-specific knowledge further helps to evaluate queries, handle them accordingly and contact the right doctors. He explains that the home country of a patient can be a clue to the nature of a particular disease. Such knowledge about the geographical spread of disease and country-specific particularities makes it easier for medical travel companies to approach their patients with tailored offers.

Knowledge about individual patients and their care needs

Facilitators not only need to know about generalised country-specific needs but also need information about the actual patients that they serve. Thus, knowledge about different aspects related to the individual person is relevant including their medical history, the actual state of health, related mobility and care requirements, the patients' travel experience, their fears and doubts regarding medical travel and their financial and temporal resources.

This knowledge can only be gained by being in contact with the patients. Some information can be gathered directly via means of communication such as telephone, email or Skype but sometimes facilitators also make deduction from the way the people speak, the questions they address and the country they come from. However, the patients' needs seem to be best evaluated in face-to-face contact. Being experienced in handling international patients makes facilitators sensitive to the patients' care needs.

To know about the individual situation and needs of their patients enables facilitators to tailor their services towards the patients' specific needs, expectations and budget. Knowing the personality and independent needs of their patients indicate to the facilitators when to reduce or expand their involvements.

Knowledge about medical issues

Another kind of knowledge concerns medical issues, diseases and the resulting needs of the patients suffering from them. Only one of the interviewees is a doctor and another is a pharmacist; all the others are from a non-medical background. Working in medical travel facilitation, knowledge about medical terminology, different diseases, treatment options, success rates, possible complications, medication, preliminary investigations and also flanking measures are important. One of the interviewee says:

> "As the patient is diabetic, what kind of food he may need? If the patient might be having hypertension, what kind of food he might need? So we provide first information and starting from there we take a decision." (I.7, 94)

The quote shows that although facilitators are not providing medical care themselves, they need an understanding about what the patient's disease is about and what they need to consider when caring for their patient. As the interviewee says, they need the knowledge to make decisions and to adapt their service to the needs that the patient has because of the state of his health. Knowledge about medical terminology and an understanding of the subject matter is crucial for providing translation services, explaining medical issues to patients and understanding medical reports and treatment plans. The merit of having such knowledge viewed as assurance that the facilitators demonstrate competence in their field, which is confidence building.

As mentioned above, gaining such medical knowledge is described as challenging and related to considerable efforts, as most of the facilitators are from professional fields other than medicine. Some of the interviewees say that in the beginning they read medical books or looked up terms on the internet. But here again, it is mostly learning-by-doing. Listening to the doctors' explanations repeatedly in consultations and asking questions, facilitators pick up terms and knowledge.

Knowledge about the medical travel market

The first kind of knowledge related to the medical travel market is knowledge about healthcare providers in Delhi. This kind of knowledge, mainly about different types and qualities of doctors and hospitals and their specialisation in particular treatment has already been discussed in Section 5.1.2 and Section 5.2.2 and is thus not further specified.

Experience seems to be the key word explaining how facilitators gain knowledge about different healthcare providers and alludes to a logic of trial and error. However, this seems to not be the only way to collect information. Some hospitals organise events where they portray and promote the doctors so that facilitators get an impression and also have the chance to meet them personally. Exchanging experiences with other facilitators and listening to word-of-mouth and rumours circulating is another source of knowledge.

The merit of this kind of knowledge is to competently advise patients in choosing doctors and hospitals, which is an important base for a successful medical travel endeavour. One of the interviewees who just recently entered the market with his company is aware of the fact that he needs knowledge about the medical travel market in Delhi to better serve his clients:

> "What I really have to get is a knowledge. If I will get a good knowledge than I can give a better treatment and better things to my clients." (I.2, 235)

The second kind of knowledge is about competition among medical travel facilitators. This means knowledge about who is competing in medical travel facilitation, what are the competitors' strategies and the facilitators' own strengths. Although the interviewees target different countries, apart from the facilitators with migratory background they do not articulate a regional focus as their strategy. Their strategies seem to differentiate in networking and additional lines of business and approaches to patient handling, although there seemed to relatively few differences. However, it seems that the facilitators' competition compromises mainly the strategies of touts to poach patients and strategies of hospitals in attracting patients. One of the interviewees says:

> "So my competition is from, let me use the word touts, in the first place, and the hospital in the second place. The organized industry players are not my competitors." (I.7, 157)

He finds that the activities of companies similar to his own do not compromise on his business. This can be explained by the fact that successful facilitators usually have well established channels through which they get new patients (see Section 6.1.2). Thus, they do not get in each other's way, which is the problem with touts. They interfere with the facilitators' business by poaching 'their' patients. The interviewee considers hospitals as relevant competitors because they try to attract patients directly and thus circumvent the facilitators' services.

Knowledge about competitors is gained by studying the promotion strategies of hospitals and medical travel companies or by talking to a hospitals' marketing staff. Another way is to attend events organised by hospitals, facilitator associations or conferences.

Knowledge about competitors on the medical travel market in Delhi is valuable for facilitators as they can adapt their strategies and position themselves differently. Regarding the problem of touts, many facilitators report to be more attentive since they know about their strategies and warn their patients about them.

The third and last kind of knowledge addresses a global perspective on medical travel. Although the interviewees seem to be very much concentrated on the Delhi market, some of them also broaden their knowledge by looking beyond the local medical travel market to get knowledge about current trends and different facilitation models. They begin to analyse and compare their model and the conditions given in Delhi:

> "If you just read the Turkey market facilitations (...) you just contact the patient, bring the patient to Turkey, and just forward it to the hospital and then the role is cut off. After that, form the airport to the airport the hospital will be responsible for all these things. (...) So, it is not working in Indian market." (I.6, 37)

To make such a statement, the interviewee needs an in depth understanding of the interplay between the different models promoted by corporate hospitals, medical travel companies and the conditions given by the government and informal players.

Such knowledge is primarily gained when travelling to other countries and meeting people engaging in healthcare facilitation at another destination site. Attending medical travel conferences and exhibitions gives valuable opportunities to gather and exchange information.

Such knowledge broadens the facilitators' horizons; initiates new approaches or makes them aware of their own strengths. Furthermore, it gives them the opportunity to contribute to the development of medical travel and healthcare facilitation on a transnational level by joining relevant associations.

The message of this section is that multiple kinds of knowledge related to different fields are conditional for facilitators to enter into and sustain their position in medical travel. They invest considerable resources and apply different strategies to gain relevant knowledge whereby learning-by-doing, interacting with patients, talking to network partners, doing research on the internet and travelling to patients' home countries are found to be most prevalent. Personal encounters with people like patients or hospital staff seems to be a relevant source of information. Thus, knowledge is transmitted along personal relations. In the case of the facilitator-patient relationship, knowledge flows in both directions. Facilitators share their knowledge about healthcare providers in Delhi and in turn learn

about the patients' home countries in their narratives during the patients' stay. The knowledge about the medical travel business, the patients' situations in their home countries and their personal needs is used to develop strategies, define target countries, customise services and also to relate to and care for patients in an adequate and personalised manner. Based on the knowledge gained, facilitators adapt their practices.

6.1.2 Networking on site and 'reaching out to the geographies'

Having a well-established network is an integral part of a healthcare facilitators' set-up as it channels patients to the transnational healthcare market and enables an effective patient assistance on site. Thereby one can differentiate the network of people present on site in Delhi and the networks of people abroad, consisting of so-called 'channel partners'. This section examines who these network partners are, how facilitators' connect to them, what their relation is based upon and why these partners are relevant for the facilitators' set-up.

Establishing a network with people in Delhi

The facilitators' network in Delhi consists first and foremost of healthcare providers, but also other partners including hotel and guesthouse owners, restaurateurs offering food that international patients prefer, taxi drivers, money exchangers and tour guides help to cater to international patients on site. As the relations with healthcare providers are more prevalent, this section focuses on that particular partner, whereby the international marketing team and doctors are the main contacts. Being connected with healthcare providers has practical benefits for self-employed facilitators and medical travel companies. Firstly, because they render the medical service that international patients are seeking in Delhi. Secondly, being on good terms with the contacts in the hospital makes it easier to discuss issues related to their patients such as treatment costs and procedures. Thirdly, these network partners are also a relevant source of knowledge for facilitators; exchanging the latest news is a common practice between the associates.

The facilitators' first step is to choose the hospitals with which they want to work. The selection criteria vary but the interviewees give interesting insights on what they base their decision. In informal conversations, some of the facilitators explain that there are doctors who are corrupt and would offer money or material goods, like a car, if they bring their patients to them. People from the marketing department would pursue unethical practices in certain hospitals and overcharge international patients, add services that they do not require and complete transactions in cash to save on taxes. Facilitators seem to choose doctors and hospitals according to their work ethics:

> "So we always prefer big brands, like [name X], like [name Y], like [name Z] hospital, there you can't play. Only 1% chance is there to play with the patients. Because doctors, they are big doctors, brand is very, they always save their name. So, in the small hospitals you can do these [bad] things." (I.18, 46)

As discussed in the previous subchapter, this knowledge about the hospitals and doctors' practices are often based on experience, which basically follows as trial-and-error method or circulating stories about certain actors. The interviewee quoted prefers big brand hospitals as he considers them as acting more responsibly and being attentive to inhibit unethical practices. However, the criteria to choose hospitals and doctors vary. Others prefer to work with a particular hospital because they have good (personal) relationships with the international marketing team or the management.

Once the facilitators know with whom they want to work, they have to establish connections. Therefore they contact the selected hospitals directly. Their relationship is based on an agreement to collaborate. These tie-ups regulate the conditions of their association and set the commission fee that the hospital pays to the facilitator for referring patients to that particular hospital. This commission or referral fee is usually a percentage share of the patients' treatment costs. Moreover, the percentage share is often subject to the amount of business that facilitators and medical travel companies bring to the hospitals. This business model, being paid a referral fee by the hospital, puts facilitators in an ambivalent position towards the patients. Taking commission fees, which are subject to the number of patients that facilitators bring to a particular hospital, questions their integrity and might compromise the facilitators' claim of finding the best doctor and hospital.
The relationship between hospitals and facilitators also seems to be ambivalent as the two parties are mutually dependant. On the one hand, the hospitals rely on the patients that facilitators bring to their hospital, as their options to target international patients are limited:

> "A hospital has a very limited staff. You can't target so many countries at the same time. If you have 20 people, most of them have 20 people, how much do you think they can cover? A country?" (I.9, 322)

The interviewee tells that facilitators working in smaller groups and having strong network ties to the patients' home countries are more efficient in bringing business to the hospitals. As for the hospital, having an armada of facilitators and medical travel companies reaching out to attract patients is thus an efficient way to increase their business. The director of a large medical travel company bringing a considerable flow of international patients to the hospital reports that he and his team have a high standing in the hospital:

> "But it's like we get invitations from these hospitals, we get souvenirs from this hospitals, we're called to parties form this hospital. And whenever we enter, there are a lot of people from CEO to anybody are recognizing us. And whenever the people moves they invite us to the new hospital, they'd like us to see the hospital and the facilities, they would like to tell that they are hiring so and so doctor, now you should promote this doctor well. So there is a lot of *erhm* you could say a lot of respect that you get into the industry from a hospital point of view." (I.5, 78)

Although the statement's validity is limited to companies and individuals generating a lot of business on the hospital's behalf, it shines light on the facilitator's status conferred by the hospital. The interviewee underlines his relationship with the management of the hospital and gives insight on the hospital's strategies to win facilitators that have a steady flow of many patients coming to Delhi through them.
On the other hand, facilitators and medical travel companies also depend on the hospitals in the sense that, firstly, they agree to work with them, and secondly, they pay an attractive commission for patient referrals and thirdly, they are open to negotiation upon the wishes and needs of the facilitators' patients. Some of the facilitators are also under pressure to meet the agreements regarding the number of patients they are supposed to bring on a monthly basis. Hospitals can also be considered as competitors as the following quote illustrates:

> "Because there is such a huge competition between the hospitals, they want to secure their patients. And if I do not choose to work with a particular hospital or I do lesser amount of business with a particular hospital, the hospital tries to reach out to that particular geography themselves and becomes my competitor." (I.7,157)

This 'reaching out to particular geographies' is highly relevant for getting in touch with prospective patients. That hospitals become competitors means that they interfere with the facilitators' practice of connecting with partners in the patients' home countries, which is the subject of the next section.

Establishing a network with people in the patients' home countries

This activity coined in the quote above, namely reaching out to geographies is virtually and physically one of the facilitators' core competencies and key for their set-up. In the medical facilitation context reaching out to particular geographies means that facilitators connect with people in the patients' home countries, either by travelling there or by contacting them by means of communication. The people to whom facilitators strive to connect, the way they relate to them, the modalities of their relationship and the reason why they are important are sketched out here.

According to the interviewees, a channel partner is a person or institution based in the home country of possible medical travellers who is co-operating with a medical tourism company or a self-employed facilitator, referring patients to them. Relating to such channel partners follows the logic that these people get in touch with possible patients and connect with them more easily than anonymous facilitators sitting miles away in India. In addition, they are available on the patients' site, they speak their language and they are familiar with their situation. These trust-building qualities of channel partners are beneficial to facilitators as they can outsource this difficult task of convincing patients to get treatment in Delhi. The strategy to establish channels with partners abroad through which patients are directed to Delhi is widely applied and proves to be successful. Most of the interviewees report, that the bulk of patients contacting them are referred to their person or company through a partner in the patient's home country. Therefore, establishing a network of such referral partners is an important task for business development.

Who are these channel partners? The following quote gives insight:

> "So let us say starting form business development, we contact the doctors, the insurance companies, the travel agents, or any source from where the business, from where a patient can come. As I told you, 50% of the patients coming to us are through channel partners, who might be doctors, private people, travel agents. About 40% of the people are from insurance companies. So insurance companies contact us." (I.7, 65)

Apparently every source of business is contacted, especially doctors or other medical staff, travel agents, insurance companies or private people. Doctors and other medical staff are popular because they are in contact with patients on a regular basis. Whenever these patients cannot get a diagnosis or treatment in their country or they cannot afford it, these partners advise them to seek healthcare abroad. Either they hand over the telephone number of the medical travel company or facilitator that they are associated with or they connect them directly. Having a tie-up with an insurance company is also favoured as they are expected to regularly send many patients. However, only medical travel companies with a larger set-up tie-up with insurance companies or even the ministry of health from

a particular company. Self-employed facilitators often work with other individual and private people who send them patients. Another group of channel partners that has not yet been mentioned are the facilitators' former patients. Sometimes they also become more or less sophisticated referral partners once they are convinced of the validity of medical travel to Delhi and are back in their home country. These particular channel partners are highly important for most of the interviewees, which is why Chapter 7 will elaborate specifically on that.

The relationship between the channel partner and the facilitators are conditioned differently. Sometimes these business relations arise from previously established personal friendships and do not require any incentives. When the relationships are deliberately set up for business, channel partners are usually rewarded monetarily or in alternative ways, perhaps in the form of a training session in a Delhi hospital offered to doctors.

The ways to create such a network are multiple and depend on the facilitators' existing relations and resources. Some interviewees report that they search for possible channel partners on the internet; perhaps finding and contacting suitable network partners via LinkedIn or Facebook. Larger companies even have business development teams that are devoted to establishing and maintaining those relations. Participating in medical travel conferences seems to offer good opportunities to network and meet possible channel partners. Travelling to the target countries and reaching out physically to the geographies, is a common practice to build trust, establish networks and maintain the relations with channel partners:

> "To make this relationship go on we have to go there, visit them, we have to do dinners, lunch, and everything with them and tell them what we do. So all those things keep on moving and then only we get the trust with them, established there." (I.5, 57)

This section outlined social and economic relations in which the facilitators' economic activities are embedded. Relationship building is an important practice of their work, because having a network of people on site in Delhi enables facilitators to better assist medical travellers and to smooth out the process during the patient's stay. The intention of spanning relations across transnational space seems to be the establishment of channels that pave the way for future clients. The strategies to build such relations differ as do the nature of the relationships that result. However, some of the examples displayed in this section show how power structures unfold in economic and social relations and the dependencies that result. This theme will be taken up in the course of this chapter (Chapter 6) and the next one (Chapter 7).

6.2 Mobilising patients towards the Indian healthcare market

Once facilitators have gained knowledge and have established the necessary network relations, they have the set-up to assist international patients. The next step is to mobilise patients towards the Indian healthcare market. But, persuading people of getting medical treatment in India and of being the right person to assist them is a tricky task. This subchapter analyses the difficulty to build trust over distance (Section 6.2.1) and explores the facilitators' patient mobilisation strategies to circumvent this difficulty (Section 6.2.2).

6.2.1 The issue of trust and distance

Trust was an ever-present factor in almost all the interviews. To mobilise patients towards the Indian healthcare market, building trust is seen as the key to success and at the same time as being one of the major challenges of their job. Trust is essential for almost all kinds of relationship; and is no different in a business environment. Simply put, one of the interviewees says, "without trust, nothing is there" (I.2, 339).

One of the reasons why it is so difficult to establish trust with international patients is the sensitivity of the subject matter, namely health. Consequently, trust in a medical context is of particular importance because it is about nothing less than a person's state of health, or as an interviewee states in a straightforward manner:

> "You're dealing with matters of life out here, these are very sensitive issues. So you have to gain an excellent trust." (I.1, 100)

Even in the familiar environment at home, deciding upon treatment plans, hospitals or doctors is a difficult task and these challenges are multiplied when all these processes are translated into the context of another country.

Thus, a second reason why winning the trust of potential medical travellers is distance. For many people, the unfamiliarity with India as a whole as well as the geographic distance to their home country is accompanied by a certain mistrust towards the unknown:

> "The problem is, that the patient does not trust me, he does not trust the hospital, he does not trust the doctor. Because he does not know me, I am from a different country all together. He does not know what I am selling to him. Nothing." (I.1, 34)

The interviewee explains that mistrust first arises because of the central aspects of a medical travel experience; the choice of the hospital, the doctor and the facilitator are surrounded by uncertainty. Second, the lack of knowledge of the patient or rather the incapability of evaluating the trustworthiness of medical travel facilitators and healthcare providers causes distrust. In addition to the uncertainty about the facilities and services mediated and provided by the facilitator, a prospective medical traveller takes the risks involved in the healthcare market in India.

A third obstacle that complicates the trust-building process is the circulation of negative stories associated with medical travel to India. Some of the interviewees hold that the mistrust towards Indian facilitators is associated with the unregulated healthcare market. One of them explains:

> "Major mistrust is coming because they [individually operating agents] don't have a commitment level and they're unorganized. So this sometimes destroys the reputation of a company as well as the country (…) So, the mistrust comes from the agents." (I.5, 57)

This section showed that the sensitivity of healthcare issues, geographical distance and associated unfamiliarity, and confusions about the Indian medical travel sector are all factors that hinder the building of trust and confidence. Thus, medical travel facilitators need to develop certain strategies to overcome these obstacles and persuade prospective patients of the advantages of getting treatment in Delhi and of their facilitation service.

6.2.2 Strategies of patient mobilisation – of channels and chains

Facilitators apply different strategies to mobilise international patients towards the Indian healthcare market. The three main strategies prevalent in the data are outlined here.

Direct patient mobilisation

The first strategy is referred to as 'direct patient mobilisation' as facilitators try to mobilise patients directly, without anyone else being involved in the trust-building and persuading process. Therefore, medical travel companies and sometimes self-employed facilitators set up a webpage as a primary medium to get in touch with prospective clients. When they enquire via email or phone, the facilitators try to convince them directly, explaining what medical travel is about, what they gain from a facilitator's assistance and why to choose this particular intermediary. For this strategy, the first contact with the patient seems to be especially decisive:

> "When they [patients] get in touch with us, we try and develop that trust with our initial conversation with them, over phone or email." (I.7, 125)

The facilitator in charge is considered to be "the mobilizing factor" (I.5 119). As the relationship is mostly personally driven, facilitators have to persuade prospective clients with their individual qualities. To develop a personal relationship, patients are usually assigned just to one person, functioning as 'case-manager'. A smaller company justifies the limited number of case-managers with the argument that they want to do the work themselves and make sure the connection is set up properly:

> "So it's only the two of us who do it [all the work]. That's what keeps it continuous. That's a lot of work. But that's what keeps it continuous, that's what makes the patient gets trusted." (I.1, 108)

Another strategy to build trust and to uphold continuity is a short response time from the facilitators' side, as it suggests a professional attitude. The strategy of 'direct patient mobilisation' relies on the convincing skills of the facilitator replying to queries of prospective clients and continuity ensured by speaking always to the same contact person.

Despite these efforts to build trust, the 'direct patient mobilisation' seems to be not very promising because the major difficulties in building trust outlined in the previous subchapter are not addressed and overcome by this strategy. Although facilitators who are based on the medical travel destination site have various advantages like insider knowledge about the healthcare market in Delhi and reliable partners in the city providing medical and non-medical services, they cannot overcome the disadvantages of physical distance as well as unfamiliarity with the language and culture:

> "The patient always gets convinced with the person sitting in their own country because we are to away from them and our language does not matches to them. Even we do have facilitators and translators for them. (...) But still, they are very much convinced with the person sitting there." (I.5, 23)

Implicitly, the interviewee provides a possible solution to overcome the locational disadvantage, which hinders 'direct patient mobilisation': collaboration with a person who is locally present in the patients' home country.

Channel partner mobilisation

The second strategy, which employs exactly this logic, mobilises patients indirectly towards the Indian healthcare market and is here referred to 'channel partner mobilisation'. Section 6.1.2 previously introduced the people who are contacted as potential channel partners and the nature of the relationship between facilitators and their associates aboard. To recall, the logic that drives the networking practices with channel partners is to win people in the patients' home countries as channel partners who then refer patients to the medical travel facilitators with whom they are attached. To build such valuable links, facilitators invest time and energy to persuade potential channel partners of the medical services delivered in India and the additional services provided by facilitators:

> "To make this relationship go on, we have to go there, visit them [channel partners], we have to do dinners, lunch, and everything with them and tell them what we do. So all those things keep on moving and then only we get the trust with them established there. And so there are a lot of doctors there whose major aim is to get their patient to the right hand. So they check everything before sending the patients to us. And once we have a relationship built in and they have get two or three patients treated through us, they are satisfied. Then the channel is very clear and we don't have to make trust. Patients trust their doctor there. And the doctor trusts us here. So that channel is very clear." (I.5, 59)

The quote illustrates the efforts made by facilitators to prove their trustworthiness and ability to cater satisfactorily for the patients sent by their associates. If they succeed in this, the 'channel is very clear'. This means that many patients will be referred to the facilitator along the linkage with the channel partner. Having established a network of such linkages, the task of convincing, mobilising and building trust can be 'outsourced' to the channel partners:

> "When the patient is coming from a very reliable agent, specifically the doctors or insurance companies, then we do not have to build the trust; they already have a channel-based trust." (I.5, 57)

Contacting a person who is physically present in their home country and speaks the local language, heightens the confidence level of the patient. The reason why many facilitators adopt the strategy of having a network of channel partners in the target countries is that the people trust their fellow citizens the most. Placing a middleman is circumventing the physical distance between facilitators and prospective clients.

Patient testimonial mobilisation

The third prevalent strategy is the 'patient testimonial mobilisation', which is pursued – more or less actively – by all interviewees. The principle is simple: the aim is to absolutely convince international patients on site when they are in Delhi, of the benefits to this type of medical care so that they tell their friends and relatives back home about the fabulous experience with 'their' facilitator. Thus, the 'former patient mobilisation' strategy is based on word-of-mouth, which is a personal and informal way of passing on information (Yeoh et al. 2013, p.197). The principle is simple:

> "If somebody has come and I served him well, he'll go and tell okay this is a good man." (I.4, 122)

Such positive and authentic testimonials given by a trustworthy friend or relative are considered to be a high form of confidence-building:

> "So first they [prospective clients] come in contact with you because of their past experience. So maybe their friends, their relatives, their doctors, their insurance company may have trusted us with their past patients and when they [past patients] have gone back, they have given a very trusted testimonial, that these are the people you can be trusted with your life, with your pocket and everything." (I.7, 125)

This strategy seems to work well; the interviewees repeatedly emphasise how many new clients former patients have referred to them. However, this quote shows that at best, the 'channel partner mobilisation' and the 'former patient mobilisation' strategies are combined: patients sent by channel partners get convinced on site and then help in the mobilising of other people. The 'former patient mobilisation' strategy can even be combined with the strategy of direct patient mobilisation. One of the interviewees explains that if somebody inquires directly but has apprehensions about coming to Delhi for medical treatment and there is no official channel partner available, he gets him or her in contact with previous medical travellers:

> „What I tell them if they don't trust us is take my previous patients numbers, speak to them. Visit them in your city. That's the best thing." (I.9, 154)

Involving a former patient with whom a prospective client can meet is thus another strategy to circumvent geographical distance and eliminate mistrust.

This section outlined how facilitators mobilise patients either directly by being in contact with them personally (direct patient mobilisation) or indirectly by interjecting another person in the mobilisation process. This can be a channel partner (channel partner mobilisation) or a former patient (patient testimonial mobilisation). In some instances the lines between the different strategies become blurred. Some of the former patients are effectively turned into channel partners, which means that they have a more sophisticated level of giving testimonials and convincing other people to seek medical treatment abroad and some of them are also rewarded by the medical travel company or the facilitator they are working for. However, how former patients are won as unofficial 'brand ambassadors' is examined in detail in Subchapter 7.2.

6.3 Assisting patients before, during and after their stay

When medical travel facilitators have prepared the groundwork and have established a first contact with the patient, they can start their facilitation and assistance service. This chapter frames the different steps that facilitators usually undergo with international patients before (Section 6.3.1), during (Section 6.3.2) and after their stay in Delhi (Section 6.3.3) as well as their duties and tasks throughout the process of assistance. Of course, the processes and practices vary slightly from interviewee to interviewee. Yet the following outline of the facilitator's job can be considered as the usual course in Delhi as it is derived from the data.

6.3.1 Before the stay in Delhi

The patient assistance provided by medical travel facilitators starts when they first make contact with the patient. In other instances it is the patient him or herself that approaches the facilitator by phone or email, sometimes it is a family member, a friend or a channel partner. As shown in the previous subchapter, facilitators try to build trust over distance with the initial conversation. The next task is to maintain contact with these clients from afar until they set forth on their journey to Delhi. Most of the facilitators update their patients on a regular basis about the preliminary arrangements or just drop a message to ask about the patients' well-being. The reason for doing this is twofold. Firstly, the facilitators are signalling interest and professionalism that promotes trust. Secondly, the facilitators ensure that they do not lose their clients.

The phase before the patient travels to Delhi – variable in length from a few days or up to a year – is used to prepare the medical journey as well as the stay and medical procedures on site. The patient is asked to send medical reports, which are then forwarded to different doctors by the facilitator. The facilitator then returns the cost estimates and suggested treatment plans according to the doctors' opinion to the patient. Although some of the patients already know in advance which doctor they want to see, most of them rely on the facilitator's experience and knowledge and thus count on his or her recommendation:

> "Some people have their opinion, most people don't have an opinion, they totally rely on us, on our opinion. And we honestly guide them to the best doctors." (I.18, 38)

Assisting patients in choosing doctors and hospitals is thus a very important task of medical travel facilitators. The options that are available in Delhi are vast and facilitators have to filter them and prepare a list with preselected providers for the patient to choose. The interviewees express their sensitivity towards the patient's needs, and negotiate carefully between giving advice and letting the patient choose on his or her own. Then, the facilitator collects a visa invitation letter from the chosen hospital and helps the patient to apply for a medical visa. If requested, the facilitator books the flights and accommodation in a hotel or guesthouse. If everything goes well for the facilitator, the patient and his or her attendants finally travel to Delhi. According to the dominant remuneration scheme, facilitators get no reward up to now because the referral fee is issued by the hospital only after having admitted a patient to undergo treatment.

6.3.2 During the stay in Delhi

The process once the patient arrives in Delhi is best summarised by the following quote:

> "We go and pick them [the patients from the airport], settle them in a guesthouse, hotel or whatever they like; take appointment with the doctor, show them in the hospital. Once the investigation is done, explain to the patient okay these are the findings and this is the plan of the treatment now. Then surgery or whatever is required is carried out. Once they are discharged from the hospital, we again bring them to the guesthouse. And all this while, like other things, like transportation and money exchange and all those small, small things we arrange that for them." (I.4, 40)

The quote illustrates that the facilitators are engaged in both spheres, the medical one in the hospital and the life outside the hospital. After a first consultation with the doctor, the patient usually has to do some investigations before he or she is admitted to the hospital. The medical reports that the patients bring with them – if at all – are often of poor quality and the diagnosis made by their local doctors is subject to uncertainty. In the quote, the facilitator says that he has to explain the findings to the patient. Translating and explaining is an important function of the facilitator. They gained their language skills differently: A considerable group of the facilitators studied languages at university, some Muslim Indians learned Arabic in Islamic schools. Some of the facilitators are immigrants who translate between English or Hindi and their mother tongue. However, that the facilitators' translation service is not limited to translate word by word is further elaborated in Section 6.4.2. The moments when the facilitators explain the findings of the investigation is often critical as the patients are confronted with a diagnosis and must decide upon the further proceedings. As the cost of the treatment is a crucial factor in the patients' decision-making process of whether or not to proceed, facilitators quite often have to prove negotiation skills to get a discount for the patient. Once the patient is admitted, the hospital staff looks after his or her needs. Nevertheless, the facilitators are still concerned and ensure that their patients feel comfortable.

With regard to the non-medical sphere, facilitators are similarly engaged in satisfying their patients and attendants and try to make them feel comfortable. They would take the patients and their attendants out for dinner occasionally, accompanying them for shopping in the market or in malls or show them around Delhi. Sometimes they offer a day-trip but as already discussed, tourism aspects are considered to be only very marginal (see Section 5.3.3). The interviewees emphasise that wherever the patient goes, they would offer their company:

> "One facilitator from our company always accompanies them. Always. In every place." (I.18, 157)

The facilitators carry on with their service that is entangled in almost all dimensions of life. Their understanding of medical travel facilitation service exceeds the function of an intermediary by far and unfolds in a personal multifaceted care:

> "All thing, all thing. From *erhm* receiving from airport, Sim-card, [money] exchange and if they are Arabic people, their Arabic food, different types of food, and their hotels. In everything they ask us. For example, if they are sitting in front of a grocery, I want to buy this, can I buy? They are asking this money. We verify, okay this is the good price, you can, okay. Like this." (I.18 164)

Facilitators seem to feel literally responsible for each and everything, even such small things as negotiating grocery prices in the market. One of the interviewees calls the facilitators' service 'concierge' service and illustrates the consequences of the facilitators' encompassing efforts:

> "Let me use the word concierge. Everything. So much so that the patient or the attendants even forget to carry soap with them (laughs). It happens, very often." (I.7, 184)

In these quotes 'doing everything' becomes the facilitators' prevalent, recurring motto. Actually it seems that it could even be complemented with spatial-temporal dimensions: 'doing everything, everywhere at any time'. The activities outlined here are time-intensive and demand a quasi-permanent availability from the facilitators' side:

> "I'm available almost 18 hours. But I'm available 24/7. If somebody calls me at 3 a.m. in the night, I'll pick his call. Like there was a patient from Liberia okay? There is a difference of 5.5 hours (…) he used to call me 2:30 in the night. Fine. I understand." (I.4, 205)

The interviewee refers to 18 hours of physical presence, of being away on business, but via phone he is available around the clock, 24/7. The facilitator shows understanding, even for calls in the middle of the night. To be available for their patients 24/7 is regarded as a matter of course. To invest their own person and being available for their patients at all times and in every situation is like a commitment towards the job. To the question if he has a private life, the director of a large medical travel company replies: "Don't ask that question never again" (I.7, 271). He travels to his company's target countries on a regular base and gets permanently updated from all his operational staff about every step with their patients and the progress made by the business development team. Although he is not directly involved in the assistance of patients on site, the job demands a high level of commitment from the management of medical travel companies.

Another dimension of the facilitator's job, which becomes relevant during the patient's stay in Delhi, is the negotiation of culture and religion. People are seeking medical treatment in Delhi from all over the world, brought up in completely different socio-cultural contexts. To successfully negotiate between different mind-sets, religious beliefs and socio-cultural habits, facilitators have to acquire knowledge about the patients' home countries and familiarize the international patient with the Indian way of life. Otherwise, problems respecting the medical and non-medical sphere likewise can arise:

> "So convincing patients across form different countries, what they see, what they speak, what they do. Sometimes you even have to respect their religion. Right? So you have to understand what their religion is, what they eat, what they don't eat. All those things (...) It becomes a point where we make special arrangements for them so that they don't have any problems here. So it depends from country to religion that we have to take care and we have to learn those religions from the people and then learn all the stuff how you have to deal with these particular things." (I.5, 66)

As it becomes apparent, assisting the patient on site requires a broad cultural knowledge. How such knowledge is obtained has already been discussed in Section 6.1.1. As Chapter 7 is delving into the facilitators' daily practices on the hospital site during the encounter with the patient, the tasks addressed in this chapter will be analysed there in more depth.

6.3.3 After the stay in Delhi

After the treatment in Delhi and a period of recovery, patients return to their home countries, but the facilitators' role is not yet over. Many of the interviewees stress that they keep in touch to ensure that the patient is doing well after the treatment in India:

> "A lot of follow ups going on, asking them if there is any healthcare they need. So, generally, in most of the cases patients have queries after a month. Which more medicine to continue, which not continue, some more changes that he see

> in the process or in health. So he wants to talk to a doctor. And there are plans to repeated visits also." (I.5, 51)

As this quote illustrates, repeated visits and follow up checks are not unusual and a share of patients return to Delhi after some time. The facilitators still take on the task to answer the patients' questions, to connect the patients with the doctors and to make travel arrangements. Although the interviewee in the quote says that the patients produce some questions and thus resume the contact, the facilitators are also maintaining the contact from their side. The purpose seems to be twofold. Firstly, the facilitators ensure that the patients are happy with their medical travel experience after returning to their country. Secondly, they maintain the relation from which further business can be generated. These practices are elaborated on in detail in Chapter 7.

6.4 Zooming in: check-up marathon with Tariq and two patients

In the following, the field notes (*in italic*) taken from the observations during one day in January 2015 in a hospital in Delhi are presented in the form of eight successive episodes that address different aspects of the facilitator's job. Tariq, an Indian facilitator, is at the hospital with two Omani patients and goes through various check-up tests and consultations with them in the outpatient department (OPD), where patients that are not yet admitted for treatment come during the daytime to meet doctors and do investigations. After displaying the episodes, they are commented and analysed in detail.

6.4.1 Episode 1: the first encounter – the facilitator meets his patients

Tariq [7] and I[8] meet in the entrance area of a corporate hospital in central Delhi at 11:00. He is working for a medical travel company and we wait for his patients to arrive. Yesterday evening they flew to Delhi from the Middle East. After waiting for some time, Tariq calls his patients. Obviously, the taxi driver had just dropped them in front of the other hospital entrance.
The patient, a man in his twenties, is standing there with another slightly older man. With a big smile on his face, Tariq says hello and shakes hands. He asks: "How are you? How was the flight? How is Oman?" The patient says that he's doing well, thumbs up for the flight and notices that it is not as cold in Oman as it is in Delhi right now. "I told you!" replies Tariq, laughs and slaps him affably on the back. Then the patient asks whether he or his uncle is going to see the doctor first (the patient brought his uncle with him as he's suffering from an undiagnosed back pain). Tariq says that it depends on the doctors' availability. We walk back to the North Wing; Tariq guides us through the maze-like corridors, he walks ahead and we follow as ducklings follow their mother. We end up in a room with seats; many people are waiting there – it's the OPD [outpatient department].

This episode of the field note protocol offers an insight in the first encounter between the two Omani patients and Tariq, their facilitator. Strictly speaking, for the younger man (called Kamal as we learn later on) and Tariq it is not the very first encounter as they have already met a few months ago dur-

[7] All the names have been changed, the medical travel company is called company X
[8] Refers to the researcher and author of this thesis who took the field notes

ing Kamal's former visits in Delhi. Still, it is the first encounter during this visit and Kamal brought his uncle along, who is here for the first time.

In the first encounter, it seems that the facilitator is intending to break the ice and to relate to his patients by body language and by seizing on their previous conversations. Tariq's welcome, underlined by a big smile, signifies that he is happy to meet his patients and that he is interested in getting to know them better. The initial questions to break the ice mirror his focus upon his patient's well-being and their travel experience so far. With the question "How is Oman?" he immediately relates to them and shows that he is informed about where they come from and interested in their home country. When one of the men mentions that it is cold here in Delhi, Tariq replies that he had told him in advance. This shows that the facilitator was in touch with the patient before the flight and updated him about the actual weather conditions. Interestingly, in the interview with Tariq's superior and manager of the medical travel company, the interviewee emphasised their comprehensive approach when catering to the international patient's needs. The director illustrated that by saying that they give the first pieces of advice even before the patient steps out the airport:

> "When they land here the case-manager receives them at the airport, start helping them from the first. Let me say, before you checkout the airport, it is always best you take a SIM card form here. Because here the SIM card will be activated within an hour, if you buy it outside it will take three days to activate. So, first piece of advice. The second piece of advice, please if you have warm clothes in your suitcase, take them out, it's cold outside. The third piece of advice, we are going directly to the hospital, it's going to take about 40 minutes, if you want to have a cup of coffee before you leave the airport, the coffee shop is right here, the coffee is on me. Okay? So you start building up that relationship. When the patient and the case-manager reach the hospital, case-manager continuous to help in each and every step." (I.7, 181)

As the director of the medical travel company says, being in touch with the patient from the first moment, being concerned about his or her well-being and giving advice, even if it is just about small things like having a coffee or bringing warm clothes, initiate a relationship. Tariq's advice to be prepared for cold weather entails a double care-component. The facilitator assumes or knows from his experience that the patients have difficulties in coping with the exceptional situation they are in, the unfamiliar place and lack of knowledge about the procedures that follow. All these factors evoke insecurity. So the facilitator is concerned about his patients' well-being and he is a person with foresight, attentive to the overall conditions that might affect their physical health. Additionally, this attitude of being concerned about the patients' well-being from the first contact and being sensitive to details conveys a feeling of being in good hands. This is underlined by Tariq's body language; the bright smile and the physical contact. The gesture of slapping Kamal's back in an affable manner can be taken as a token of friendship and familiarity.

After saying hello, today's schedule is addressed. Tariq prepares his patients for the uncertainty surrounding the first day in the hospital. However, Tariq is eager to get started and walks straightaway to their first station. Confidently, he guides his patients through the hospital subtly showing that they would have spent more time on finding the right way without him. Without paying attention on where exactly they go, they follow their 'hospital-guide'. Many people have difficulties finding their way around a hospital; the locality itself is challenging. Most of the corporate hospitals in Delhi

catering to international patients are quite big and divided into different compartments structurally into different blocks or wings, into units for domestic and international patients, into an outpatient department (OPD) and an inpatient department (IPD) and of course into different wards as well. In the very beginning, Tariq expected his patients to arrive at another entrance. Instead of asking them to come over, he decided to pick them up as it would have been too difficult for them to find their way.

6.4.2 Episode 2: in the doctor's office – communication and control

Without knocking, Tariq opens the door to check if the doctor is in his office. We need to wait but can enter the room soon; it's approximately 11:20. The doctor is sitting behind the desk and welcomes us. First, the doctor and Tariq talk in Hindi. In English, the doctor wants to know which of the two men the patient is and what the problem might be. The younger man, his name is Kamal, translates the question to his uncle, Jassim, who responds in Arabic. Kamal tells the doctor that his uncle suffers from a pain in his back. The doctor wants to know the name and age of the patient. Tariq checks what the doctor has written down and asks something in Hindi. The doctor wrote down that the uncle is 45 although Kamal said 35. The doctor corrects the age and asks how long he's been suffering from the pain and if the pain is radiating into the legs. Kamal translates but his uncle doesn't really understand. Even the doctor says a few words in Arabic. Jassim stands up and shows with his hand where he feels the pain. He cannot describe what he suffers from in his own words. As this gesture is not giving enough information, the doctor tells him to lay down on the bed, which is behind a curtain.

When the examination is over, the two men come back to the desk. The doctor tells us that Jassim requires surgery. He wants to see the images from former examinations in Oman and studies them. Tariq says something in Hindi and after that the doctor shows on the image where he can see an abnormality. He notes down something on the paper and explains that Jassim has to undergo various tests. Based on the results they will decide about the exact treatment plan and the surgery. The MRI[9] image needs to be repeated as well as it's too old and the quality not sufficient. Kamal wants to know how long this will take. Tariq says that they have to get the test results first and then they can tell. Kamal says that they can change the return flight if necessary. Before the doctor hands over his notes to Jassim, Tariq talks to the doctor in Hindi again. After that the doctor asks if the patient suffers from diabetics and if there's a problem with blood pressure in English. No reaction from Kamal or Jassim. Tariq repeats: "Sugar?", Kamal translates to his uncle who denies both. After the consultation Tariq tells me that patients sometimes do not understand what the doctor says. For example the word diabetic they do not know. So Tariq said sugar and the patient knew what it was about. Tariq says that it's the case-manager's job to choose the right words for them, so that the patient understands. After overcoming this communication barrier, the doctor hands the paper to the patient and asks if they have any questions. They say no and we leave the office, it is approximately 11:35.

This second scene, the consultation with the doctor, constitutes one of the pivotal situations for the patient and the facilitator equally. Within a few minutes time, the doctor examines and speaks to the

[9] MRI stands for magnetic resonance imaging, the technique is used scan the anatomy and physiology of the body

worried patient. Meanwhile, the facilitator simultaneously takes on the role of an interpreter, a supervisor and a caregiver.

The constellation in the outlined scene is of particular interest. Four people are present: Jassim – the patient, Kamal – his nephew, Tariq – the facilitator and the doctor (and the researcher in the background); and three languages are spoken: Hindi, Arabic and English. These four people communicate in multiple constellations, furthermore switching between the three languages. Although Kamal takes on the function of an interpreter, translating between his uncle and the doctor, Tariq has to help out. Only Jassim, actually the main person as it is all about his health, is incapable of communicating properly. He does not know how to make himself understood but by using gestures to explain where he feels the pain. Communication becomes even more difficult when knowledge about medical terminology is required.

The situation shows that the facilitator's function is not restricted to translating literally. As Tariq correctly says, he has to 'choose the right words' that the patients understand. As one of the interviewees notes, it is not only a challenge of language but also a challenge of understanding:

> "I make it easier for them [patients]. Because you know some people they do not understand very well. Even if you talk in their language, in the same language." (I.30, 50)

The facilitators' translation services basically include a double transmission: they make the patients understand in their language and explain the medical evidence in a way that they understand. Another interviewee gives a good example:

> "He [the facilitator] explains them in very simple language. Recently there was a patient who had multiple problems: neuro [neurology] problem, cardio [cardiology] problem, ortho [orthopaedics] problem, eye problem, multiple problems. So the patient said no, I want to go with first the gastric problem, then we will manage other problem. So now he explained to the patient in very simple terms. Suppose you have a car, the main part of the car is what? Engine. If the engine is not working, the other parts are of no use. So first get your engine repaired. The same way the heart is the engine of the body. First get your heart, then move on to the other things" (I.29, 257)

Apparently, sometimes facilitators have to use figurative language and their creativity to make the patient understand; by making comparisons, using metaphors, and simplifying procedure. This task is demanding and entails the risk of giving wrong information. Consequently, it is the facilitators' responsibility to find a balance between medical correctness and comprehensibility for the layperson, which is demanding and involves decision-making authority.

As suggested earlier, the facilitator takes on multiple roles at the same time. Becoming a mouthpiece for the patient, voicing his or her concerns and simultaneously interpreting and explaining what the doctor says are challenging tasks. Thinking in the interest of someone, speaking for this person and negotiating in this person's interest is the job of a patient advocate that is overlaid by the job of an interpreter. One of the facilitators tries to voice this 'intersection' in his person:

> "At same time, the interpreter [used synonymous for facilitator in this context] is like a doctor and like a patient. A very important role from the interpreter's side. (...) I think interpreter should be very serious in his job." (I.15, 134)

The facilitator feels as if both parties, the doctor and the patient, were collapsing in his very person. He has to take the doctor's role in the sense of telling the patient about his or her health condition and ensuring that he understands properly; simultaneously he tries to put himself in the patient's shoes to figure out how to best explain the diagnosis and assumes the questions the patient have; in between, the facilitator takes on the role of an interpreter to enable communication. This task requires sensitivity, responsibility and expertise. Many of the interviewees admit that this task is challenging and that they had difficulties in the beginning. However, after some time they picked up some of the medical terminology and got used to explaining to a layperson.

While analysing the challenge of translating and explaining, it becomes obvious that Tariq functions as mediator between the patient and the doctor. This position of being in the middle manifests in Tariq's position in the doctor's office. Whereby a table separated the patient and the doctor, the facilitator was sitting at the short end of the table, between the two parties. This spatial configuration is of importance for the discussion of the next aspect apparent in this field note episode.

Facilitators do perform a control function. Several times during the consultation with the doctor, the facilitator took on the role of a supervisor. It first becomes apparent when Tariq points out to the doctor that he misunderstood the patient's age. He noticed the doctor's mistake because he could read his notes thanks to his position next to the doctor. The second incident that points towards the facilitator's influence on the doctor's interaction with the patient is when he – supposedly – tells the doctor to explain and visualise the patient's problem by means of the X-ray image. A third incident is the situation in which the doctor already wants to hand over his notes to the patient. Tariq interrupts him and talks to him in Hindi. Following his suggestion, the doctor asks whether Jassim suffers from diabetics or high blood pressure. Here again, Tariq makes sure that the doctor does not forget to ask all relevant questions and makes notes according to his investigations. This function of supervising and controlling can be carried out to a variable extent and transferred to various dimensions of the facilitator's job. In the given example, Tariq ensures that the doctor and the patient are both correctly informed by checking that the right information is exchanged and the relevant questions are asked. The facilitators' function as supervisor can also be found detached from the patient assistance on site, when carefully selecting network partners. By advising them to choose a reliable doctor or hospital, facilitators ensure and control that their patients get into the right hands (see Section 6.1.2). Another attempt from the facilitators' side in exerting a control function are their attempts to impede the activities of touts and agents and their contribution towards establishing uniform work ethics (see Section 5.3.3).

Before entering the check-up marathon with Tariq and his patients that follows the doctor's consultation, there is a last note on a situation that calls attention in this episode: The doctor asks the patient to redo the MRI image because it is too old and of poor quality. Facilitators report poor image quality and especially wrong diagnoses given by doctors in their home countries as a challenge. It is difficult to estimate the uncertainty that the medical reports entail with which the patients approach them. Yet, based on this material they provide the patient with a (provisory) treatment plan:

> "Another major challenge is the evaluation of treatment with the reports and the final delivery (…) in about 10-15% of the cases, that diagnostics prove to be wrong when they come here. So the treatment plan changes." (I.5, 60)

Changes to the treatment plan can have severe consequences for the patient. In the best case a fatal diagnosis proves to be wrong and the patient can return to his or her country without any treatment.

In other cases, the treatment costs end up being several times higher than expected because of the new diagnosis. Apart from the cost factor, incorrect or incomplete diagnoses can cause serious complications; for example if the doctor realises that the patient has multiple diseases after the surgery has begun, the patient's life is at risk.

6.4.3 Episode 3: waiting in the OPD – time to talk, taking photos and relate

While we are standing outside, Tariq goes back to the doctor's office. Later I ask him what they were talking about. Tariq says that it was not related to the patient. The doctor recognized him and asked where they met before. They checked if they both still have the correct phone number for each other. Then we go to the billing counter where many people are queuing to pay for the investigations Jassim needs to undergo.
After this encounter, approximately at 12:00, we go to the sample collection, which is still in the OPD section. There we are waiting quite a long time. Tariq says hello to somebody who passes by, makes some phone calls and then talks with the two men he is assisting today. Kamal asks Tariq where Azeen is, another case-manager who picked them up from the airport the night before. Tariq explains that this case-manager is not available today as he needs to go for another pick up. It is Tariq who takes care of the two patients today because he knows Kamal already from his last visit. Actually, Tariq is not working as a case-manager anymore as he is now head of the operations team. Today he makes an exception.
After some time Jassim can sit down and they are doing some tests. I ask Kamal if he has been here in India before. He says yes. I ask if he has been with Tariq before and Kamal says: "Yes, Tariq and Azeen [the name he mentioned before, the other case-manager] are my only friends here". His English is not so good and he has difficulties understanding my questions, so I decide not to ask further questions.
However, Tariq continues to talk with Kamal and wants to know if he still plays football and they start a conversation about their hobbies and the national football teams of their countries. Then Tariq tells Kamal that part of the X-Team are in Oman today to attend a conference. He shows him some photos of the team on his phone and asks if he recognises the people in the photo. They talk about them as if they were common friends. One photo shows an Omani friend of Kamal's who came to Delhi via X for treatment as well. Now Kamal asks me if he can take a photo of Tariq and me and then I take one of the three men together. We are still waiting for Jassim to finish the tests. Kamal asks Tariq about the Wi-Fi in the hospital to send him the photos. The two men check his phone. Then Kamal shows some pictures to Tariq. Then they talk about marriage and Tariq asks: "Are you going to invite me when you get married?". They both laugh and Kamal says "Sure!".

The key theme in this episode is establishing ties, relating to people, and building relationships. This is actually seen as one of the very core tasks of the facilitators' work and this is why different modes of relation building feature in several parts throughout this thesis. In the beginning of the third episode, Tariq is actively networking with a doctor and greeting someone else who is passing by in the corridor. Relating to doctors and other hospital staff and with other facilitators is a common practice and such networking is actively performed. The importance of networking with channel partners and providers has already been outlined in Section 6.2.2.

Apart from that, the situations in which the relationship building between facilitators and patients happens become apparent. From this episode, the logic 'waiting time is relating time' can be drawn. Wait as caused through the delay in starting the check-up procedure that lies ahead of Tariq and his patients can actually be considered a typical feature in a facilitator's workday. From the hours spent in the hospital, often from 10am to 6pm, repeatedly expanded in the evening, many consist of waiting time. Facilitators and patients wait together for the doctors' consultation, queue in front of the billing counter, wait for the results to come or the reports to be collected. The perception of these periods of waiting time is ambivalent. As facilitators usually strive for speeding up the process, waiting is considered as a waste of time. Alternatively, this time is actively used to consolidate the relationship with the patient, which is a crucial part of their work and thus meaningful. This episode exemplifies how the facilitator and his patients have time to get into conversation and get better acquainted.

The first conversation between Kamal and Tariq indicates the patient's attachment to his former facilitator. The facilitator that assisted Kamal during his last visit in Delhi is not available this time, which is why Tariq takes over. He no longer works as a case-manager since he is managing an operations team but makes an exception because he also knows Kamal. The patient's question about the facilitator who is usually taking care of him shows that the patient feels emotionally attached to his facilitator. He expected Azeen to come and wants to know why he is not here. However, Tariq seems to be a good substitute thanks to the already established relationship with the patient. Kamal even says that these two men are his 'only friends here'. This statement gives insights into various aspects. As indicated, the fact that this patient calls his facilitator his 'friend' shows that he does not consider his facilitator as an impersonal service provider but as a confidant. The boundaries between business and personal sphere seem to be blurred. They probably have a personal relationship similar to the one that friends have which is based upon trust. The fact that these two facilitators are the 'only' friends indicates that Kamal would probably feel lonely and forlorn without them. The word 'here' furthermore indicates that this perception of the only friends applies to a particular surrounding, here the one of Delhi.

The following conversation still evolves around people to whom both the facilitator and the patient can relate. Tariq tells Kamal that part of the company's team is currently in Oman. The facilitator shows interest in the patient's life world and brings up a conversation topic to which both can relate. By talking about the patient's home country, Kamal probably feels personally addressed and respected. Talking about common 'friends' like Tariq's colleague working for the same medical travel company and other Omani patients related to Kamal respectively strengthens the bond between the patient and his facilitator.

Talking about personal and intimate topics is another practice that consolidates the facilitator-patient relationship. Tariq's question if Kamal still plays football shows that he knows about his patient's personal interest and that he still remembers this information from earlier encounters; either face-to-face or via means of communication like phone, email, text messages or Skype. The sequence when Tariq and Kamal come to speak about marriage shows that they not only do small talk but also speak about more intimate topics. The two bachelors exchange their thoughts in a relaxed atmosphere, joke about possible prospects to the future, just as friends would do. That they share such personal information, which is not relevant for medical travel facilitation, suggest, that they are mutually interested in the other person as a companion or friend. They even make plans for an event in the future that they want to share as Kamal promises to invite Tariq to his wedding. Tariq reports that he has al-

ready been invited to his former patients' weddings. This might express the patients' gratitude to the facilitator's help but might be a gesture out of the friendship that evolved between the patient and the facilitator.

This last section addresses sharing and taking photos as a typical activity practiced to kill the waiting time and that furthermore helps the patient and the facilitator to relate. Throughout all field days, photos were either shown to each other or newly taken. Photographs taken via smartphone can be mobilised and put into circulation, which seems to be a popular practice in the medical travel industry for multiple reasons.

Prior to the patients' arrival at the airport, facilitators sometimes ask them to send photos so that they can identify them more easily in the airport's entrance hall. Then during the stay photos of the patients and facilitators are taken, especially during waiting times but also in special moments of the patient's treatment or stay. The photos serve as a souvenir, but the activity itself often seems to be a common occupation to pass the waiting time, doing something together and relating to each other. Patients show photos of their family and home country, which animates them to tell about their life and situation there. This information is of interest for facilitators because this helps to better understand their patients' situations and needs. The photos that facilitators share often show them in action with the patient, for instance in the hospital room, in front of historical sites and even in the operation theatre. They seem to be proud of all the people they know and stay in touch with. These photos also function as evidence of the facilitators' experience and when they tell about having successfully assisted former patients helps to build trust and confidence with the current patients.

Apart from this function, mobile phones with cameras can play another important role in connecting people and transmitting information. Photos of medical reports, x-ray images or medicine labels are often sent via mobile phone. One of the interviewees reports that he had difficulty with patients because they could not send their medical reports and X-ray images to him. Some of them did not have access to the necessary equipment like computers, scanners and good internet connections to transmit large volume data files. In this instance he had to come up with an idea to access these images:

> "So what we are doing is, we look at available equipment, everyone has a webcam, everyone has a cell phone with a camera. Why can't you capture those images with your camera without affecting the image quality and send it." (I.9, 36)

Actually, many facilitators get photos of X-ray images and other medical reports sent to their mobile phones. Apparently, the quality of the images is good enough for doctors to give a first diagnosis and the transmittance is simple and quick.

6.4.4 Episode 4: the check-up marathon goes on – being next in line

Now Jassim is finished with the first tests and Tariq navigates confidently to another department where he speaks to the staff and tells Jassim to sit down on a chair in the corridor. He needs to wait approximately 30 minutes and can then do the X-ray. Tariq, Kamal and I go back to the other department to check if the doctor for Kamal's follow-up check is available. We need to wait and Tariq wants to see some of the documents that Kamal carries in a big envelope with the hospital logo on it. Now he sends Kamal to the nursing room, which is to our right.

After this first check-up, Tariq opens the door to the neurology doctor's office. We are next and enter the room although a woman and her son (I guess – or is he the facilitator?), are still sitting

there. It's an odd situation because we are in the room and the doctor is still having a consultation. I imagine that the patients must feel uncomfortable to be disturbed by strangers in such an intimate moment. Now they leave the room and we all sit down. The doctor has just said hello when the door is opened again. It's a case-manager from another company who wants to see the same doctor but he has to wait outside. Now Kamal asks the doctor: "Well, how are you?" The doctor says he's fine and wants to know about Kamal. He says that everything is perfect. The doctor examines Kamal and says that an MRI and a blood test are required to determine if the medicine is still adequate and to see if there are no side effects from the medication. Kamal says that the medication is fine, the last epileptic attack is more than a year back. Tariq asks his patient if he needs a sick leave and tells the doctor to confirm that Kamal came for a follow-up check. The doctor notes down a few things on the paper and hands it to the patient. Tariq says something in Hindi and the doctor takes the paper again and adds something. Later I ask Tariq what he told the doctor. He says that he told him to note on the paper that the checks needed to be done today. He wanted to make sure that Kamal gets appointments for the tests today. After having done the billing, we go to pick up Jassim.

Once again, the locality within the hospital changes several times and the facilitator's qualities as guide are appreciated. He brings one of the patients to the department where the X-rays are done, then accompanies the other to the nursing station and finally navigates to the doctor's office. The patients vacillate between multiple places within the hospital, grateful to the facilitator's guidance. However, this personal navigator not only helps them to find their way around the hospital but also proves his qualities in scheduling the consultations and investigations as well as his tactics to efficiently to navigate the patients through the procedures.

The insight into how the facilitator gets his patient inside the doctor's office is a perfect example to illustrate the facilitator's efforts. First, he checks with the doctor's assistant if the neurologist is available. As this is not yet the case, the facilitator changes his plan, makes sure that the patient has the necessary documents with him and then sends him to do the first investigations. After that the facilitator gets back to the consultation and opens the door to the doctor's office without any inhibitions. Although the doctor was still in the middle of a consultation with another patient, he would not be persuaded to drop his plan. He enters the room with his patient to make sure they are next. Some other facilitators pursue the same strategy proven by the incident with another facilitator entering the room. However, there must be some unwritten rules defining who is allowed to step into the doctor's office and who is not allowed to do so. Having good relations with the doctors is an advantage to accelerate the process. Some additional strategies from the facilitator's side to speed up and refine the process are scrutinised in field note episode 6.

The consultation with the doctor by itself resembles the scene in field note episode 2, although the communication barrier is not prevalent here. The patient can speak to the doctor directly; they communicate in English and the facilitator does not have to mediate. The facilitator's main function here is again to supervise and control: He reminds his patient to ask the doctor for a sick leave note and makes sure that the doctor notes down that the investigations need to be done the same day. In accordance to the first note on this episode, the facilitator thinks ahead and is attentive to speed up the process.

6.4.5 Episode 5: being lost – without a facilitator

Jassim is sitting on a chair in the corridor and gives the impression of being lost. When he sees us approaching he leaps out of his chair and smiles. Tariq asks if the X-ray has been done. Jassim nods and Tariq informs us that he needs to do another test, an EEG [Electroencephalogram, measures brain activity], and heads towards the South Wing. On the way there, the two patients talk in Arabic and finally Kamal asks Tariq what an EEG is. Tariq explains that a machine screens the brain, "it doesn't hurt – don't worry". Kamal translates to his uncle. I doubt that the two men know in detail what is actually going on with them. They seem to trust Tariq and follow him without asking any further questions.

This episode gives insight into the patient's vulnerability and the resulting dependency on an honest and caring facilitator. When Tariq dropped Jassim in one of the stations to do the X-ray and told him to wait there alone until he comes to pick him up again, Jassim accepted the facilitator's instruction. But his body language expressed discomfort and a sense of being lost. So when he finally sees the familiar face of the facilitator approaching, his relief is expressed by his smile and his sudden gesture of getting up from the chair.
This feeling of being lost that engulfs Jassim even more than Kamal arouses not only from the unfamiliarity with the hospital and his disorientation in the spatiality as such. His inability to communicate, the lack of knowledge about what is actually going on with him and the anxiety related to his health condition intensify his feeling of being lost. To cling to the only people he knows, Kamal and Tariq, seems to be a comprehensible reaction. That insufficient knowledge and understanding of medical procedures result in confusion and anxiety becomes apparent in this episode. When Tariq tells his patients to get the EEG done, he does not realise that they do not know what an EEG is. First, the two men confer among themselves; then Kamal braces up and admits that they actually do not know what an EEG is. That they are insecure and hesitate to ask the facilitator, maybe because they feel ashamed for not knowing, indicates certain power structures between the facilitator and the patient. But Tariq tries to provide clarification. He assumes that they do not only lack the knowledge about what EEG stands for but assumes that they are concerned about the pain that could arise from the investigation. Based on this anticipation he says, "it doesn't hurt – don't worry". His function is to comfort them and take away their fear. His patients believe and trust him and do not ask any more questions. Probably, Tariq could have given them more medical knowledge but it seems that he does not want to confuse them.
The episode shows just a short incident that exemplifies the patient's feeling of being lost. However, in the interviews many more incidents were mentioned that point towards the patients' dependency on facilitators. For example the travel endeavour as such is challenging to some patients:

> "50% of the patients who are coming here travel for the first time in their life outside their country – 50% of them. There are maybe at least 10% of them who are taking an air flight for the first time in their life." (I.7, 131)

The quote shows that facilitators deal with people who are absolutely new to travel. A trip to Delhi to seek medical treatment exposes these patients to additional stress. They enter a completely new world by getting on a plane and flying to a country they have never seen before.
Because of the inexperience of some patients in travelling but also generally in getting around in unfamiliar places, some interviewees fear that their patients could get lost:

> "If a patient is coming in the night, two o'clock, and we are not there [at the airport], so he will be lost, he will get lost from there. And where they will go and who will come they don't know. So our role is very important for them and we are taking care from the airport to the airport. (…) we are facilitating all this and we are not letting our patients, our tourists, our friends, get lost in anything." (I.3, 355)

Facilitators prevent their patients from getting lost in a spatial and metaphorical sense alike. To prevent their patients from being lost in the unfamiliar hospital or in the unknown city, but also from getting into the wrong hands of an agent or a tout – which would also result in a loss of their business – facilitators make sure to pick them up and drop them off at the airport. The interviewee feels responsible to take good care and keeps his eyes riveted on the patient. The variety of terms he uses to express the intersection of patients, tourists and friends prompt different extents of attachment and shows that these understandings may overlay.

Another issue raised by the interviewees is that patients have difficulty focusing and thinking about all the things related to their medical travel endeavour. Even if they know the language and are aware of the procedures, they can easily get confused and seem to have difficulty fending for themselves:

> "Even you know the English, but you don't know the local areas. If you will go to the doctors, doctor will just prescribe; write the medicine for you then will go. (…) So it's very important someone should be there and he will help you to get this thing done. Like your appointments, your FRRO [Foreign Regional Registration Office] things, your flight and your medicine and this. So we are here for the help of the people. And we are facilitating these things." (I.3, 349)

As the interviewee says, even people who know English face difficulties because they are not familiar with medical issues, the local area or the formalities associated with their stay in Delhi. Furthermore, doctors usually do not have much time to explain the diagnosis, the treatment required or the medication in detail to the patient. Thus they need help from the facilitator who takes them by the hand and supports them even in such things as taking medicine correctly:

> "They will not understand about the medication. So I will tell him this is very important medicine, take it twice a day. They will not manage. (...) I message him, I write, I text him, send him in a envelop (...) See, every small thing I have to manage. That's very demanding. If they miss those medications there could be complications. (...) I make a chart where I write in Arabic everything." (I.29, 285)

The facilitator feels responsible to ensure that the patient knows about the medication and thus even draws a chart and sends reminders via mobile phone. Again, assistance and control from the facilitators' side is required. The statement in the second to last quote that "we are here for the help of the people" alludes to a benevolent motivation but helping in each and every step seems to be an integral part of their work.

A reason that some interviewees mention to explain why patients have difficulties fending for themselves is that they are distracted by their worries about their state of health and thus are only concerned with getting medical treatment:

> "The patient didn't know, he was new to this country and he was more concerned with his treatment, with his personal issues, so he never knew what happened." (I.9, 138)

Jassim too seems to be concerned about his health but simultaneously confused and lost in thought. He completely leaves it up to Tariq to guide him and does not even ask questions. It seems that he has difficulties properly assessing what is going on around him and thus cannot cope with the situation on his own.

6.4.6 Episode 6: from one department to the next – speeding up and smoothing the process

We can take the lift to get to the department where the EEG is done. When the door of the lift opens, Tariq shouts: "Come, come!" and makes sure that we all get in. He pushes the button of the 3rd floor. There, Tariq guides us to another room where Kamal needs to do an EEG. Kamal gives his jacket, backpack and mobile phone to Tariq who tells Jassim to sit down and hands over Kamal's belongings. He tells him to call once he's done with the test.
Tariq and I go to the international patients' lounge where he tells me that it is very important that the patients do not feel like they are wasting time. Therefore he tries to coordinate the tests of both patients simultaneously. I ask him how he manages to do this. He just says that he always has to decide at the moment, at short notice what to do first. Therefore, it's important to have good knowledge about the hospital's departments, the medical issues and where the different test centres are. I ask him if a patient can manage this without the help of a case-manager. Tariq says that it is very difficult, v-e-r-y difficult for a patient alone. He adds that sometimes the case-manager does not know things as well but they always know somebody they can ask, whereas the patient alone does not even know where to ask and often does not even speak the language. I ask Tariq if it is an advantage that he worked in this hospital before, to know where which department is and how the hospital is organised. He says not really and explains that he needs to know in every hospital, not only the hospital he used to work in but of course he knows some people.
The conversation is interrupted by several phone calls. One of the calls is from Kamal, the EEG is done and they are waiting in the OPD for us. Tariq asks if everything is okay, how they feel and if they want to go to the cafeteria. They decline and we walk to another department where the MRI of Jassim will be done. I wonder how Tariq knew that it's time for the MRI. He tells me that he told the MRI-team to call him if his patient can come earlier than scheduled. Tariq stresses that it is a major challenge to make the process smooth and not to waste time. He always tries to speed up the process and make it as comfortable as possible for his patients.

The beginning of this scene is reminiscent of a teacher on a school trip who has to make sure that all his protégés follow and keep on track. Thus the facilitator not only functions as a guide but also as an instructor who advises the patients on what to do. When Kamal and Jassim arrive at the EEG section, Tariq gives them some clear instructions – a phenomenon that can be observed throughout all the field observations. It seems that the facilitator who is well familiar with the procedure, makes decisions on how exactly to organise the proceedings and gives instructions according to this. In this instance Tariq briefs Kamal to take off part of his clothes and not take his mobile phone into the room. Then he tells his patients to stay and do the test while he is going to the international patient

lounge. When they are done with the EEG, they should call and he comes to pick them up. Such clear instructions help to structure and smooth the proceedings and seem to be accepted by the patients without any question. With the analysis of this first sequence, the dominant theme in this episode is already addressed: the coordination of the proceedings in the hospital.

This coordination task is completely ascribed to the facilitator's responsibility. Good coordination is needed to succeed in a quick and smooth process. Cutting time in turn is a central goal, also because the expenses can be limited when the stay is shorter. Such an efficient time management by facilitators seems to be highly valued by the patients. One of them emphasised that one of the reasons to come to Delhi for medical treatment is that "you get everything under one roof and within one day you get a reliable diagnose", to which the facilitators' coordination contributes considerably.

However, because the processes in the hospitals, at least those in the outpatient department, are situation-based and on short notice it is difficult for facilitators to plan in advance. This unpredictability is often mentioned as a challenge by the interviewees, as it demands a lot of spontaneity, improvisation and coordination from them. During the field observations it happened several times that doctors were not available, diagnoses proved to be wrong, another specialist had to be found, medical equipment was not available in the particular hospital or reports were not issued. Such incidents kept the facilitator on the go.

To handle unpredictability, to improve coordination and to cut time Tariq seems to follow different strategies. If he has multiple patients at the same time, one of the strategies is to synchronise their procedures and investigations to make the most out of the time, reduce wait and make them feel that their case is progressing. Another more general strategy is to gain knowledge about the diseases, the investigations needed and common treatment plans so as to gain knowledge about the hospital's structural and functional organisation. Networking with hospital staff is another strategy in which this episode gives insight.

The importance of relating to the staff in the hospitals has already been mentioned but this episode gives further insight into the enactment of these relationships in daily business. Being connected with doctors, the doctor's assistants, staff from the international patient marketing and also with the staff in the investigation centres enables knowledge and information flow, which is advantageous to the facilitators. In this episode, Tariq explains that he got a phone call from someone in the MRI department to let him know that he can bring his patient earlier than scheduled. The staff can provide further aid when the facilitator has any questions himself or assist them if there are any complications with patients. As international patients lack such a network and the knowledge about the proceedings in the hospital, Tariq emphasises that undertaking medical travel to Delhi without a healthcare facilitator is very difficult, according to his articulation they would experience unnecessary trouble and thus act irresponsibly.

6.4.7 Episode 7: a delicate issue – what if something goes wrong?

As we are still waiting and I dare to raise a delicate theme by asking what happens if there are any complications with the patient. Tariq tells me that when a patient is admitted the phone number of the case-manager is noted on the admission form. Whenever something happens, the hospital first informs the case-manager, who then talks to the attendants and informs the management of X company. But it happens very, very rarely that something goes wrong; maybe 1 out of 100 cases. The responsible case-manager would immediately go to the hospital and manage the situation accord-

ingly. If the attendants are in the hospital as well, he meets them. If a patient dies, it is the doctor who informs the patient's attendants. However, it is the case-manager who looks after them and also informs the referral partner in the country of origin. It's a very difficult situation to handle, Tariq says, "it can happen, but still…". I ask if there is a document at X company where this scenario is written down. Tariq denies and laughs: "There is nothing written down, as I told you. Everything is situation and requirement based". I ask him how the case-managers know what to do in such a situation. He just says that they know what to do, but in the beginning he asked someone of X company with more experience.

This episode of the field note does not directly give insight in observable practices on the spot. Nevertheless, thanks to the informal encounter between the facilitator and the researcher, a sensitive issue could be addressed: what happens if something goes wrong, if there are complications with the patients, if he dies? In the interviews and on the webpages, the risks associated with medical travel and medical treatment in general are very rarely a matter of subject. These insights are therefore particularly interesting.
Tariq explains that the facilitator is the first contact person for the hospital so he is informed if there are any complications. In such a situation the facilitator is again the point of contact between the hospital, the patient's family and the medical travel company. Tariq's emphasis on 'managing the situation accordingly' and his statement that 'everything is situation and requirement based' shows that again, he has to adapt to the given situation, make appropriate decisions and coordinate on the spot. There is no fixed scenario issued by the company based on which the facilitator can take action. Tariq laughs at the question if there is no guide of practice available. Indeed, the chances are high that there is no such document if there is not even a defined job description available. The facilitator just learned how to deal with such a situation from another facilitator who was already experienced. Talking about his employee's training, the director of another company explains:

> "I don't say aaah the new trainee, I'll give him bunch of papers read this, this is the processes and protocols for our company. I don't believe this. (…) So when an employee or a new trainee comes with us, his put to on the job training programs with our existing staff there and they are meant to note everything what they are doing." (I.28, 166)

According to the data, informal on-the-job training is the most often practiced way to pass on knowledge in this business. To learn the facilitator's job, most of the newcomers accompany another facilitator on his daily routines and that is how they pick up knowledge and skills. Through on-the-job training, knowledge is trickling down from the more experienced facilitators to the beginners. In an earlier informal talk with Tariq on another day, he was asked if he got a specific job description when he started working as a facilitator for X company. He denied it and said that he learned from other employees. The only rule limiting the scope of his activities that comes to his mind after thinking for a while is that facilitators are not allowed to drink with their patients or their attendants. But that is the only restriction he knows. Apparently, the facilitators' duties and responsibilities can be read in several ways; they are subject to the facilitator's interpretation and influenced by the facilitator that introduces the job to a newcomer. In this episode, Tariq considers looking after the patient's family as his duty. What it practically means seems to depend on the facilitators' understanding and is not made explicit. However, looking after the patient's family who just lost a beloved member

arguably involves comforting and emotional support. Thus, the facilitator is meant to manage not only the situation accordingly but also the emotions evoked – those of the attendants and those of the facilitator him- or herself. To manage the situation the facilitator has to keep calm and professional. However, Tariq's incomplete sentence "It can happen, but still…" can be read as an indication that although he is aware of the possibility that something goes wrong it is an extraordinary situation to handle and that challenges him.

6.4.8 Episode 8: at the pharmacy – why your face matters

Finally the MRI is over, so all the tests are done for today. Tariq asks the patient if they want to go for lunch now or first buy the medicine. They say they first want to buy medicine. After discussing with Tariq they decide not to buy it in the pharmacy of the hospital but outside. So we go to a nearby pharmacy, which is small but well organised. There are many transparent boxes, labelled with diseases. Inside the boxes the blisters are bundled and kept together with an elastic band (I wonder if you do not get a carton box with instruction leaflet? How do the patients know about the exact dosage and side effects?) Kamal shakes hands with the pharmacist to say hello. He tries to find the prescription. Tariq asks him if he went to collect the prescription at all. Apparently Kamal did not but he has a photo of the medicine he needs on his phone. Although a prescription is required the pharmacist hands over the medicine without one. On the way back I ask Tariq how this was possible and he replies: "In this business your face matters a lot – it's all because they know me". In the hospital Tariq tells Kamal to go and get the prescription. Kamal hesitates and Tariq indicates where to go. We wait there until Kamal is back. As everything is done for today, we all leave the hospital. Tariq accompanies Kamal and Jassim to the shopping mall next to the hospital; they want to get something to eat there. Unfortunately, I have another interview planned for today and cannot go with them.

This final episode that displays again the facilitator's control and assistance function provides new insights in the sense that the negotiations of power relations become apparent between the facilitator and his patients but also between the facilitator and the pharmacist.

The episode introduces a new spatiality that seems to go along with shifting positionalities. Tariq and his two patients move outside the hospital for the first time to buy medicine in a nearby pharmacy. Although the facilitator accompanies Kamal outside the realm of the hospital, he seems to restrain his assistance. The patient seems to be more self-determined than in the previous encounters. He greets the pharmacist and asks for the medicine himself. Unfortunately, he forgot to bring the prescription. Nervously he looks for the prescription in his bag but cannot find it. The only thing he can show is a photo of the medicine's packaging. To recall, in Episode 3 the importance of photos and mobile phones as a medium to transmit information has already been discussed. Because he cannot find the prescription, Kamal falls back into the role of the insecure and helpless patient. In a slightly patronising manner, Tariq asks him whether he forgot to collect it before. This happening reinforces Tariq's practice to ensure personally that all the reports, images, prescriptions and sick leaves are brought along, exhibited or issued. Then Tariq is helping his patient out of the situation by his mere presence. As the pharmacist knows and respects the facilitator, he sells the medicine despite the missing prescription. Being accompanied by Tariq, Kamal can save time and effort and

benefit from the facilitator's network and status within. Self-confident, Tariq explains, "in this business your face matters a lot". Once more he makes himself indispensable.
The logic that 'your face matters a lot' became apparent throughout several incidents during the check-up marathon. Tariq holds a certain status within the field and network in which he operates. Being well-connected with other players, having good relations and holding a certain reputation confers agency to the facilitator. The suggestion of unwritten rules and hierarchies discussed earlier fits well with this logic. That Tariq enters the doctor's office and gets served first although other people are waiting to see the doctor indicates that his status and relation with the doctor entitle him to do so. Other field observations support this logic. Thanks to the relation and acquaintance between facilitators, doctors and marketing staff, patients have considerable chances to get discounts on the treatment costs. Such an example illustrating that the facilitator's face matters in negotiating could be witnessed first-hand. Discontent with the cost estimate that the international marketing issued for his patient, the facilitator declared that he would not accept that. Following the announcement "Let's go and fight", he went to talk immediately with the head of the international marketing department who he knows well. In a fiery discussion, the facilitator explained that the treatment costs are too high and if his patient does not get a discount he would take her to another hospital. As he already called someone from this other hospital, the head of marketing came under pressure. She offered some tea and went to talk to the management of the hospital. Finally, the management decided that the patient gets a discount, because they know the facilitator well and as he is from the company that brings the greatest amount of business to the hospital, they want to be on good terms with him. Here again, because of the facilitator's network and his status in the hospital, he could achieve success for his patient – who was not even aware of these negotiations, as the facilitator did not tell him about the discussions he had.

6.5 Discussion: (care) work in the performance dimension of practice

This discussion section is two-fold. The first section (6.5.1) assembles the various tasks that medical travel facilitators perform in their daily practice and relates this information to current literature. The second section (6.5.2) explicitly discusses the facilitators' practices with the concepts of care work.

6.5.1 An assemblage of various tasks performed by facilitators

Chapter 6 discussed the broad range of actions, tasks and duties in both general and explicit terms that constitute the facilitators' practices in their daily business. These practices have been studied on the analytical practice dimension of *performances* that, according to Jones and Murphy, enable researchers to study social interactions and "situationally appropriate actions, bodies, language, materials, and emotions" (2010, p.20). This first discussion section reviews the assemblage of responsibilities and tasks (coordinate, guide, assist, support, cater, interpret, advocate, mediate) that constitute the facilitators' work performance with regard to existing literature.

Two superordinate sets of tasks
The first set of tasks that medical travel facilitators perform consists of gaining knowledge and establishing a network with business partners. These efforts in creating a set-up constitute the base on which facilitators operate. The importance that the interviewees attach to gaining knowledge about

the patients' needs can be related to Sobo et al.'s (2011) study. The authors explain that medical travel agencies operating in the American market "have vested interests in attaining a keen understanding of consumer concerns and desires: they want to leverage this understanding to meet consumer needs and/or sell their goods" (Sobo et al. 2011, p.122). The facilitators' interest in gaining knowledge is presented as a selling-strategy. The facilitators in this study present knowledge as a prerequisite for themselves to position them on the market and to tailor their services to their patients' needs and desires as best as possible. The relevance of a satisfied or even delighted patient in this business is further discussed in Chapter 7. The importance that the interviewees attach to well-established network links offers new insights to the subject of networks in medical travel. Whereas the existing literature points towards the importance of social networks for international patients (Hanefeld et al. 2015; Ormond et al. 2014; Yeoh et al. 2013), this study illustrates the relevance of network connections for medical travel facilitators. Treatment pathways reconstructed by Hanefeld (Hanefeld et al. 2015) from a patient's point of view are here presented as 'channels' that are actively built by facilitators. The connections that medical travel facilitators have with partners situated in the patients' home countries are an integral part of their mobilisation strategy that follows the logic to 'outsource' the trust-building process to countrymen of prospective clients. The finding of Ormond et al. (2014) that patients are not the only clients of facilitators but that they also have to satisfy the hospitals and the channel partners at the other ends of the link is supported by the data. The conditions of the collaboration between facilitators and hospitals are negotiated and facilitators report that they are under pressure to meet the hospitals' expectations regarding the number of patients they are supposed to refer. With respect to the channel partners, facilitators also have agreements that they have to fulfil: for example, sending them a share of the commission fee or inviting them to Delhi and organising training sessions for channel partners who are doctors.

The second set of tasks that medical travel facilitators perform can be described as the actual patient assistance service. The literature that focuses on facilitators based in the patients' home countries only marginally touches upon the assistance provided by facilitators at the destination site. Sobo et al. (2011, p.128) for example mention that US-based agencies allocate a 'personal assistant' who will accompany the patients to medical appointments. Similarly, Dalstorm (2013, p.29) notes that some US medical travel facilitators provide a 'medical concierge' to "accompany the patients throughout their time abroad". This study does not research the function of assistants and concierges that are tied-up with foreign medical travel companies but gives insight into the services demanded and provided on the destination site. Referring to matters like travel arrangements, leisure activities and hospital selection, Mohamad et al. (2012, p.362) find that "although the functions of these facilitators can be self arranged by the patients themselves in searching information and booking through the internet, yet the existence of medical travel facilitators is vital in coordinating these matters". The interviewees indeed follow the reasoning that their coordination service – or facilitation service in general – is vital, even in the stricter sense of the word, and not just a 'nice to have' supplement. The facilitators' articulation of the dauntingly unfathomable environment and the patients' vulnerability and helplessness implies that undertaking a medical travel endeavour successfully without the help of a medical travel facilitator is risky and quasi impossible. Furthermore, the narration implies that the assistance of medical travel facilitators provide the perfect solution for the patients' difficulties. The consequent effect of this narration on patients is that they (should) consider the help of facilitators as a vital necessity. The effect on the facilitators' service is its comprehensiveness, which has been explicated in this chapter and which is discussed in the following sections.

Tasks of direct patient assistance

Coordination work is one of the key tasks of medical travel facilitators. It seems that facilitators are basically doing all the coordination related to the medical journey and the stay of international patients. Several studies ascribe facilitators in a coordinator role (e.g. Snyder et al. 2012; Mohamad et al. 2012; Turner 2011; Gan & Frederick 2011). Thereby some authors generally refer to the facilitators' work as coordination and some others see coordination as one of the tasks taken over by facilitators among others. The findings of this study show that coordination work is required and carried out at different levels by healthcare facilitators. Even before the stay, facilitators coordinate for the flight, accommodations, visa assistance and tele-consultations with doctors. Once the patient is on site in Delhi, they make sure that the patient is arriving at the hospital on time and as comfortable as possible, make appointments with doctors, negotiate with the staff in different departments of the hospital, ensure that the procedures comply with the treatment plan and try to provide the smoothest possible investigation procedure. Therefore, being in touch with the relevant people proves to be a strategic advantage. Expressing the patients' needs, being cooperative and giving clear instructions helps to coordinate efficiently and speed up the process in the hospital.

Guiding and navigating patients is another task that facilitators perform in their everyday practices. Some studies speak about guiding and navigating patients refer either to a subordinate level like Snyder et al. (2011, p.531) who see the facilitators general role "in guiding patients towards specific destinations" or restrict it to a virtual dimension saying that web-based medical tourism facilitators "help patients navigate countries, doctors and specialties" (Wagle 2013, p.28). In this study, guiding and navigating have a physical and spatial component. Facilitators who walk around in hospitals, navigate through corridors, wards and buildings and also guide their patients outside the realm of the hospital actively perform the practice of guiding. Facilitators direct their patients to the different stations and – as a tour guide would give interesting information about the sights –facilitators tell the patients where they are, what is going to happen there and why this station is a necessary stop in their treatment procedure. In a figurative sense they help the patients to get on the right track. Healthcare facilitators guide their international patients in the decision-making process when choosing the suitable treatment, doctor and hospital.

Making decisions on the patients' behalf is viewed as a relevant practice of the facilitators' work that can be understood as a component of their guiding and coordinating tasks and adds another aspect to the current literature. In this chapter, the facilitators' decision-making power became apparent when they pre-select doctors and hospitals that come into question to serve the patients. Other areas in which facilitators make decisions were exemplified in the facilitator's autonomy in organising the concrete check-up procedure or the example of the facilitator who negotiated the treatment costs without even telling the patient that he has done so. In consultation with the doctors, facilitators sometimes decide on the patients' behalf concerning the order of their treatments. Typically, the facilitators discuss the concrete treatment arrangements with the doctors and marketing staff. Sometimes the patients themselves are only marginally involved and thus the facilitator has the considerable power to make decisions such as the room standards but also upon the material used during the surgery. When translating for their patients', facilitators frequently decide on the words to use and sometimes on the information they pass on or do not pass on. At times, the doctor would give the facilitator information and advise them not to pass that information on to the patient. These issues

raise critical and ethical questions and refers explicitly to power structures. This is discussed more thoroughly in Chapter 7.

In line with the allusion to a tour guide, facilitators effectively function as cultural mediators. This aspect is also touched upon in the literature, though rather marginally. Ormond et al. (2014, p.1) however clearly refer to facilitators as 'cultural brokers' and says that patients and facilitators both have to adapt to the culture of the other. Although this function did not feature openly in the field note sections, the interviewees elaborated on the knowledge they need about the patients' cultures and how they adapt their services towards their cultural expectations and religious needs. One way in which this is demonstrated is the way, in which the facilitators show patients the prayer rooms in the hospitals, help them to find the necessary ingredients to prepare their food or organise events so that the patients can hold their festivities. Facilitators cater to international patients in the sense that they welcome them in their country, they provide accommodation and food and also help them to familiarise themselves with the cultural context of the medical travel destination.

Translating languages is another task that facilitators satisfy and which is described as challenging. As illustrated, the interpreter's role is usually not limited to language translation. The complex communication situations often involve a double- or threefold interpretation. It is about the facts that are translated from one language to another, it is about making these specifics understandable and is furthermore about negotiating the feelings attached to the message. Similarly to the four-sides communication model of Schulz von Thun (1998, p.13) that introduces factual information, appeal, relationship and self-revelation as components of communication that can be critically intertwined, there are many pitfalls involved in the tasks of understanding, transmitting and making someone understand. Specifically in the context of transnational healthcare, Kaspar (2015) elaborates on the relevance of communication in healthcare, the complex task of interpreting and the challenges posed by a transnational context.

The function of a patient advocate is another distinct task that is actively performed by facilitators. As the facilitators' understanding of this task has already been explained and related to current literature in Section 5.3.2 it will not be repeated here. Chapter 6 gave insights into how this role is actively performed in the facilitators' daily practices. It became apparent that advocating means much more than negotiating upon treatment costs. Advocating for international patients can be understood in a more comprehensive way including other dimensions as the ones that the interviewees mention themselves. On a micro level, also the tasks of communicating with people in- and outside the hospital on the patient's behalf can be taken as advocating so as their involvement in supervising the situation and practices of other actors and their control function. On a superordinate level, the facilitators' efforts to improve the issues of the medical travel market in Delhi, for example their attempts to establish universal standards, guidelines and even training courses for facilitators, can also be conceptualised as a way of advocating for international patients.

An important dimension of the facilitators' work has not been made very explicit in this section up to now: care work. Depending on the conceptualisation of care work, several dimensions of this practice have already been implicitly addressed. To evaluate in what sense care work features in the performance dimension of the facilitators' practices, the second discussion section (6.5.2) scrutinised their work with regard to care work.

6.5.2 Caring for international patients

This section explores in what sense the practices performed by facilitators comprise care work. Thereby the tasks just assembled in the former section (6.5.1) are related to the conceptual framework of care work. The analysis of care-aspects in the field note episodes that stuck deliberately close to the data is now to be taken further. As the emotional dimension of care work is closely related to the facilitator-patient relationship, this aspect of care work is spared out here as it can be discussed more thoroughly at the end of Chapter 7.

6.5.2.1 Purpose and dimensions of caring for international patients

To approach the fourth research question of this thesis, namely to examine in what sense the facilitators' performed work practices comprise care work, the different conceptualisations of care work presented in Section 3.2.1 are consulted, related to the data and discussed.

According to Engster (2005, p.55) caring is "everything we do directly to help other to meet their basic needs, develop or sustain their basic capabilities, and alleviate or avoid pain or suffering". The position that 'the name says it all' is applicable for healthcare facilitators: The merit of their services is to facilitate healthcare, which means that they make medical treatment more easily accessible which in turn alleviates pain and suffering. They do help international patients to get treatment but whether they do it directly or not is questionable. Nevertheless, the data demonstrates that facilitators do act in an "attentive, responsive and respectful manner" (Engster 2005, p.55), which are the central virtues of caring as defined by Engster.

Responsiveness is also a relevant aspect for care work as it is conceptualised by England and Folbre (1999, p.40) who understand caring work as based "on the assumption that the worker response to a need or desire that is directly expressed by the recipient". On one hand, the field note episodes illustrated how patients express their needs by verbalising them or by expressing them with gestures and bodily enactment. On the other hand, the particular articulation of international patients as vulnerable and in need of help shows that the facilitators' services are based on their personal interpretation and assumption of the medical traveller's needs. Although it can be assumed that experienced facilitators can evaluate the care needs of their patients accordingly, there seems to be room for interpretation. This in turn demands attentiveness as stated by Engster (2005) and Lynch and Walsh (2009) who list attention as one quality of a care worker. Attentiveness and responsiveness from the facilitators' side is expressed firstly in the comprehensive service that they see as a matter of course considering their clientele and their work environment and secondly in their ability to tailor their services to personal needs and desires. Because facilitators spend the majority of their time in direct contact with the patients, they are able to get to know them well and can respond to their needs at any time. The facilitators' interest in gaining knowledge about the people they serve in terms of their personal wishes and about the cultural environment in their home country is another expression of their attentiveness and willingness to learn. This has the double effect that they can better care for the patients and use their knowledge to push their business.

Razavi's (2007) differentiation between direct and indirect care work is another approach to examine if the facilitators' work performances comply with her interpretation of care work. Obviously, facilitators do not deliver direct care in the sense of medical care or looking after the basic physical needs of their patients. Yet, other dimensions outlined by the author as direct care like "accompanying them to the doctor, taking them for walks, talking to them and so on" (Razavi 2007, p.6) are definitely part of the facilitators' job and thus care work. In this sense, the check-up marathon pre-

sented is a detailed description of what it means to accompany patients to the doctor. The facilitators' practices also match activities ascribed to indirect care. They would not clean, wash and cook, but they do go shopping for and with their patients, organise meals that they like and even deliver meals personally. Following Razavi's (2007) description of care work, basically the whole range of tasks outlined in this chapter can be considered as care work. To coordinate and guide, to translate and mediate, to advocate and take decisions all "provide the preconditions for personal caregiving" (Razavi 2007, p.6). Personal caregiving can be either understood as the direct care delivered by doctors and nurses or other personal caregiving activities from the facilitators' side.

The third form of care work that Stingelin et al. (2012, p.10) introduces along with direct and indirect care is 'care responsibility' (Betreuungsverantwortung) which means that a care-giver ensures the well-being of the person looked after by being present; the care-giver does not need to directly interact with the care-receiver. Medical travel facilitators seem to take over care responsibility in several ways. In many situations the facilitators offer security to their patients by their mere presence on site and the permanent availability that they offer. They are present at the airport, in the guesthouse, in the hospital and even at an ordinary market. However, their practices do usually go beyond just being present and supervising the situation. They are actively involved in the processes, interacting with the patients, and caring for their well-being through various practices.

Facilitators apparently do engage in the multiple dimensions of care work specified by Lynch and Walsh (2009). Coordination work like booking flights, finding accommodations, scheduling appointments, collecting reports or paying bills are part of the facilitators' daily work practices and can be understood as the *mental* dimension of care work that includes "considerable amount of planning" (Lynch & Walsh 2009, p.42). Navigating spaces, being present with the patient, guiding them by taking them by hand and holding their hand in difficult situations physically (and literally) is *physical* work. *Cognitive* work defined as "discovering what needs to be done" (Lynch & Walsh 2009, p.42) has already been discussed as attentiveness and responsiveness, which all involve gaining and applying knowledge. The aspects of care discussed so far in this paragraph and in this section as a whole mainly refer to the notion 'caring *for'* in the sense of catering for the general well-being of the care-receiver (Lynch & McLaughlin 1995, p.256). The dimension of care work that has not yet been discussed is the one of *emotional* work. There are different ways of conceptualising emotional aspects in care work. Common to them is a particular focus upon the relationship and interaction between the care-giver and care-receiver, as for example pointed out by Lynch and McLaughlin's interpretation of 'caring *about'*. As the facilitator-patient relationship is scrutinised in Chapter 7, the care work dimension of emotional work is explained in the medical travel facilitation context in the discussion section of the respective chapter.

6.5.2.2 Logics and issues of caring for international patients

Another approach to explore in what sense the practices of the medical travel facilitators comprise care work is to look at particular logics that underlay care work. Some of the characteristic logics and issues that became apparent in the facilitators' work performance – or non-performance – are taken up in this section. Logics and issues that are closely related with the facilitator-patient relationship and with the emotional dimension of care work are omitted here to discuss them thoroughly in the discussion section in Chapter 7.

One of the logics underlying care work is that performance and effect of care are of a complex nature and thus difficult to quantify (Madörin 2009a, p.67). This also establishes difficulty when trying

to define the scope of the facilitators' work. For the interviewees it is difficult to define their duties and scope of responsibility. They do not use the term care work to conceptualise their work explicitly as such, but it is assumed that the care work comprised by the facilitators' work complicate the definability. Although there is no clear-cut definition of what the facilitators' services must or should include, the interviewees all offer a comparable service and it seems that they follow some intuitive guidelines that their experience consolidated. In addition to this, it is difficult to evaluate and quantify the working hours performed.

A particular temporality is thus another logic of care work that is prevalent in the medical travel facilitation context (Madörin 2009a; Lynch & Walsh 2009). A quasi-permanent availability of personal presence or via phone is standard for medial travel facilitators. To be on standby 24/7 is an often demanded service of the care worker and applies to facilitators (Schwiter et al. 2014; Stingelin et al. 2012). This makes the working hours difficult to quantify. The timing and temporal nature of the activities are another time-aspect and important structuring elements of the facilitators' work. The proceeding in the hospital is marked by sequences of continuations and moments of interruption whereby facilitators strive to make the process smooth and continuous. Saving time is a constant imperative. However, again and again, the course of the treatment is interrupted due to unforeseeable incidents and the given structural arrangements in the hospitals to handle patients. The predictability of the conditions for the care work are limited and the options to rationalise and speed up the process restricted (Madörin 2009a, p.68). Although facilitators may manage to speed up the treatment process considerably, caring for their patients is still time-intense and demands the facilitators' presence as this results in quality care time for the patients.

The gendered nature of care work is another issue that differs in the context of care work in medical travel facilitation. The point of departure for many arguments applying a gender sensitive lens is the fact that care work predominantly has been ascribed to the feminine sphere (Anttonen & Zecher 2011; Hochschild 1979; Knobloch 2009; Madörin 2009b). In contrast to the literature, women seem to be clearly underrepresented in this branch. Out of the thirty interview partners only five were women. As already stated in the Section 4.2.1 about the sampling it can be assumed that cultural and religious reasons lead to the dominance of men in medical travel facilitation. Jejeebhoy and Sathar (2001) argue that both Hindu and Muslim Indian women still have limited work opportunities outside home and especially Muslim women are denied to engage in close contact with men (Essers & Benschop 2009, p.410). Nevertheless, some medical travel companies employ women specifically to care for women who do not feel comfortable with a male facilitator. The situation is though more complex and further research would foster a better understanding of the gendered nature of medical travel facilitation in Delhi. Apart from the underrepresentation of women in this job, Anttonen and Zecher (2011, p.23) stated that the "dimension of care, such as commitment, duty and devotion, are a part of both men's and women's care experiences". This is in accordance with the commitment and devotion expressed by male facilitators in the sample for whom carrying care work seems to be a naturalised part of their work. No one coined the term 'care work' but almost all paraphrased particular aspects. Maybe this has to do with the gendered perception of care work (Anttonen & Zecher 2011; Calasanti 2003).

A critical point put forward by Anttonen and Zecher (2011, p.27) criticises the statement that a focus upon the care-givers' agency represents the care-receiver usually as "a helpless, passive and dependent person". This image is reproduced by the facilitators' articulation of international patients in both practice dimensions, perception (Section 5.2.1) and performance (Subchapter 6.4) and should be

reflected and integrated in studies focusing on the patients' experience of medical travel as stated by Kingsbury et al (2012) or Kaspar (2015).

6.5.2.3 Space and care work in medical travel facilitation

To give the care work comprised in the medical travel facilitators' work performances a spatial component, this section elaborates on Conradson's (2003, p.452) call to focus on "the spaces, practices and experiences that emerge through and within relations of care".

Space is relevant for healthcare on several levels. A macro-level perspective shows that the supply of healthcare varies in different geographical regions. The variability in quality, availability and accessibility drives people to become mobile. In the case of medical travel, patients become mobile across national boundaries to obtain care at places that offer more favourable conditions for them. Patients and medical practitioners from different countries are brought together through and within relations of care, which demand a particular spatial setting. Thus, on a meso-level, it becomes apparent that spaces like the hospital landscape of Delhi are well directed and designed for the provision of healthcare services. From a micro-level perspective as applied in the field notes episodes, the spaces that emerge through relations of care manifest themselves materially in the form of an International Patients Lounge and practically in the form of the care work performed within the space of the hospital.

From a spatial perspective one can argue that the facilitators' practices of care are crucial in mobilising patients towards the transnational healthcare market. The facilitators' assistance and the care work entailed therein contribute substantially to the realisation of medical travel because they meet the needs of international patients to overcome spatial (and also cultural) distance. To put it in a relational perspective: the care practices that emerge through and within relations of care have a space-compressing effect and thus help to bring the transnational healthcare market into being.

7 Power relations: the facilitator-patient relationship

This chapter scrutinises how facilitators relate to their patients on site in Delhi. The facilitator-patient relationship has been outlined in the previous chapters as it relates to the facilitators' understanding of their work and in the way in which that work is oriented in the interaction and practice when working with international patients. The aim of this chapter is to focus specifically on how the facilitators' tactics and power unfolds in the establishment of a close relationship with the patients on site and why this relationship is important for fostering their business. The analysis is guided by the third dimension of practice according to Jones and Murphy (2010) which is *power relations*. Power relations in practice manifest in two ways: Firstly they are manifested in the strategies and tactics of actors to build trust and mobilise others and secondly in relational geometries (Jones & Murphy 2010, p.383).

The first subchapter (7.1) explains why the facilitator-patient relationship is important to build up new contacts and to increase the facilitators' business. The second subchapter (7.2) scrutinises the facilitators' tactics to establish a close and personal relationship with their patients whereby emotional care work becomes particularly relevant. The third subchapter (7.3) takes the relational geometries into account to see how power unfolds in the facilitator-patient relationship within the system of agencies and dependencies. The discussion in the last subchapter (7.4) inserts the practices used to build relationships and the unfolding of power into debates on care work.

7.1 Why relations matter

The economic activity of medical travel facilitators is mediated through the facilitators' practices and their interrelation with other actors, whereby the relationships with network partners (see Section 6.1.2) and the relationships with patients are of particular importance. In this chapter, the facilitator-patient relationship is taken into consideration. This relationship is first and foremost part of the facilitators' practices of medical travel facilitation as elaborated in Chapter 6. Though these relationships can also be considered as part of the facilitators' strategy to increase their business, the strategies facilitators use to contact new clients and how they mobilise them towards the Indian healthcare market have been outlined in Subchapter 6.2. As these strategies are the starting point to explain why the facilitator-patient relationship is crucial for their future business, these strategies are briefly reviewed.

Acquiring new clients is fundamental for the business of medical travel facilitators. The first strategy, 'direct patient mobilisation', is meant to convince prospective clients to make use of a medical travel facilitation service when they are investigating facilitators directly or via their webpage. Yet, this strategy is not very promising because it is difficult for facilitators to build trust unpremeditated. As explained in Section 6.2.1, building trust poses a major challenge that is accentuated by the spatial distance between facilitators and their prospective clients and by the sensitivity of the subject

matter interrelated to healthcare. For this reason, the two other – indirect – patient mobilisation strategies are favoured. They are more promising for medical travel facilitators because they can circumvent the challenge of building trust with the patients when the link with them is only recently established and there is a spatial distance between them. The second strategy, 'channel partner mobilisation', is based on the principle that facilitators build relationships with people who are located in the patients' home countries. These people who are locally available can build trust with prospective medical travellers more easily. When the patients are convinced that their best course of action is to receive treatment in Delhi, these channel partners refer the patients to the facilitators with whom they are associated. The third mobilisation strategy is called 'patient testimonial mobilisation'. This strategy is based on the principle of building trust with prospective clients via the positive testimonials of former patients. Facilitators must ensure that they convince international patients on site in Delhi of their expertise, professionalism and caring. When these patients return to their countries, they will probably tell their friends and relatives about the experience with 'their' facilitator. Such authentic testimonials build trust with prospective patients who are referred to the facilitators in Delhi. As word-of-mouth is passed on to several people and is reinforced by every satisfied patient, referral chains are established that multiply in what is known as the snowball effect.

The third mobilisation strategy, 'patient testimonial mobilisation', draws on word-of-mouth as an effective and direct way to transmit messages in informal networks and communities and it proves to be practiced on a regular basis in the context of medical travel. Word-of-mouth is highly influential to the medical travel branch because international patients seem susceptible to testimonials of former patients who can give detailed and authentic insights into medical travel from a patient's perspective. Consequently, positive testimonials can boost medical travel and medical travel facilitation and correspondingly negative testimonials can harm the image of the branch. The interviewees emphasise importance of word-of-mouth for their business and consider the establishment of reference-chains as an integral part of their work as the following statements show:

> "That's the main thing. It's a link and a reference work. (…) it's chain-work." (I.2, 149)

> "So, but we work mainly through word-of-mouth. That's how we work on. It's slow and steady, but it's good." (I.1, 124)

Some of the interviewees are even more specific about the importance of word-of-mouth in the local context of Delhi. They argue that word-of-mouth is of particular relevance for them because the clientele they serve in Delhi relies on word-of-mouth much more than medical travellers that go elsewhere:

> "See, if somebody is guiding someone to you, it doesn't have anything to do with the sale. It has to do with the person (...) That is different in the case I told you; in US and America it is different. It has nothing to do with person. It has everything to do with how professionally the company is and they go to the website and all those things. In Africa it is more through personalised way." (I.4, 336)

The interviewee contrasts a personalised way of relating patients and facilitators via a personal recommendation with an impersonal way whereby prospective clients guide themselves to facilitators by evaluating the company's professionalism. In so doing, he argues that African patients believe personal testimonials of friends and families utmost whereas patients from the US would rely more

on professionalism expressed on the websites of medical travel companies. The relevance of personal recommendations and guidance is associated with social structures. Some interviewees describe patients from the Middle East and those from African countries as clannish and argue that this is an advantage for them because word-of-mouth is effectively being circulated:

> "But people from Nigeria, Kongo, Kenya, Uzbekistan, Oman, all these people they're easy to get, to build up trust well. (…) They definitely are asking the referrals whom they know form their country and all the stuff. A kind of testimonial from the patients." (I.5, 61)

If someone of this community is convinced of the worth of the medical care in Delhi and the assistance of a particular facilitator, more people from this community will follow the same route. Word-of-mouth is therefore considered by some interviewees as especially influential for Delhi because the people who are coming there highly value personal testimonials.
To make use of this promotional channel, medical travel facilitators must ensure that their patients are convinced to such an extent that they would refer their facilitators to their loved ones. They use the time when they are in direct contact with the patients in Delhi to establish a trusted and personal relationship according to the 'patient testimonial mobilisation' strategy:

> "When they [international patients] are here, my role is to ensure that their experience in India is so fabulous that they go back and become brand ambassadors of the situation in India." (I.7, 284)

The trust-building process between the patient and the facilitator is thus mainly taking place on site in Delhi and the mobilisation process follows when the patients return to their countries and activate new clients with their testimonials. The question however is on what it means to guarantee a fabulous experience and how medical travel facilitators turn patients into their 'brand ambassadors'.

7.2 How facilitators win the hearts of their patients

Power in practice manifests in "the strategies and tactics they [actors] use to control, build trust, and/or mobilize others in relation to their desires or intentions" (Jones & Murphy 2010, pp.383–384). To reveal how facilitators powerfully craft the relationship with their patients, this subchapter looks at the strategies and tactics they apply to relate to their patients on site in Delhi, to build trust, to guarantee a fabulous experience and to finally turn them into 'brand ambassadors' – or, in other words: to win the hearts of the patients.
The most prevalent tactics used to build trust and to win the patients as their ambassadors among the interviewees is encapsulated in the following quote:

> "A) by providing them a good quality service, B) by making sure that you're not fleecing them, that's very important. You know, the whole pricing them you have to pricing them right, according to the market rules. And C) by looking after them. By actually being concerned. (…) Because this business is a word-of-mouth business. If you have a good experience with me today, you go and tell the

> people about me. And that's my philosophy. (…) Then only you'll tell other people about me. And that's how my business will increase." (I.1, 93)

The interviewee condenses the core tactics into three points and amplifies that word-of-mouth is the driving force for these tactics, which are designed for rendering a positive experience to the patient and for establishing a close relationship. These three tactics are elaborated in the interviews and are thus used as the guidelines in this chapter. The practices performed to realise these tactics have already been explained in the previous chapters; yet, this chapter approaches them explicitly as tactics, which shows them in a different light and points out how power is enacted through them.

7.2.1 By delighting the patient with their services

The first tactic to build trust with international patients and to relate to them on site in Delhi is to provide good quality service. Service provision has already been discussed as the most prevalent self-understanding of the facilitators' job (see Chapter 5) and the range of services that are provided has been illustrated (see Chapter 6). This section however looks at the facilitators' services from a different point of view by considering them as an integral part of the facilitators' business strategy. From this perspective, the comprehensiveness of their services is not only derived from the patients' needs but contributes to the facilitators' tactics to fully convince the patients on site. They provide a little extra with the purpose of ensuring a fabulous experience and delighting their patients. One of the interviewees makes that crucial point very clear:

> "One is the satisfied patient, second one is the delighted patient. So there is two terms: satisfaction and delightedness. Obviously if you talk about this, satisfaction is okay. (…) They have come to India only for the care so now they are fine. Surgery is good and they are happy. But in terms of [name of the company], we try to make them delight." (I.6, 88)

Delighting the patients seems to be the driving rationale. Differentiating between the satisfied and the delighted patients goes along with differentiating between a standard service and a service including some extras. The interviewees try to delight their patients in multiple ways.
One option consists of offering services and articles for free, or by covering a part of the costs that would otherwise be at the patient's own expense. Most facilitators buy Sim-cards, top them up and hand them to the patients on their arrival. Some provide accommodation and food for free, either for a certain period of time or for a certain number of the attendants. Organising additional treatments that are supportive for a speedy recovery like physiotherapy for the patient or a spa treatment for the attendants on the expense of the company are other examples of how facilitators try to delight patients. The desired effect is the following:

> "She [the patient] is alright and she is delighted. Because she didn't expect that we will provide free of cost all these things. So they are not only satisfied there." (I.6, 88)

The logic is to provide a service that the patients do not expect and that is specifically tailored to the patients' needs or wishes so that they are positively surprised by the facilitator's generosity and attentiveness. The surprise effect is thereby an integral part of the strategy as the following quote shows:

> "If we say them [the patients] we will give them these things, they are satisfied. So we don't say that." (I.6, 89)

Apparently, some facilitators try to exceed the expectations but deliberately keep them low in the beginning so that the surprise effect delights them even more.
Material values can have a similar effect on the patients and thus is a second option to delight patients. Several facilitators mention that they give some presents to their patients when they leave Delhi. That these gifts are not limited to Indian tea or craftwork is discussed in the following quote:

> "I have very nice relationship with patient. And everything, for example kids, women, I bring them some gifts and PlayStation and everyday I come to visit them for two to three times every day. Okay? And that is why they love me. (…) With what I told you, when they come back and if there is someone who wants to come, they will send him here with you." (I.19, 146)

Buying presents seems to be a promising strategy to win the patients' favour and thus to enhance or confirm a 'very nice' relationship. The facilitator seems to target women and children especially. The way the interviewee discloses his tactic alludes to bribery, offering presents and care for positive testimonials in return. Handing something material over to the patients or attendants that they can take back home has the effect of attracting the attention of friends and relatives and gives an open invitation to the former patients to tell the story about their generous facilitator. Narratives and emotions attached to the materiality of the facilitators' gifts become mobile when the patients return to their countries and start to circulate.
Being present on site and visiting patients regularly or even several times a day is another way to impress patients. Being in close contact has several advantages: The personal relationship between the patients and facilitators is strengthened, the facilitators can ensure that the patients are satisfied or if not they can react in a timely manner and by being in regular contact facilitators can more easily confirm that their patients are not being poached by another facilitator or a tout respectively. Providing a free Sim-card and offering permanent availability by phone or in person is thus not only useful for the patients but also tactical for facilitators.
In addition, offering an exceptional experience to patients and attendants is a fourth option to delight them. Enjoying shared experiences like going out for dinner together or participating in cultural festivities affects and forms a relationship among patients, attendants and facilitators. They have a positive story to share, often captured in pictures that can be shared with a larger community. Another opportunity is to organise a special experience for the patients and attendants without the facilitators' participation. Although the interviewees say that holiday tours are very rarely demanded by the patients, because most of them cannot afford it and they are much more concerned about their health, offering a short trip at the company's expense seems to be a perfect opportunity to exceed the patients' expectations:

> "Either by taking them out, maybe for a meal or telling them if they want you get them a tour on the city or it could be as symbolising and taking them all on a small two day vacation or something like that. So that they feel happy, they feel safe and they feel trusted upon and yes, we've not been cheated. And they have good things to say when they go back about India and about your people as well. And everybody is happy. So that's what the idea is." (I.1, 96)

Again, the strategy to delight patients for the purpose of ensuring positive word-of-mouth is made explicit. According to the 'patient testimonial mobilisation', patients that return from a fabulous experience in India are likely to tell their friends and relatives about the treatment but specifically about the people that rendered such an extraordinary service. If they pass the phone number of their facilitator on to other people, the strategy is working: the facilitators' business is increasing.

7.2.2 By ensuring the right pricing

The second tactic to build trust and relate to international patients is by ensuring right pricing. Apprehensions regarding financial misconduct is a big issue in the Indian medical travel business where the service and treatment pricing is not clearly regulated or disclosed (see Section 5.2.2). Stories of facilitators, agents, touts and doctors who cheat on their patients circulate and alert medical travellers. The interviewees acknowledge being fleeced of money either by the healthcare providers or facilitators as a serious concern of international patients and a reason for mistrust towards facilitators. As facilitators are aware of the patients' apprehensions, they are especially sensitive about the pricing and reassure the patients that they are in charge of correct pricing.

One option to counteract the patients' mistrust towards healthcare facilitators is to de-articulate a commercial context regarding the facilitator-patient relationship. As the financial part of the business relation between the facilitator and the patient is transacted and interrelated with a third economic actor, namely the hospital, the commercial context is concealed. To reiterate: the business model applied by medical travel facilitators in Delhi follows the principle that facilitators themselves do not charge the international patients who make use of their facilitation service, but they do get a referral fee paid by the corporate hospital to which they admit the patients. The referral fee is usually a percentage share of the patient's treatment costs which is variable but according to the interviewees around 20%. That most of the facilitators do not directly charge the patient is an important argument in de-articulating a commercial exchange. Many interviewees make clear:

> "I don't charge the patients a single rupee. I tell them that we are getting paid. The more transparent it is, the better it is." (I.9, 221)

Although the interviewee refers to transparency, it is doubtful whether international patients do actually know how this "fee-model kind of thing" (I.5, 122) works. The point is that albeit facilitators do not take a service fee directly from the patients in most cases, patients still pay for it because the hospitals that pay the facilitators apply a price mark-up for international patients. Indirectly, international patients do co-finance facilitators:

> "Because hospitals are not giving it [referral fee for the facilitators] out of their own pockets. They are putting the complete costs to the patients. (...) Patients are actually not aware of this, but *erhm* almost six years ago I can be dam sure about this that the patients were not aware of this. But today, out of hundred patients, at least 35 - 40% patients know that these guys [facilitators] are getting some kind of referral fees and this referral fees are coming out of my money which I'm paying to the hospital [I as a patient]." (I.28, 99)

This interviewee discloses that patients do pay indirectly for the facilitators' services but that this is difficult for patients to know as it is included in the mark-up that the hospital charges them. Yet this model is even more complicated as patients do pay this additional fee for being international patients

whether they come through a facilitator or not. Thus in an individual case there is no difference in price if patients come to the hospital directly or via a facilitator. The business model that has been developed does pass the costs along to international patients. From the quote it can be determined that patients gained more knowledge about the referral-fee-model over the last years, but the majority are still unaware of the pricing scheme. The patients may understand that the hospitals are paying a commission to facilitators for referring patients but are unaware that hospitals charge them higher fees, which compensate for these referral fees. That most of the patients do not know about this model or are only partially informed is an advantage for facilitators as they can position themselves as not fleecing money from the patients.

A second option for the facilitators to convey their efforts in ensuring the right pricing is to present themselves as patient advocates who stand by the patients' sides and help them to cut the costs. In this manner the facilitators do articulate a commercial context albeit unfolding in the patient-hospital relation:

> "What the situation is, we stand with the patient. You know, hospitals are made for profit. Not for charity. Frankly. They are not for charity; they are just for earning money. So, if there is something bad, (…) in this case our role starts. We try to get a discount for the patient." (I.6, 124)

The facilitators' role in this context is to ensure that the hospital does not overcharge the patients or to obtain the patients' treatment at a discounted rate. Therefore, facilitators make use of their knowledge, network connections and strategies. As introduced in Section 5.3.2 seeing themselves as a patient advocate is one of the main dimensions of the facilitators' self-conceptualisation and is closely related to ensuring the correct pricing. Performing this role in daily business and enacting the moral commitment that goes along with the function of an advocate demonstrates to the patients that they are working in their favour. They are striving to reduce the expenses and control the situation to ensure that everything is proceeding correctly and according to the market rules. This is important to counter the patients' apprehensions of being cheated and is conductive to building trust. Most of the interviewees therefore position themselves clearly on the patients' side respectively as opposed to the hospitals:

> "If you are using the word of international services, international charges, you are taking [money] from the patients, we always try to insure that we fight with the hospital, we fight with the corporate, we fight sometimes with big people in the hospital." (I.18, 52)

This facilitators' representation of hospitals as overcharging patients and the positioning of the self as patient advocate nevertheless omits the mutual dependencies between the facilitators and the hospitals: the facilitators depend on the hospitals' commission and the hospitals marginally depend on the business that facilitators bring in. Thus, the facilitators' position towards the hospitals is ambivalent and articulated differently according to the situation.

The facilitators' narratives sometimes reinforce their self-ascribed positionality as advocating for their patients and protecting them from actors who try to fleece them. Some of the interviewees report that they warn their patients about being poached by touts or about overcharging and unethical practices pursued in some hospitals. Sharing such insider knowledge can be considered as another option to build trust and relate to patients. By making the patients aware of the risks that they are

exposed to as medical travellers they communicate indirectly the benefits that patients have when being accompanied by *their* well-informed, honest and solicitous facilitator.

7.2.3 By actually being concerned about the patient

Looking after international patients and actually being concerned is the third tactic to build trust, relate to the patients and it is arguably the most promising for winning their *hearts*. Looking after someone means caring for this person and the state of someone 'actually being concerned' implies that this person is to a certain extent emotionally attached to the person being looked after. Being concerned is a feeling of being interested in and caring about a person which goes along with feelings of solicitude and responsibility and requiring that the concerned person becomes involved (Websters' Encyclopedic Dictionary 1994, p.304). Thus, being concerned has different shades and implies attachment and a personal relationship, in this case between the facilitator and the patient.
The facilitators' concern about international patients encompasses several aspects of their well-being. The perception of international patients discussed in Section 5.2.1 demonstrated that facilitators are concerned about patients struggling when undertaking a medical travel journey on their own. The facilitators' concern about the patients' physical and mental well-being was also expressed in the field note episodes in Subchapter 6.4 in a whole range of gestures, questions, actions, and advice that may seem insignificant at first glance but contribute to the overall well-being of the patients. Reminding them to wear a warm jumper like a concerned mother, giving them a hug like an old friend, or making jokes to cheer them up as an affiliated brother can evoke a sense of being in good hands. The interviewees seem to be especially concerned about the emotional state of international patients. Most of the medical travellers coming to Delhi are in a quite depressing emotional state: they accept an arduous journey into an unfamiliar city to seek a cure from their physical disease of which the treatment is often so expensive that the whole family is exhausting their savings. Traveling abroad is for many people the only option to acquire the needed treatment. The facilitators catering to such emotionally distressed patients support them emotionally in several ways and are involved in handling their emotions and feelings of worry and anxiety, of insecurity and mistrust.
Evoking positive feelings and counteracting the patients' anxieties and worries is one way facilitators look after the international patients' psychological well-being. Deliberately steering conversations and choosing unencumbered topics according to the patients' emotional states follows this tactic:

> "Yeah, there are a lot of emotional aspects. So definitely we also train our people because the person is already in a kind of a serious, difficult emotional moment of getting treated or having suffered of some disease. So we can't just talk too much commercial things or too much difficult things, which confuses him. So we talk more about their family when they are here. So at the OPD waiting lounges for a doctor to see, so rather than being talking too much on their medical thing we try to talk to them on their families, who are all there, what they do, how the things are going on. So that they are okay with us." (I.5, 63)

This example illustrates that facilitators are aware of the emotional stress to which international patients are exposed and that they carefully choose the topics of conversations. The subjects that facilitators discuss with their patients are often deliberately unrelated to their health, treatment plans and costs. That the interviewee, the director of a medical travel company, instructs his employees to be

attentive and sensitive to their patients' state of health and mind, and to make them feel relaxed and comfortable by offering suitable conversation topics, shows that this practice is well reflected.
Being concerned about the patients' emotional well-being further includes providing emotional support in difficult situations by comforting words and gestures and by expressing confidence:

> "Of course, the interpreter and any facilitator first give him courage. Give him courage, don't worry, you will be good and fine and happy and go back with good health." (I.15, 153)

Radiating confidence and optimism often serves to counteract the patients' insecurity about having made the right decisions when choosing hospitals and doctors. Hence, facilitators are engaged in reassuring their patients that they have made the right decision coming to this particular hospital and that everything will be fine:

> "Hundred time we are telling you will be good and don't worry. This is the good hospital, you choose the best one, the doctor is very good. He will take care about you. So we have to encourage them. Otherwise ... (laughs)." (I.3, 359)

The interviewee underlines the importance of the facilitator who is looked upon as competent in evaluating the patients' choices. They use encouraging phrases and offer comfort in various ways to reassure the patients. in reassuring and comforting the patients. 'Otherwise ...' (I.3, 359) alludes to the fact that patients would have difficulties coping with the emotional stress they are exposed to without a facilitator. They might not even dare to undertake medical travel or decide to cancel the treatment at the last minute:

> "Actually like that woman *erhm* yesterday she called me and I went to her at night. The doctor told her that maybe that when they will remove the disc between the vertebras, when they remove it, it m-a-y-b-e they will hurt the spinal cord. She said no, I wouldn't dare to do so, I will not do the surgery tomorrow. What are you doing in these things? Right? (Laughs) It is difficult to me." (I.30, 54)

The interviewee admits that sometimes it is difficult to handle the patients' emotions. Her rhetorical question illustrates that sometimes she does not know how to cope with such situations when patients call the night before the surgery in a state of agitation, wrecked with tension and fear, ready to cancel all the treatments. The confrontation with and management of the patients' emotions and the assumed obligation to be available around-the-clock are significant for the interviewee to feel uncomfortable. Yet facilitators are meant to brace up to reassure and calm the patients. The ability to provide emotional support is therefore an essential quality of a facilitators' repertoire. One of the interviewees says quite frankly that emotions are an inherent part in their work and being an emotional person is a quasi-conditional character trait for working as a medical travel facilitator:

> "If you are not emotional, you don't have emotion, we can't do this work." (I.3, 357).

Being present on site is another often mentioned requirement to care adequately about the patients' emotional well-being. The interviewee quoted above went to see her patient in the guesthouse even in the middle of the night as she realised that the patient would not calm down otherwise. Yet, not only the patients themselves need emotional support. Often it is the attendants who need emotional

support from facilitators when they are breaking down out of concern for their loved ones. Some of the interviewees' narratives convey the impression that in a case of emergency they would pull out all the stops to stand by the patients and their families. A facilitator who is in the management of a big company that sends people not only to hospitals in Delhi but also to a few other destinations experienced such a situation:

> "The woman was alone and very concerned about her son so she called me. She was crying on the phone because she thought that her child might die. So what could I do? I decided to go to Chandigarh and wait with her until the surgery was over." (FN.4[10], 23).

The interviewee sees no other option to comfort the concerned mother than to drive immediately from Delhi to Chandigarh, which takes about five hours by car, to wait with the mother at the hospital for the result of her son's surgery. As the treatment is not available in the patient's home country and the family does not have the financial means to send another attendant with the baby, the mother cannot count on emotional support on site. This role is taken over by the facilitator. He takes the place of a family member who would have supported the mother in this difficult situation back home. That facilitators replace family members who cannot be present on site is actually indicative of the importance that the facilitators' emotional engagement has for their patients.
Accompanying the patients throughout the whole process, standing by their side in difficult situations, listening to their worries, holding their hands, encouraging, comforting and consoling them or being present on site are integral of the facilitators' work practices but also of their tactic to build a close relationship with their patients. Thus, the desired effect of the personalised and emotional care articulated by the interviewees is to strengthen their relationship with their patients. The interviewees argue that they win the hearts of their patients with their commitment, honesty and reliability and with their dedication to care about them:

> "Because of our services, our dedication to win the heart of our patients from all over the world, we work tirelessly from sunrise to sunset, sometimes in night we are standing in airports waiting our patients and providing him. And you are not just a facilitator, translator or interpreter for that person who is coming from far away. You are like his family member." (I.18, 20)

The interviewee contends that his personal involvement and dedication creates an atmosphere of the patients seeing him as a family member who is committed to the well-being of his relatives. It seems that by delighting the patients, by ensuring the correct pricing and by caring about them, facilitators can overcome mistrust and strangeness and evoke family-like closeness. That the initial distance and unfamiliarity is renegotiated is exemplified in the following quote:

> "Let's say, the case-manager [used synonymous with facilitator] is the first alien family member." (I.7, 179).

This expression of an 'alien family member' illustrates the complexity that is inherent to the facilitator-patient relationship. Although they are strangers in the beginning, facilitators manage to be affiliated with the family circle as they evoke sentiments that make the patients feel emotionally attached to them.

[10] FN refers to field notes

The far-reaching effect of such a close relationship on the facilitators' business is made explicit by several facilitators. They disclose that they are eager to nurture their patients through a personal relationship because it is conducive to increasing their business:

> "I will deal with them like our family. So that is the reason why one patient come, one family, so I think, through one patient, ten patient will come in the future." (I.15, 127)

As in this quote, the interviewees often relate the manner in which they care for and about their patients, namely as a caring friend or relative, directly to the positive effect on their business. Former patients are more likely to recommend a close 'friend' in Delhi than just an impersonal facilitator.

This third tactic, being actually concerned about the patients, differs from the other two tactics in that the facilitators' personal and also emotional involvement is required to a large extent. Being in actual concern though raises the question of whether this quality is enacted and displayed only out of tactical rationales or whether facilitators *are* actually concerned about their patients because they feel sympathy and are emotionally attached to them. How facilitators feel about the patients that they serve has been neglected up to now, but will be revealed in the next section.

7.2.4 Relationship building as business strategy – but what about authentic sympathy?

The focus on the facilitators' business strategies and the emotions they try to evoke among their patients leave the facilitators' own personal attachment towards their patients out. That the interviewees articulate a personal relationship with their patients as being an integral part of their business strategy does not mean that these relationships evolve only from calculation. Actually, most interviewees show their interest in their patients as persons and not only as clients and express their concern about them genuinely. The ways in which facilitators articulate their sympathy authentically and express their emotional attachment is thus another facet of their work that deserves a closer look.

The relationships between the facilitators and their patients evoke emotions that seem to affect not only patients but also facilitators. A circumstance that contributes to facilitators' becoming attached to their patients is that they spend considerable time with their patients. As it became apparent in the field notes episodes (Subchapter 6.4), patients, their attendants and the facilitators often share their daily routines. They begin their day together in the morning, go to the hospital to do the investigations, have lunch together, continue with their program, have a coffee in the afternoon and leave the hospital at the end of the day and sometimes even go to dinner together. Facilitators and patients also undertake activities outside the hospitals and go shopping, sightseeing, take daytrips outside Delhi or celebrate festivities. This contact between facilitators, patients and attendants that is induced by economic exchange is extended to several dimensions of their private and social lives. The people become deeply involved in each other's lives during the patients' medical stay in Delhi. Hence, facilitators are not only companions to their patients; the patients also become companions to the facilitators.

By spending time together, patients, attendants and facilitators have a lot of time to get to know each other. Facilitators become acquainted with the patients' situation back home, their struggle to access

healthcare, the problems in raising the money to afford the treatment and the journey to Delhi and the desperation that resulted from these difficulties:

> "While they [international patients] are traveling in, a lot of people tell their issues with the collection of money, the discounts that they need. And some more things and we then go back to the hospitals, fight for them, negotiate form them, tell them okay it's a person who wants come but he can't afford. That's the money that he can pay, so he's been collecting this sum of money. So what are the options we can give him? " (I.5, 63)

Obviously, the patients' narratives evoke compassion and result in the facilitators feeling emotionally attached. As a result they become even more involved and try to help the patients. The interviewees repeatedly use rhetorical questions when relating situations in which they are confronted with the patients' despair and predicament as in the following quote:

> "She is old woman so if she is crying in front of you what will you do in that time?" (I.30, 77)

Such questions are taken as an indication that the facilitators themselves are sometimes overwhelmed by the situation and the emotions involved. The woman who openly displays her desperation and starts crying arouses compassion and draws in the interviewee helping her.
Another example of such rhetoric questions indicates that feelings of sympathy with their patients are sometimes considered as a dilemma in the sense that facilitators find that they do not actually have the responsibility to care personally about their patients' fate but still they feel obliged to care in a certain way. Some statements of the interviewees evoke the impression that they basically have no other choice than becoming attached and helping their patients. One of the interviewee who found himself torn between the responsibilities given in a context of rendering a commercial service and personal moral reasoning outlines this dilemma:

> „Suppose there is a patient who came to India. Ok. And he has run out of all his money. So should I let him to starve? I cannot. I don't have anything to do with him. I have done what I have to do, is hospital, accommodation and all. That is my responsibility. Is he starving or what he's doing is not my business. But being a human being, if he's starving I have to do that." (I.4, 330)

The interviewee states that his scope of responsibility as medical travel facilitator is limited to certain fields of activity (although they have never been articulated in a clear cut way and there seem to be no written documents outlining the facilitators' duties). Nevertheless, the facilitator feels responsible to support his patient financially although this is not considered to be part of the duties as a facilitator. Yet, helping people in dire need is considered an obligation as being a human being. This example indicates that the interviewees' roles as economic actor and social human being are closely entwined. It seems as if some facilitators cannot help acting in any other way than becoming emotionally attached and helping their patients. Hence, this reaction is being naturalised:

> "After all it's a human being, so you try to understand and learn something from them [international patients] and you will get some more attached and emotional." (I.5, 62)

It is argued that it is in the nature of human beings to be interested in their fellow men and to become emotionally attached when spending time together and learning more about the other. Thus, an emotional bond between the facilitator and the patients is considered as evolving naturally from their interest and personal interaction.

Sharing a large part of the everyday life with their patients, witnessing their distress and going with them through the ups and downs associated with the patients' illness and treatment procedure seems to affect facilitators personally and emotionally. The relationship that unfolds between the facilitator and the patient is often marked more by a sense of friendship and familiarity than by commercial undertone. As mentioned earlier in this study, the interviewees usually refer to the people to whom they provide their services as 'patients' but according to the situation they also use affectionate names like 'my friend', 'my brother' or 'my uncle'. These names express respect and emotional attachment. The use of these words reflects the facilitator's perception of the relation as being "more of a personal relationship than a professional one." (I.4, 408). The frequent use of possessive pronouns to refer to 'their' patients further indicates a sense of belongingness.

The sense of belongingness and attachment that resonates with the relationship between patients and facilitators in their daily encounters illustrated in the field note episodes in Subchapter 6.4 is consistent with the statements in the interviews. The following quote reflects that facilitators consider their relationship with patients as much more intense than a mere business relationship:

> "Not on business base. You know, I am not just translator, you know? I'm feeling they are just like my family. For that I am requesting, helping them. I'm doing my best. Okay? For that it is not business, not just friend. I'm feeling that they are my family, real family." (I.30, 77)

The interviewee explains that to her the patients are more than clients and more than friends and emphasises that they are like family members with whom she is closely related and about whom she is emotionally concerned. The facilitator expresses commitment and devotion in doing her best to help the patients. This quote shows that not only patients articulate facilitators as being like family members but that facilitators too use the same allegory by taking their patients as family members. This indicates mutual attachment.

A sense of mutuality, belongingness and emotional attachment is well reflected in the statements of an interviewee who uses the metaphor of a marriage:

> "So it is a marriage, every patient that we serve, we are married to that patient throughout his life." (I.27, 11)

This metaphor alludes to a strong bond between two parties who are both committed to their relationship and expresses a certain temporality. Consistent with the metaphor of family ties that for a lifetime, the relationship between the facilitator and the patient are often maintained after the patient returns to his or her home country. They keep in touch via phone or email over distance and not uncommonly there is the opportunity for a reunion. One facilitator who is mainly serving Nigerian patients proudly explains that whenever he goes to Nigeria to meet with channel partners he feels like he is coming home because of the warm welcome he receives from his 'friends' living there. These 'friends' to whom he refers are former patients. His days in Nigeria are always packed and he gets numerous invitations from his former patients to stay at their houses, to meet for lunch or dinner

and to say hello to their families that he can hardly meet them all. He feels honoured he says by the appreciation these people show for him and explains his motto:

> "It's all about relationships. If you treat them well, you get that back." (FN.1, 7)

The interviewee clearly points towards mutuality as an important quality of the facilitator-patient relationship. The patients are not only the recipients of care given by facilitators but offer something in return, trust and attachment, gratitude and esteem, friendship and affection. Stories of patients give something to the facilitators in return ranging from material values to the expression of deeply felt gratitude and respect feature repeatedly in the interviews. The relationship they have with their patients seem to be of a particular value to the facilitators.

Facilitators with migratory backgrounds seem to feel particularly attached to their patients when helping fellow citizens. Some of the non-Indian self-employed facilitators experienced medical travel as a patient or as an attendant themselves. They can relate to their patients through first-hand experience. Their activity as facilitators often began by assisting friends and family members from back home who came to Delhi to receive treatment. Often they do not just take their patients as family members but the patients actually are family members or people designated as relatives in their cultural conceptualisation of family ties. Some facilitators would accommodate these patients and their families in their private homes. These relationships seem to be of another intensity, entwined with feelings of sympathy but also with feelings of being obliged to help resulting from family responsibilities. Facilitating 'family members' who are temporarily living with the facilitators disguises a business relationship and resembles more of a family-intern friendly affiliation. This poses some challenges to facilitators in negotiating family relations and business relations and evokes ambivalent feelings. One of the facilitators explains that her brother and her mother are also involved in catering and facilitating patients coming from their hometown. As to the question of whether they ask them for money for providing accommodation, food and facilitation services, the interviewee responds:

> "My brother sometimes asks for money but actually it's the patient who give the money. It differs from patient to patient if they give money and also the amount. They give money for respect. But my mom would not ask for money. She even prays for the patients when they are with her." (I.20, 11)

Asking for money for helping and caring about 'family members' seems to be critical. The interviewee encounters the 'suspicion' that she and her family would help these patients only out of financial incentives by bringing in her mother's spiritual commitment. The relationships with such 'distantly related family member patients' thus seem to complicate the facilitators' negotiation of personal attachment, family responsibility and business acumen. This excursus relating to a particular group of facilitators and their relationship with their patients exemplifies the facilitators' attachment to their patients in a particular relational geometry.

This section elaborated the argument that relationships between facilitators and international patients should not only be seen as strategically crafted but can also evolve from the close interaction between facilitators and patients, the sympathy felt and the mutual attachment evoked. The authenticity of an emotion cannot be evaluated; only indices can be described. Hence, the authenticity of the sympathy and affection expressed by the interviewees can be approximated in their statements and

illustrated with examples from the field observations but the actual feelings cannot be assessed. This should be kept in mind when thinking about the emotional attachment expressed by the facilitators. Their narratives can be questioned critically. One can argue for example that facilitators stay in touch with the patients when they return to their country not – or not only – to maintain their friendship but also to foster future business. Similarly it can be argued that the facilitators' readiness to invest money from their own pocket to pay for the patients' treatment results from the commission they get in return only when the patients are getting treated.
It is important though to acknowledge that both rationales, sympathy and strategy, drive the establishment of close, personal and long-lasting relationships between facilitators and patients. Personal, intrinsic motivations for caring about their patients and building a close relationship and economic rationales feature both in the data. Out of commercial relations friendships can evolve and personal relationships can be beneficial towards the facilitators' business. The way strategy and sympathy are articulated by the interviewees suggests that that both rationales coexist:

> "Increase business is other thing and human being relation is other thing. So we are doing medical tourism in India with relation, human relationship. Not only for the money." (I.15, 173)

Although the interviewee presents the rationales as two different things, he makes clear that they are both part of his work. Human relationships are considered as central in 'doing medical tourism' in the Indian context but do not dismiss the economic incentives. Sympathy and strategy are presented as existing side by side; they are closely entwined and often cannot be separated. Hence, both rationales contribute to the building of the facilitator-patient relationship.

7.3 Relational geometries – on agencies and dependencies

To look at relational geometries is another way proposed by Jones and Murphy (2010) to examine how power unfolds in practice. Relational geometries as defined by Yeung (2005, p.38) are "configurations of relations between and among them [actors and structures]". As such, relational geometries "shape or limit the opportunities available to actors" (Jones & Murphy 2010, p.18) and hence indicate how power is involved in relationships. To analyse power structures that bring about the relationships between medical travel facilitators and international patients, the interrelated dependencies and agencies that shape the actors' opportunities are examined. The mechanisms that shape the structural economic setting are integrated in the analysis, as they are also part of powerful relational geometries. As the facilitator-patient relationship enacts a commercial as well as social context, power in the facilitator-patient relationship unfolds in these contexts.

The relation between facilitators and international patients enact a commercial setting that brings along a particular relational geometry. On the one hand, there is the patients' demand for assistance to undertake medical travel and on the other hand there is the service offered by medical travel facilitators. The patients' opportunities to successfully access good quality treatment abroad are limited mainly due to their lack of knowledge and network connections. On the contrary, facilitators present themselves as empowered by their knowledge, experience and connections, which render them the capabilities to facilitate the patients. Although often partly obscured, there is a certain commercial

context articulated by the exchanges between facilitators, patients and hospitals. In such a commercial context, clients have the opportunity to choose the facilitator they want to assist them or to decline their services. Although the decision is up to the patients, facilitators have the opportunity to present themselves and persuade potential medical travellers to make use of their services. By the patients' expression of their needs and the facilitators' articulation of their offerings, the actors position themselves in a commercial relation and reproduce relational geometries in which asymmetrical resources (e.g. money and knowledge) are negotiated and exchanged.

The business model that most of the facilitators follow has its effect on the power relations between facilitators and patients. Facilitators only get rewarded for their work if they admit an international patient to a hospital under their name. Therefore, they are working towards this moment of admission that guarantees them that their efforts prove to be financially rewarding. That patients have the opportunity to cancel their medical journey or switch to another facilitator at any moment is an incentive to facilitators to establish and maintain a close relationship with their patients. For them it is frustrating if they work long hours on the queries of a patient and in the end the patient decides not to come to Delhi or to go with another facilitator:

> "See, first of all you are putting your effort time and everything on a patient and if he is coming after two months and then he comes here and you show him everything. And after two days suddenly he says okay I'm not satisfied with it and he finds a local guy of his home country. He calls him and he goes with him. I cannot forcefully tell him not to go. But this is the problem in the end. (...) It's not only about money. It's about effort. Since three months you are working on that patient and he comes in India and he just left of." (I.4, 294)

Sometimes patients are influenced by touts and 'snatched away' but it is still the patients' decision to choose by whom they want to be assisted on site. The interviewees feel quite helpless regarding the strategies of their competitors. Yet, they have their own powerful tactics to convince their patients and to ensure that they do not lose them.

The relationship between facilitators and international patients and their positionalities within are furthermore reconfigured by the practices of care-giving and -receiving. Caring can be understood in the sense of a non-commodified form of social cooperation whereby the care-giver decides to help people in need (see Section 5.3.2). In this constellation, the care-receiver depends on sympathy and moral obligation felt by the person who decides to help. Although this understanding of care and help may drive some of the interviewees, the prevalent care arrangement between facilitators and patients is situated in commercial service provision. Thereby patients as clients enact power in the moment when purchasing a care service, respectively when choosing and engaging facilitators. Afterwards, they depend on this persons' care and commitment with their life in the following course of their medical travel endeavour. Medical travel facilitators are given a huge responsibility and agency that they can promote in several ways. The discussion of the empirical data in Chapter 6 has already illustrated the many tasks taken over by facilitators. Thereby facilitators enact power in the sense that they can substantially influence the outcome of the patients' medical treatment and their well-being. Three practices that exemplify how facilitators enact agency are briefly taken up.

Making decisions on the patients' behalf – sometimes even without seeking their opinion – is one of the practices in which the facilitators' power unfolds directly. Facilitators can steer the patients' decision-making process to choose a healthcare provider with their pre-selection of possible provid-

ers and their advice. As the patients' abilities in evaluating different options and their understanding of market mechanisms are limited, they rely on the trustworthiness of the options given by the facilitators. Therefore, patients usually hand over all the coordination and negotiation work to their facilitator. In most cases facilitators are also responsible for the formalities and the financial management. Consequently facilitators are empowered to decide on several dimensions of the patients' life.

Another practice in which the dependency and vulnerability of international patients becomes most obvious and the facilitators' agency is enacted prominently is language translation. When patients lack language skills they are not able to make themselves understood, they cannot understand what people like doctors, hospital staff or cab drivers say nor what is written on any kind of forms, bills, brochures or signposts. They rely completely on what the facilitator translates and tells them, whether the information is correct and complete or not. The agency is handed to facilitators who can choose the words to translate, the information that is transmitted and the issues to negotiate upon. The patients' agency is limited by their inability to understand and express themselves. As a result they cannot take part in the conversations, cannot stand in for themselves and cannot control what is going on. It is the facilitator who is speaking and acting for them. However, there is a fine line between advocating in favour of the patient and patronising behaviour.

Providing emotional care is another practice in which power and dependencies unfold. As explained in the previous subchapter (7.2) facilitators have particular tactics to influence the patients emotionally and nurture them for business purposes. Their knowledge about how they win the trust of the patients solidifies their position by influencing them emotionally. In some instances, it seems that facilitators demonstrate their knowledge and abilities deliberately to show the patients that they would be lost without their assistance. By making them feel gullible and ignorant to the risks involved in medical travel they reinforce the patients' dependency upon their services. Nevertheless, emotions can work in both directions and are transmitted from facilitators to patients and from patients to facilitators alike. Their relationship and position towards each other is thus reconfigured by emotional attachment, which is often articulated as being mutual. Facilitators seem to perceive and enact their agency differently when feeling emotional attached to their patients. They say for example that they try especially hard to negotiate a price discount or accommodate them in their own home.

Structural effects resulting from the mechanisms that shape the medical travel business in Delhi finally reconfigure the relational geometries underlying the facilitator-patient relationship again in another way. As the patients' testimonials and personal referrals of new clients have significant effects on the medical travel branch as such and the individual business of medical travel facilitators specifically, it can be argued that word-of-mouth as a structural element tames the facilitators' agency. International patients in turn have a powerful 'tool' in their hands. They are empowered by the relevance that they have for the facilitators' business. In this line of reasoning, word-of-mouth works as a corrective measure for unethical practices because the interviewees are aware of the consequences:

> "If someone is trusting you, he's trusting you with their life. If something goes wrong, you've had it. So, that's why I don't do it." (I.1, 92)

Facilitators are operating in a field that is highly sensitive: the health and respectively the life of international patients is their business. If they want to enhance personal referral chains, they cannot afford to exploit the patients' dependencies. Although international patients often seem to be in a

precarious situation and at the mercy of their facilitators, some structural effects seem to impede unethical practices to a certain extent.

The relationship between medical travel facilitators and international patients is constituted in economic and social relations, whereby power unfolds in relational geometries configured by the actors' practices and structural logics. Facilitators and patients take ambivalent positions towards each other, which are reconfigured regarding to the actors' agencies and dependencies.

7.4 Discussion: (care) work in the power relation dimension of practice

Chapter 7 focused on the practice dimension of power relations and therefore scrutinised the relationship between medical travel facilitators and international patients. It could be revealed that power unfolds in the facilitators' strategies and tactics to build trust and personal relationships for business purposes. Thereby, care work, especially the emotional dimensions, become a useful tool to win the hearts of international patients. Care work is embedded in particular relational geographies in which power manifests. This discussion section relates the facilitators' practices to build relationships with patients explicitly with the framework of care work. Practices of emotional dimensions of care work (7.4.1) and logics and issues (7.4.2) are discussed with regard to the context of medical travel facilitation. Drawing on debates about the commodification of care work, strategy and sympathy are taken up as rationales for building relationships (7.4.3). The circulation of emotions induced by facilitators and the phenomenon of referral-chains are discussed in the last section on geographical implications on care work carried out in the context of transnational healthcare (7.4.4).

7.4.1 Emotional dimensions of care work and caring about international patients

The first approach draws on Hochschild (1979, p.561) who understands emotion work as "the act of trying to change in degree or quality an emotion or feeling". Such a management of emotions or the influence upon emotional states respectively can happen "by the self upon the self, by the self upon others, and by others upon one self" (Hochschild 1979, p.562). To such emotion work carried out in a commercial context Hochschild (1983, p.7) refers to as emotional labour which is the "management of feeling to create a publicly observable facial and bodily display". Such emotional labour is carried out by medical travel facilitators who state that they caring for their patients' emotional well-being is an important task. Thereby they are engaged in managing their own emotions, in displaying emotions that they consider as appropriate in the given situation and that are contribute to making the patients feel comfortable and reassured.

The big smile with which Tariq, the Indian facilitator portrayed in Subchapter 6.4, welcomes his patients at the beginning of their check-up marathon, his attempt to comfort them by saying "it doesn't hurt – don't worry", or gestures expressing interest, respect or friendship are meant to affect the patients. Facilitators express their efforts in making their patients feel comfortable and relaxed; they strive to give them a feeling of being in good hands and well cared for by an amiable facilitator. In order that the patients do not enter a nervous state of worry and concern, facilitators carefully choose conversation topics and offer activities that divert them. In order to express, show and induce emotions, facilitators need to manage their own emotions. This becomes apparent in extraordinary

situations, such as when facilitators have to carry bad news or when a patient dies. The management of emotions, also referred to as deep acting (Hochschild 1979, p.562) can be stressful and demanding. The facilitators explain that they need to control their feelings to act professionally and support the patients or bereaved family members. In the interaction with the patients, facilitators report that patients often tell them about their suffering and pain, strokes of fate, their desperation because they could not find medical care in their countries or the financial burden that the medical travel endeavour means to them. Such emotion-laden stories evoke feelings of sympathy with the facilitators and an impulse to help them. In this case it can be argued that these emotions might be deliberately evoked by the patients who themselves manage their emotions to transmit certain messages. By expressing their feelings, they are likely to command the facilitators' sympathy and make them fight for a lower price or another benefit.

What emotions facilitators actually feel, whether they experience the emotions they display or engage in surface acting can not be evaluated, just approximated by the interviewees statements and the field observation. However, it seems that the management of emotions is an acknowledged issue among the facilitators. The director of a medical travel company declares that his employees are trained to handle the patients' emotions carefully whereby he means that he raises awareness towards the patients' feelings and reminds the facilitators to be attentive and responsive to those emotions. This is in line with Hochschild's (1983, p.147) statement that employers can "exercise a degree of control over the emotional activities of employees". Although employers can ask their employees to do emotional labour, the author argues that the extent to which emotional labour is performed and its quality also depends on the character and motivation of the individual, the expectations of the care-receiver and the situation given (Hochschild 1983, pp.148–153). The extent to which emotional labour is carried out by facilitators indeed seems to vary according to the patients' needs for care or their desire for autonomy respectively, the facilitators' attitudes and presumed attachment to the patients and the situational context.

The second approach towards emotional aspects involved in care work draws on Lynch and McLaughlin (1995) that differentiate 'caring *for'* and 'caring *about'*. As introduced in Subchapter 3.2, the authors conceptualise 'caring *for'* as "catering for the material and other general well-being of the one receiving care" (Lynch & McLaughlin 1995, p.256). This dimension of caring has already been discussed in Section 6.5.3 that scrutinises several practices carried out by facilitators to care for the patients' general well-being. As emotional aspects of caring and the facilitator-patient relationship are central in Chapter 7, the dimension of 'caring *about'* is reintroduced as useful conceptualisation to discuss the findings of this Chapter. 'Caring *about'* is understood as "having affection and concern for the other and working on the relationship between the self and the other to ensure the development of the bond" (Lynch & McLaughlin 1995, pp.256–257). Concern as an essential element of 'caring *about'* is explicitly articulated by medical travel facilitators. They express concern about the patients they serve by showing interest in their person, by being worried about their well-being, by taking responsibility and by getting themselves involved in caring about the patients. As Subchapter 7.2 pointed out, facilitators are actively working on their relationship with the patients and make considerable efforts in strengthening the bond during the patients' stay in Delhi, which is another criteria of 'caring *about'*. The most critical aspect to evaluate however is 'having affection'. Several statements and work performances in the field express that facilitators do feel attached to their patients and enter into close and loving relationships that reflect affection felt from the facilitators' side as well as from the patients' side. A sense of being like a family features prominently in

the facilitators' statements and the ways facilitators and patients act towards another observed in the field supports this sense of friendship and familiarity. Hence, these articulations and expressions are considered as strong indications towards authentic sympathy and affection felt by facilitators. Nevertheless, how facilitators actually feel about their patients and how much affection is involved in their relationships cannot be disclosed, only approximated. As the facilitators' engagement in 'caring *about'* is coupled with commodifiable forms of 'caring *for'* complicates the analysis as different rationales for caring and for building relationships are interplaying. Lynch and McLaughlin (1995, p.257) question "the extent to which 'caring about' itself can be developed within commodified 'caring for' relations". From the facilitators' narratives it can be argued that feelings of sympathy and personal attachment arise in the course of the close interactions with the patients resulting from commodified 'caring *for'* tasks. Such feelings of attachment can make facilitators care *about* their patients, which in turn reinforces the strengthening of a solidary bond.

The concept of love labour as third approach towards emotional aspects involved in care work, extends the scope of attachment of 'caring *about'* respectively the caring rationales of attachment and affection even further. Given the focus on tactics to nurture clients in Chapter 7 so as the conceptualisation of the facilitators' practices as emotional labour and surface-acting, it might seem inappropriate to speak about love in the context of medical travel facilitation. Nevertheless, departing from the conceptualisation of love labour it can be argued that facilitators who are caring about their patients engage also to a certain extent in love labour. Lynch and Walsh (2009, p.44) differentiate love labour from general forms of care work by conceptualising it as "not only a set of tasks, but a set of perspectives and orientations integrated with tasks" that "is undertaken through affection, commitment, attentiveness and the material investment of time, energy and resources" (Lynch & Walsh 2009, p.42). The facilitators' practices to care *about* their patients just outlined resonate with several aspects of this understanding. Considering patients as their friends or even as family members expresses a particular orientation towards the people facilitators care about and this orientation shapes the caring tasks performed by facilitators and the manner in which caring is carried out. The virtues of attentiveness, responsiveness and commitment are upheld by the interviewees and enacted in tailored service, quasi-permanent readiness to respond to the patients' desires, in the acts of advocating on the patients' behalf and devoted care. Being personally involved and permanently on call demands time and energy and other resources. Being emotionally attached, several facilitators report to invest money from their own pocket to enable the patients to access the needed treatments. As several statements of the interviewees showed, the bond that is established between facilitators and patients through such intense care can evoke a sense of belongingness to the patients and facilitators alike and mutual feelings of familiarity and also affection. Though many facilitators show attachment, devotion, commitment to care about their patients in an affectionate and loving manner, the intensity, intimacy and profoundness of the feelings involved remain undisclosed to a considerable extent.

7.4.2 Logics and issues of care work that unfold in the facilitator-patient relation

One of the logics that is fundamental for care work has not yet been discussed although the three empirical chapters (5, 6, 7) elaborated on it: "to care is to relate" (Jochimsen 2003, p.3) then care work always involves a relationship between the care-giver and the care-receiver, irrespective of the quality of the relationship and direct interactions between the two parties (Madörin 2009a), the facil-

itator-patient relationship. Chapter 7 showed that building relationships is a core task of facilitators. To excel in care work proves to be a successful strategy of medical travel facilitators in Delhi to do so. As indicated by Madörin, the quality of facilitator-patient relationships is variable and as argued in the former discussion section the quality can differ with respect to the attachment and affection brought in by the care-giver and care-receiver. From the insights gained at the IMTJ Medical Travel Summit in London in April 2015 and the interviewees' perceptions of other facilitation models, it can be argued that the facilitator-patient relationship in Delhi is of a special quality in international comparison and excels particularly in the extent of care work in which facilitators engage. There seem to be other facilitation models practiced around the globe that do not require face-to-face interaction let alone care work. These models are more about linking and connecting people but are not designed to build long-term relationships.

Another logic that Stingelin et al. (2012) discuss is the limited replaceability of care workers. Following this line of reasoning that care work always involves a personal relationship, it seems obvious that it is difficult to replace the care-giver due to the personal bond established between the care-giver and the care-receiver (Stingelin et al. 2012, p.10). When asked about the internal division of responsibilities within medical travel companies, most of the interviewees say that each patient is assigned to a facilitator who is personally in charge of him or her. As a result of this, the people involved are likely to build relationships that are even compared to close relationships among family members. Patients thus expect to be assisted by the same person when returning to Delhi for follow-up care and it is difficult to replace facilitators, as it is typical for care work. The example of Kamal in Subchapter 6.4 shows that the patient wonders why 'his' facilitator is not guiding him that day in the hospital. But as the patient already knows Tariq from his former visits in Delhi, he can relate to him as well. In particular situations, the facilitator seems to be replaceable but the interviewees argue that it is not conductive to building trust and long-term relationships.

Another logic of care work introduced by Madörin (2009a, p.67) that has been touched upon in Subchapter 7.3 is the imbalance of power that leads to dependency and responsibility. The analysis of relational geometries in which power within the facilitator-patient relationship is negotiated can be integrated into the power framework of care work. Jochimsen (2003, p.21) distinguishes between different kinds of power that shape the power structures in care-relations. That power is constituted in physical capabilities featured in the data in the sense that international patients' agency is limited because of their mental and emotional state. Jochimsen (2003) argues that another kind of power in care-relations is constituted by skills. In the given context, medical travel facilitators are empowered with skills in the sense that they have the knowledge, the know-how and the necessary network connections to care for and about international patients. That power manifests in resources applied to facilitators and patients alike. Patients need to have financial resources to undertake medical travel and purchase the service of facilitators (though indirectly). On the other hand, facilitators invest considerable amounts of resources in satisfying their clients such as manpower, time, money (e.g. spent on inviting patients to dinner, booking short trips or buying presents) and emotions that could also be considered as invested resources. That power is likewise constituted by moral values and motivations and can be linked to the rationale of helping people articulated by the interviewees.

7.4.3 Commodification of care work in medical travel facilitation

As medical travel facilitators get paid for the facilitation service they provide to international patients the care work they carry out can generally be seen as commodified and exchanged in a setting of commercial service provision. Nevertheless, dimensions of emotional care work and especially the facilitators' efforts in caring *about* their patients can be related to debates about the extent to which such forms of care work can be commodified and about the consequences on the quality of care work carried out.

The myriad tasks comprised by care work are commodifiable to different extents (Lynch et al. 2007; Yeates 2004; Folbre & Nelson 2000; Hochschild 1983). Based on Lynch and McLaughlin (1995), 'caring *for*' tasks carried out by facilitators can be commodified and exchanged as commercial facilitation service. The efforts made to 'caring *about*' international patients though require feelings and emotions that are non-commodifiable. Lynch and McLaughlin (1995, pp.260–261) state: "intentions and feelings of others cannot be commodified; one cannot commodify the quality of a relationship". Facilitators who get attached to their patients and develop relationships based on friendship engage in caring activities similar to those rendered by friends and family members in private spheres that are not for profit but personally motivated. As shown in the data, facilitators get attached in the course of caring for their patients, which illuminates that "commodified 'caring for' tasks may yet permit the development of 'caring about' at least sometimes and to some extent" (Lynch & McLaughlin 1995, p.257). Although the relation between facilitators and patients is framed by commercial service provision, solidary bonds can evolve that reshape the caring practices and renegotiates the underlying rationales.

The ways in which facilitators articulate and negotiate business strategy and authentic sympathy as driving rationales for caring for respectively caring about international patients can be linked to debates revolving around conflicting rationales in care work. In the article "For Love or Money – or both?", Folbre and Nelson (2000, p.123) bring together "the world of money and profit and the world of care and concern". These worlds are also brought together by the facilitators' practices. In the interviewees statements, business strategy and authentic sympathy both feature as rationales for carrying out care work and for building close relationships. The dichotomous representation of the motives for doing care work in the sense that "one works either for love or for money – that is, out of spiritual values, affection, and altruism, or out of crass materialism, self-interest, and greed" (Folbre & Nelson 2000, p.131) is critically evaluated by the authors. They elaborate on the expectation that someone who is involved in care work motivated by ideals of charity and altruism should not demand money for the work carried out as the person is rewarded with personal fulfilment and satisfaction (Folbre & Nelson 2000, p.132). This logic can help to explain the facilitators' practice to de-articulate a commercial context with regard to their patients. As they do not charge their patients directly, the impression of altruistically motivated help to people in need, personal concern and moral values is promoted. Financial incentives that are considered as compromising the quality of the care work and the relationship that evolves are thereby obscured. However, the facilitators seem to deconstruct the dichotomy by articulating strategy and sympathy not as exclusive rationales but as coexisting ones. Folbre and Nelson (2000, p.133) arrive at the same conclusion and argue that external motivations like money do not necessarily undermine intrinsic motivation or caring feelings. The authors state that it cannot be argued per se "that markets must severely degrade caring work by replacing motivations of altruism with self-interest" (Folbre & Nelson 2000, p.124). Accordingly, care work carried out by facilitators in a commercial context does not necessarily compromise the

quality of care work carried out. That facilitators are making considerable efforts to make patients feel comfortable by caring for them seems to be beneficial to both parties: International patients are being well cared for and supported in their needs and wishes and at the same time medical travel facilitators can generate business with these practices.
As stated by Schwiter (2013, p.500), care practices and relationships "blur the boundaries between private and public spheres, between formal and informal labour". Such blurred boundaries apply to medical travel facilitation as the facilitators' care practices range from for-profit care service to informal companionship and their relationships can take different forms ranging from business connection to solidary bonds of friendship.

7.4.4 Geographical implications of the facilitator-patient relationship

Two aspects of the facilitator-patient relationship and the power of word-of-mouth that have spatial implications are chosen to be discussed. The first phenomenon is the circulation of emotions and the second one draws on the 'chains' in care work and medical travel.
Emotions seem to play a crucial role in building a relationship between facilitators and patients and also in promoting medical travel through word-of-mouth. The facilitators' tactics to deliver a fabulous medical travel experience to their patients, which they will most probably share with their families and friends back home, seems to make use of the circulation and stickiness of emotions as elaborated by Ahmed (2012). Facilitators try to evoke particularly positive experiences and emotions that 'stick' to the international patients who experienced them. When these patients return to their countries, the emotions come with them. In this way, emotions move within space, become transnational themselves, are shared with and transmitted to other people and start circulating within communities. Drawing on Bondi et al.'s (2005, p.3) account on emotions as "socio-spatial mediation" it can be argued that patients' testimonials mediate social and spatial distance between prospective clients and medical travel facilitators and bring them closer together by sharing experiences and emotions. Thus, it seems that the facilitators in Delhi recognised emotions as a powerful tool to promote their work.
Studying global care chains (Hochschild 2000) reveals geographical implications of care work by tracing mobility patterns of care workers and globally spanned linkages of people involved in caregiving and care-receiving. Such care chains "usually start in poor countries and end in a rich one" (Hochschild 2000, p.131) and people looking for jobs as care givers move along these chains. In the context of medical travel facilitation chains this also matters but they are constituted differently and have other implications. Facilitators talk about referral-chains with regard to people being mobilised through word-of-mouth that is transmitted from one person to another. Along these chains constituted by people linked through the recommendation of facilitators' patients, seeking care becomes mobile. Thus the mobility pattern and the purpose seem to be reversed compared to global care chains. Following Hochschild's (2000, p.131) conceptualisation, medical travel facilitation opens up another field to study personal linkages between people in space based on seeking (medical) care abroad.

8 Synthesis and final discussion: re-assembling practice and integrating care

By means of de-assembling practice into three dimensions, different aspects of the work practices of medical travel facilitators in Delhi could be scrutinised and a broad variety of themes could be examined, clarified and illuminated from different angles. This final discussion condenses the key points of the answers to the research questions of this thesis (8.1) and re-assembles the practice dimensions of perception, performance and power relation to collect and reorganise the knowledge gained and to reveal how the three dimensions of practice mutually enrich and reinforce each other (8.2).

8.1 Answering the research questions

The four research questions have been addressed and answered throughout this thesis so far as possible on the basis of the data gathered. Although all three empirical chapters (5, 6, 7) contribute to the answers of the research questions, each of the chapters is specifically devoted to one of the first three questions. The fourth question is addressed in all three empirical chapters.

I) How do medical travel facilitators in Delhi understand their work?

This question has been approached on the basis of the *perception* dimension of practice to bring out the facilitators' understanding of their work more clearly. To reveal the rationales underlying their conceptualisations of medical travel facilitation two indicators were studied: Firstly, how they position themselves with regard to other medical travel intermediaries like agents and touts, namely as being a more organised actor pursuing ethical practices and working in favour of their patients. Secondly, how they articulate a market niche based on their perception of international medical travellers and conditions that shape the medical travel market in Delhi. International patients are articulated as vulnerable and helpless and the unfathomable chaotic setting as complicating their difficulties in accessing healthcare abroad successfully, which is why they need the assistance of medical travel facilitators. The perception of the international patients is considered as particularly influential to the facilitators' understanding of their work and therefore it is argued that the conceptualisations vary depending on the facilitators' clientele.

Different ways of how facilitators understand their work could be identified. The interviewees' most prevalent way of understanding their work is as commercial service provision. The understanding as mediating patients is closely entwined with the conceptualisation as service provision in terms of constituting the basic form of facilitation service. Helping people and advocating on the patients' behalf are two other ways to conceptualise the facilitators' work that point towards particular rationales and work ethics. The interviewees convey personal and moral motivations for helping and functioning as patient advocates and express concern, commitment, sympathy and responsibility. Con-

cepts of caring and care work are thus implicitly anchored in these understandings of the facilitators' work. Although caring can be intrinsically motivated and practiced in private and non-profit settings, care work can also be a form of commercial service. In this sense, helping and advocating can be considered as a specifications of commercial service provision. Another way the interviewees understand their work is coupled with the rationale to contribute to an improvement of the healthcare provision in the patients' source countries and working on the issues apparent in the medical travel business in Delhi. These objectives lead to additional areas of business in which medical travel facilitators are involved apart from the assistance of patients in Delhi.
The different understandings of the facilitators' work overlap. The prevalence of different rationales shaping the facilitators' understanding varies and different combinations of motivations are possible. Furthermore it is argued that the facilitators' understandings indicate certain manners in which they carry out their work.

II) How do medical travel facilitators in Delhi perform their work in daily practice?

This second question has been approached on the basis of the *performance* dimension of practice to bring out the multitude of tasks, activities, doings and duties that medical travel facilitators enact in everyday work. The articulation of such performances in the interviews and observation field notes gave insights into three main areas that constitute the facilitators' work.
The first set of performed practices contributes to the creation of an operational set-up structure in the background, which is a precondition to successfully engage in medical travel facilitation and especially to relate to patients. Attaining knowledge is a relevant practice to develop business strategies and to tailor a service that meets the patients' needs. The establishment of network connections with partners in Delhi and abroad is another important practice. In Delhi facilitators mainly connect with healthcare providers whereby doctors and people from the marketing department are the main contacts. Linkages with so-called channel partners in the patients' home countries are established. This set of practices enables facilitators to operate in transnational healthcare and contribute to an ideal setting to relate to international patients.
The second set of practices performed by medical travel facilitators consists in strategic manoeuvres to mobilise patients towards the Indian healthcare market. The main challenges are to get in touch with prospective clients and to build trust. To overcome these difficulties three strategies were identified: Firstly, patients are mobilised by having convinced them directly via webpage and query response ('direct patient mobilisation'). Secondly by interposing channel-partners in the patients' home countries who can convince patients to seek treatment in Delhi and refer them to the associated facilitators ('channel partner mobilisation'). Thirdly by convincing patients on site in Delhi to such an extent that they give positive testimonials and mobilise their friends and family via word-of-mouth towards their facilitators ('patient testimonial mobilisation'). The second and third strategy are articulated as being the most promising ones to facilitators as they can 'outsource' the trust-building process to people in the social and spatial environment of the prospective clients.
The third set of work performances is dedicated to rendering assistance to international patients before, during and after their medical stay in Delhi. This set of practices can be conceptualised as care work both in a narrow and in a wider sense. Facilitators are involved in the direct care of the patients and in supportive services that provide the precondition for this type of care. The most prevalent

activities consist in counselling, decision-making, coordination, guidance, translation, negotiation, culture brokering, advocating, providing emotional support and companionship. Thus, medical travel facilitators excel in a comprehensive all-round service and cover a broad range of services ranging from organising medical treatment on site to buying fruit at the market. The facilitators' performance expresses their outstanding disposition to do whatever, whenever and wherever required. The manner in which the facilitators carry out their work can be best described with adjectives such as attentive, responsive, responsible, comprehensive, extensive, devoted, committed, solicitous and caring but also patronising, manipulative and calculating.

III) How do medical travel facilitators in Delhi relate to the international patients that they serve?

This third question has been approached on the basis of the *power relations* dimension of practice. One of two ways in which power manifests in practice according to the practice-oriented approach applied is in the facilitators' strategies and tactics to relate to patients and to build relationships.
The preconditions for relating to patients respectively for establishing the first contact with prospective clients consist in the creation of an operational set-up and the mobilisation of patients towards the Indian healthcare market, i.e. the first and second set of practices outlined above. Hence, these practices complement the answer to this question.
Once the first contact is established and the patients are on site in Delhi, facilitators relate to them in a way that is conducive for their business. Nurturing their clients is articulated as being part of the facilitators' tactic to ensure that they give positive testimonials, which enhance further business. Three tactics could be identified that strengthen the relationship between facilitators and patients. Firstly, facilitators strive to delight the patients with their comprehensive service and by surprising them with unexpected treats and gifts. Secondly, facilitators deconstruct a commercial context by emphasising that they do not charge patients for their service but advocate for cost reductions on their behalf. Like this, facilitators build trust with the patients and counteract their apprehension of being cheated or overpriced. Although some patients know that facilitators receive a commission for referring international patients to hospitals, the financial model is obscured. A third way to nurture clients and to build close and trustful relationships is to provide emotional support to the patients by demonstrating concern, care and sympathy. The facilitators want to make their patients feel comfortable and well cared for by expressing gestures and words of comfort, standing by the patients' side in difficult situations, encouraging them and offering support at any time and at any location. In this sense, facilitators relate to their patients as caring companions.
The reasons why facilitators relate to their patients in such a particular way have been questioned. Business strategy and authentic sympathy were discussed as rationales. Building close relationships is articulated by the interviewees as part of their tactic in which power unfolds in the sense that the facilitators' practices are not only performed to render a service, they are performed in an explicit manner to meet the target of expanding business. Nevertheless, facilitators also express their personal attachment, concern, and sympathy as motivation to care *for* and to care *about* their patients in an affectionate and devoted manner. Many facilitators invest themselves personally in the relationship with their patients and say that they care about them as if they were their own family members. The often articulated dichotomy between cold economy and benevolent lifeworld seems to be dissolving

in the enacted practices of medical travel facilitators that show that the rationales of business strategy and authentic sympathy are not exclusive but intertwined, whereby the boundaries get blurred.
The second way in which power manifests in practice according to the practice-oriented approach applied is in the facilitator-patient constellation which is characterised by mutual dependencies and shifting agencies. The relational geometries in which the relationship is embedded are reconfigured by social and economic practices that induce ambivalent positionalities and shape the opportunities of facilitators and patients alike. International patients are to a large extent at the mercy of their facilitators who take the agency in facilitating them throughout the course of their medical travel endeavour. Nevertheless, the facilitators' agency is restrained by the business context in which word-of-mouth works as a powerful corrective of unethical practices. Hence, agency can be ascribed to patients in the sense that their testimonials have impact on the facilitators' reputation and consequently on their business.

IV) In what sense does the work of medical travel facilitators in Delhi comprise care work?

This fourth research question has been addressed in all three dimensions of practice. Care work is in itself a complex concept and has therefore been approached by looking at different conceptualisations, purposes and dimensions of care work, characteristic logics or issues. Care work turned out to be a useful concept to discuss the facilitators' work as actually most of their practices comprise aspects of care work or can be conceptualised as such. To what extent or in what particular sense the facilitators' practices can be understood as care work or which tasks or issues can be taken as symptomatic for care work has been described in detail in the discussion sections of the empirical chapters.
The purpose of the facilitators' work is seen as providing a service to help and support international patients practically and emotionally in order to meet their medical needs. Thus, accessing direct medical care can be seen as the overall purpose of medical travel facilitation. Consequently, the broad range of practices in which facilitators engage can be considered as indirect form of care work according to Razavi (2007) because they constitute the necessary preconditions for direct medical care. The facilitators' engagement in care work can be seen as a response to how they observe, experience and interpret the care needs of international patients (England & Folbre 1999). The manner in which facilitators care for their patients meet the virtues of attentiveness, responsiveness and respect emphasised by Engster (2005) and can be complemented by commitment and emotional engagement brought up by Lynch and Walsh (2009).
Furthermore, the work of medical travel facilitators comprises the relevant dimensions of care work according to Lynch and Walsh (2009), which are emotional work, mental work, cognitive work, physical work and moral commitment. Facilitators seem to be particularly strong in the cognitive dimension of care work in the sense of discovering the patients' needs, in the mental dimension in the sense of being attentive and far-seeing, and in the emotional dimension in the sense of comforting and encouraging their patients. Thus facilitators carry out emotional labour as conceptualised by Hochschild (1979). In the course of caring for their patients and interacting closely with them, facilitators report to get emotionally attached to their patients. Thus, it can be argued that facilitators not only care *for* the general well-being of their patients but also care *about* their patients in an affectionate manner as differentiated by Lynch and McLaughlin (1995). Caring *about* includes furthermore the involvement of the care-giver in building a bond with the recipient, which is an essential

part of the facilitators' work. Jochimsen's (2003) conceptualisation of care work as (consciously) building relationships is thus very well in line with the facilitators' practices of caring about their patients. In this sense to care is a way to relate, to build trust and to nurture patients. Economic and social rationales have been discussed as underlying the facilitators' efforts in building such personal relationships.

As the facilitators' practices correspond with several conceptualisations of care work, it can be argued that the facilitators' work not only *comprises* several forms and dimensions of care work but that the facilitators' work *is* care work. Nevertheless, such an ascription is intricate given the elusiveness of care work as a concept. Irrespective of whether the facilitators' work is considered to *be* care work or to *comprise* care work to a large extent, linking the facilitators' work to care work offers a new angle for looking at medical travel facilitation. On the one hand, care work offers a conceptual framework to study particular characteristics, logics and issues related to the facilitators' work. Particularities and issues associated with working conditions typical for care work (e.g. an elusive scope of responsibilities, variable working hours, the requirement of being on call, the demand for personal commitment) are also significant for the facilitators' work. Embedding the power relations between facilitators and patients into a context of care work illuminates tensions resulting from uneven distribution of resources, knowledge and abilities between the care-giver and the care-receiver. On the other hand, medical travel facilitation offers a new context for theorising care work. Debates revolving around care work can be enriched with the experiences made by healthcare facilitators. Discussions about the (non-) commodifiable nature of certain aspects of care work and the consequences of carrying out care work in a commercial setting can be carried on in the context of medical travel facilitation. The linkage of care work and medical travel facilitation generates new insights, but also raises further questions (see Subchapter 8.3).

8.2 Re-assembling the dimensions of practice

The epistemological approach of Jones and Murphy (2010) operationalized different practice dimensions to study. Now that the key messages of the findings gathered by examining the three dimensions of perception, performance and power relations have been summarised, it is time to re-assemble the dimensions to see how they are mutually complementing and enriching for practice.

The main contribution of the practice dimension of perception is to bring out how facilitators perceive the clients that they serve, their line of reasoning to articulate a market niche and the prevalent ways of how facilitators understand their work. The understandings of their work as providing a service, mediating, helping and advocating are mirrored in the everyday work performances, the range of responsibilities taken over and in their attitudes towards their work. The dimension of performance in turn enriches the conceptualisation of the facilitators' work by illustrating what it means to provide a medical travel facilitation service, to mediate doctors and patients, to help medical travellers and to advocate on their behalf. Based on the insights from the dimension of performance, some additional tasks or specialisations that do not explicitly feature in the facilitator's understanding of their work can be identified. Practices of counselling and decision making, of inter-cultural mediation and – in particular – of care work became particularly evident by looking at the facilitator's everyday work performances. In addition, attitudes and work ethics associated with the facilita-

tors' understanding of their work as service providers, helping or advocating are mirrored in the facilitators' daily practices (e.g. efforts made to delight patients, commitment and personal involvement, actively fighting for cost reductions). Furthermore, the practice dimension of perception pointed out that facilitators are not only involved in assisting patients but engage in several other lines of business.

The main contribution of the practice dimension of performance apart from supplementing the insights won from the perception dimension is to illustrate in a subtle manner how power unfolds in their daily practices. The necessity of performing mobilisation strategies indicates that facilitators counteract their dependency on the patients' agency to decide whether to make use of their facilitation service or not. In the implementation of trust-building and mobilisation strategies, power is enacted in the sense that these strategies influence the patients' choices. The dimension of power relations in turn contributes to conceptualise the facilitators' practices not only as mere work performance, but also as tactic. Questioning the intention articulated with which everyday practices are carried out can enhance other lines of reasoning to explain the kind of work performances carried out and why they are carried out in a particular manner. It can be argued that the comprehensiveness of the facilitators' service can be explained firstly as a response to the multi-dimensional needs of medical travellers and secondly as the realisation of a strategy to enhance further business.

It can be added that a power sensitive perspective can critically evaluate the way that actors perceive themselves and others. The facilitators' articulation of international patients as being helpless and vulnerable simultaneously articulates power, ascribes agency to facilitators and suggests the dependency of medical travellers on their assistance. Similarly, in the facilitators' understanding of their work as helping or advocating power unfolds in the sense that they ascribe agency to the person who is helping or advocating and dependency to the person who is being helped or advocated for.

The analytical detachment of the perception, performance and power dimension of practice is – of course – dissolved in reality where the dimensions are assembled and together constitute *practice*. Kjellberg and Helgesson's (2006, p.854) conceptualisation of performativity as "a process of translation that links practices appearing as ideas to practices appearing as a world out there" helps to reassemble the dimension of perception and the dimension of performance. A process of translation links the facilitators' work understanding and the everyday work performance. This means that the facilitators' understanding of their work influences the way the work is carried out in everyday performance and vice versa. The work performances also influence the way facilitators understand their work. Thinking about their daily practices, issues and past experiences reshapes the facilitators' understanding. The different dimensions of practice, including power, are interrelated and mutually influential in permanent exchange to rework practice.

What is more, practice is embedded in time and space. Jones and Murphy (2010, p.384) point out that through space "practices can be unpacked, interpreted, and reassembled in ways that reveal their meaning for and influence on socioeconomic outcome". The way the interviewees include space in their practices indicate that they see their practices and the socioeconomic outcome as closely intertwined with the spatial conditions. The facilitators adapt their practices to the local spatial setting of Delhi as a city with material and social components and as a medical travel destination that is formed by social, economic and political practices. They are attentive to the people who assemble in Delhi, the practices and strategies of other actors operating on site or the challenges posed by the locality. Thus space has explanatory weight for the practices of medical travel facilitators, their strategies and the range of services they provide. By comparing their facilitation model to those

working in other countries the interviewees express that they see their practices as having a particular local expression. Through their practices, medical travel facilitators establish links that connect and relate people situated in different places throughout the world, they span networks with partners and patients and bring people together in Delhi that would not have been connected without the facilitators' work. The socioeconomic outcome of the facilitators' engagement in medical travel is thus their contribution to bringing transnational healthcare into being. They build bridges between patients and healthcare providers, they establish links and channels along which patients become mobile and they provide the service to overcome the difficulties that both parties would have in accessing each other.

8.3 Critical appraisal of the findings and approaches

Key contribution to the current state of the art

One of the main contributions of this study to the current state of the art results from the geographical focus upon Delhi as a medical travel destination that is mainly situated in South-South medical travel. This study contrasts with the prevalent image of the Western medical traveller and contributes by bringing international patients coming from the Global South into focus. The facilitators' perception of their clients gives insight into the reasons why these people seek medical treatment abroad and what specific needs they have towards a healthcare facilitator. The reasons for people from the Global South to seek healthcare abroad differ considerably from those that drive Western medical travellers. The main reason why they become medical travellers is that they do not have the opportunity to access good quality healthcare in their countries because it is quasi non-existent. Language barriers, inexperienced travellers, poor diagnoses, cultural issues or budget constraints require special attention from the facilitators' side.

By interviewing practitioners directly, the opportunity was given to them to express their views. Such first-hand information on how the interviewees see themselves, their work and setting and on the subjects that matter to them, gives new insights into their perceptions, opinions and value systems. The facilitators' sensitivity to a particular terminology, the way they refer to and position themselves can prompt researchers to rethink the connotations of the terms used in academic literature and to distinguish kinds of actors and models of medical travel facilitation. However, the approach can be criticised for focusing solely on the facilitators' self-representation. Complementing the study with outside views upon the facilitators' work by interviewing channel partners, staff from the hospital marketing services, doctors or patients who are in close interaction could throw light on other facets of the facilitators' work and on their relationship with these people.

The detailed description of the broad scope of the practices of medical travel facilitators offers a valuable contribution to the current state of the art by illustrating and substantiating the tasks, roles and responsibilities that have already been identified and by introducing additional practices. Their function as patient advocate or in particular their roles as companion or care-giver, which are identified as core tasks of the facilitators in Delhi, deserve to be integrated into the conceptualisation of the facilitators' work. Drawing on these findings the study points out that the facilitators' work is not only about linking and connecting, it is actually more about establishing relationships. To conceptualise facilitators as intermediaries thus leaves out relevant components of their work. On the other

hand, this study is also limited in that the relationship that facilitators build with network partners was touched upon only marginally.

The finding that medical travel facilitators are involved in practices other than just the assistance of patients, for example in trade with medical equipment or in telemedicine, in conjoint organisations of marketing events with hospitals or in forming associations that work on ethical standards, points out new fields of activities in which medical travel facilitators are engaged. Such additional lines of business broaden the understanding of facilitators as economic actors and indicate that they influence the socio-economic outcome of transnational healthcare in multiple ways.

The facilitators' concern with rendering 'fabulous experiences' and establishing personal relationships with patients for the purpose of enhancing positive word-of-mouth shifts the focus away from web-based marketing strategies. Word-of-mouth is considered to be more effective in reaching prospective clients than web-promotion.

This study focused primarily on the practices of patient assistance on site. As these practices are carried out similarly by self-employed facilitators and facilitators of medical travel companies, the differences in their practices could not be pointed out specifically. A focus on the strategies to build network connections with partners and on the involvement in other lines of business is expected to bring out the differences between these types of facilitators more clearly.

Key contribution of linking the concept of care work to medical travel facilitation

The conceptual framework of care work provides a new angle to look at the work of medical travel facilitator's. As the discussion of the fourth research question showed, care work can be linked to the practices of medical travel facilitators in several ways and thus provides a valuable framework to analyse the facilitators' practices in detail. The concept of care work furthermore points towards specific care work related issues and phenomena that are insightful also in a medical travel context.

The elusive definitions of what exactly comprises care work leads to the difficulties in determining the facilitators' tasks. Facilitators seem to do whatever they feel is necessary or helpful or whatever their patients demand. The seemingly boundless care responsibility raises questions about how the workers themselves negotiate the expectations towards their service and its feasibility. It would be interesting to know what medical travel facilitators see as the limits of their responsibility, how they articulate, enact, and negotiate them. To be permanently on call, having great responsibility and being involved in emotional issues can be perceived as stressful work conditions and compromise the care-workers quality of life. This issue, which is acknowledged for care work, could become relevant for facilitators as well. Most of them seem to loose themselves in their work and it would be interesting to know how they manage to merge their work with other aspects of life.

The concept of care furthermore raises question about moral obligations, social responsibility towards fellow human beings, sympathy and compassion and how such feelings and obligations are negotiated in a commercial context. The question of what tasks the facilitators' work comprises and what it does not include can be linked to these thoughts about the scope of care responsibility that impacts facilitators as human beings and as economic actors. From this study it can be said that economic rationales as well as personal motives drive the facilitators' involvement in care work. Some authors argue that carrying out care work for money compromises the quality of care offered to the care-receiver and the quality of the relationship between the care-giver and the care-receiver. Although the facilitator-patient relationship is embedded in power structures, which are further complicated by dependencies resulting from care work, it seems that international patients benefit from

being cared for by facilitators. However, further research could illuminate some additional logics and mechanisms that have not yet been revealed.

Another starting point to link the facilitators' work with a prevalent debate on care work is the debate of global care chains and as a consequence thereof particular mobility patterns. Whereby the caregiver becomes mobile in the context of global care chains and often moves from the Global South to the Global North, the actor who becomes mobile and also partly the direction of the movement seems to be reversed in the medical travel context. In the case of Delhi, patients from the Global North, though to a limited extent, and patients from the Global South travel to India. The patients themselves become mobile and actively approach the care-giver to seek assistance. The global care chain model looks at a chain built by care-givers located in different countries caring for the families and people in need left behind. The 'chains' in the medical travel facilitation context consist of referral-chains, which mean the linkage of people though the recommendation of facilitators and correspondingly care workers. Up to now there is little known about such referral-chains in the context of medical travel facilitation and it would be interesting to examine the social and geographic extent of these chains, mobility patterns that are induced, and what and how information is transmitted along referral-chains.

The conceptual framework of care work also shows limitations and leads to tensions that should be critically assessed. Whereby the concept of care work provides a valuable framework to analyse the facilitators' practices of assisting international patients in Delhi, it shows limitations regarding other aspects of their work. To analyse the facilitators' practices in building an operational set-up and how they relate to other stakeholders than patients some other conceptual approaches would be beneficial. Furthermore the ambiguity regarding definitions and approaches to care work poses difficulties for applying the conceptual framework. Especially the relevance of emotions and feelings involved in care work, which are difficult to research and interpret, lead to uncertainties. Although such uncertainties cannot be eliminated, further research on the emotional dimension of care work would foster a better understanding of the subject matter and also of how to deal with uncertainties.

Key contribution of a relational and practice-oriented approach

A relational economic geography perspective could be well integrated in the practice-oriented approach and proved to be valuable for identifying economic and social relations and relationships and their relevance for economic outcomes. As interpersonal relationships are an important subject of study in care work, this perspective was helpful to point out characteristics of the facilitator-patient relationship in this conceptual framework and to illustrate spatial dimensions of care relations.

A practice-oriented approach is useful to gain knowledge about the contribution of medical travel facilitators as an economic actor that has not yet been thoroughly studied and its contribution to the relatively new industry of medical travel facilitation. The approach is valuable, as a broad knowledge about the scope of activities and tasks can be gained which has not yet been delineated in the case of facilitators operating at the medical travel destination site in the Global South. As discussed before in Subchapter 8.2, the analysis of different analytical dimensions of practice allows researchers to examine the conceptualisations and ideas of practices, the performances in daily practice and some underlying mechanisms and structures approximating power that are entwined with practice. Nevertheless, one can argue that a micro-scale practice-oriented approach neglects the broader scale, which makes it difficult to link the findings with large-scale economic practices.

9 Conclusion

This master's thesis scrutinised the work of medical travel facilitators in Delhi. The superordinate finding and contribution of this study is that the work of medical travel facilitators in Delhi can be linked to the conceptual framework of care work: Care work is anchored in the facilitators' understanding of their work, care work is practiced in the facilitators' everyday work performance and care work is conducive to establishing relationships with international patients. The relevance of care for the work of medical travel facilitators in Delhi is reflected in the following four key findings of this thesis.

The first key finding is that medical travel facilitators understand their work mainly as providing a comprehensive and individualised service that enables and supports international patients in successfully accessing medical care in Delhi. This understanding draws on the facilitators' perception of international patients as vulnerable and helpless, facing considerable difficulties when undertaking medical travel to Delhi. Helping these people and advocating on their behalf are articulated as rationales for providing a facilitation service that includes extensive support at the medical travel destination site. The facilitators' understanding of their work implicitly points towards care work in the sense of providing a service that responds in an attentive and committed manner to the needs of international patients for the purpose of enhancing their physical and emotional well-being. As the facilitators' services are tailored specifically to the needs of the clientele served in Delhi, it is argued that the facilitation model is locally embedded and designed for a particular type of international patients traveling to the respective destination.

The second key finding is that the work of medical travel facilitators located at the destination site consists of business development and patient assistance whereby a broad spectrum of tasks and duties are carried out which can be conceptualised as care work. The facilitators endeavour to assist their patients throughout all steps before, during and after their medical journey. The most prevalent practices to care *for* the general well-being of international patients consist of counselling, decision-making, coordination, guidance, translation, negotiation, cultural brokering and advocating, so as being comforting and encouraging to patients. These tasks can be ascribed to different dimensions of care work, for example to the dimensions of physical, mental, cognitive and emotional care work or to forms of direct and indirect care work. The attitudes expressed by the facilitators towards their work were outstanding. They show commitment and devotion by emphasising their readiness to care for each and every thing and to be available for their patients at any time. Based on these findings it is argued that particular logics and issues of care work are implied in the facilitators' work such as the vagueness of what facilitators are supposed to do and what is beyond their responsibility, the requirement of being permanently on call or the emotional involvement.

The third key finding is the relevance of linking, relating and establishing relationships for the facilitators' business. These practices range in the aspired strength, durability and intimacy and demand different resources, efforts and care work. Relating to new clients and establishing trust over distance poses a considerable challenge to facilitators. Particular strategies could be identified that facilitators employ to overcome this difficulty and establish the first contact. Firstly, attaining specific

knowledge about the patients' situations in their home and about their needs builds an important basis on which to relate to the patients. Facilitators invest considerable efforts and resources in gaining knowledge about the patients' background. The second strategy circumvents the difficulty of building trust over distance by 'outsourcing' the trust-building process to people close to patients who are prospective clients. For this purpose, facilitators establish channels with partners in the patients' source countries and maintain the relationships with former patients. The intention is that these partners and former patients establish the first contact with new clients and refer them to the facilitators with which they are associated. This strategy shows that word-of-mouth induced by patients returning to their countries constitutes an important promotion channel for medical travel facilitators. In order to enhance their business, facilitators try to ensure that their patients give positive testimonials and recommend their service to people in their communities. This study identified three main tactics with which facilitators try to win the hearts of their patients when they are on the destination site in Delhi. This in turn is conducive to being referred to as a trustworthy facilitator or caring companion to prospective clients: Firstly, facilitators strive to delight the patients with their encompassing service that is designed to exceed their expectations. Ensuring correct pricing is the second tactic that counteracts the patients' apprehensions of being overcharged. Thirdly, expressing concern and personal involvement nurtures the clients by establishing close relationships. The way the interviewees describe their relationships with the patients and the manner in which they interact with them as observed in the field suggests that facilitators become personally and emotionally attached to their patients in the course of caring for them in Delhi. As a result it can be argued that facilitators not only care *for* but also care *about* international patients in the sense of being concerned, having affectionate feelings and developing a personal bond with them. Conveying a sense of caring *about* the patients like a friend or family member would accomplish this as providing emotional support and signalling attachment are conducive in crafting relationships. As a close and trusting facilitator-patient relationship contributes to positive word-of-mouth that enhances the facilitators' future business, care work again comes into play, not only as a practice but also as a strategy.

The fourth key finding is that the way medical travel facilitators in Delhi convey their engagement in caring for and caring about international patients challenges the often-articulated dichotomy between cold economy and benevolent lifeworld. Facilitators carry out care work on a commercial basis in the sense of providing a service for money. Initiated by such commodified caring relations, personal relationships in the sense of solidary bonds of friendships can arise that involve engagement in caring *about*. Based on the data that indicates such personal involvement and attachment from the facilitators' side, it can be argued that facilitators carry out care work as economic actors but they also care *for* and care *about* international patients as social actors. These practices blend into each other. The ways in which the facilitators convey the rationales of authentically experienced sympathy and of business strategy regarding their caring efforts indicate that these rationales are not exclusive but often closely entwined. Thus the dichotomy between social and economic rationales, respectively between love and money to express it more pointedly, does not necessarily apply to the realities on the ground.

Based on the findings of this study it can be argued that medical travel facilitators contribute to bringing transnational healthcare markets into being by offering a comprehensive facilitation service that excels in caring for and caring about international patients. To further substantiate this argument more research on the scope and extent of care work provided by facilitators is needed so as to more fully understand the integration of their practices into the larger picture of transnational healthcare.

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11 Appendix

11.1 Transcription and quotation rules

Symbol	Symbol explanation	Meaning
(…)	round bracket with three dots	words or sentences left out (in the quote)
[ ]	square bracket	comment by the author for clarification
m-a-y-b-e	hyphenated word	hyphenation indicate emphasis on a word
erhm	short expression in italic	short pauses filled with audible non-words while thinking
(laughs)	round bracket with comment	comment on vocal expression
After waiting...	longer text section in italic	field notes

Table 2: Explanation of the transcription and quotation rules

11.2 Interview guide

I – Introduction

- Thank and introduction of myself and research project
- Info about interview (formalities, recording, confidential) - Do you agree with tape-recording?

II – General questions about the work of medical travel companies/ facilitators

- Could you please describe in your own words what ____ (company name/facilitator) does/do?
  definition of the company's function / field of activity
  history- how did business emerge? / motivation

→ attention to terminology!

- Can you describe the process from the beginning to the end when assisting ____ (client/patient/customer….) in detail?
  First contact (who, how, when, what) /how do people know about you
  before: preparation/ preliminary documents/ questions/ doubts
  during: tasks/ duties/ responsibilities/ in and out hospital
  after: follow-up/ maintain contact

- What business model do you follow?
  how earning money / paid by patient or hospital
  internal organisation

- How many employees do you have?
  jobs, duties / freelance or permanent employees
  medical staff / interpreter / tourism agents/ etc.
  background / education / qualification

- Who do you work with? Who are you associated with? (network partner)
  cooperation with people / institutions
  global / local
  contact/ relationship/ agreement
  link btw. people and places ((dis-)connection)

- How do you compete with other medical travel companies/facilitators?
  In what ways do you stand out from other companies?
  companies in Delhi /abroad
  strategies / specialisation / promotion / (dis-)advantages
  seals of quality / market control / regulation

III – perception of the clients /patients/ customers, similarities and differences

- Can you tell me about your ____ (clients, patients, customers…)?
  Individuals or groups
  nationality / language/ culture / background / education / travel experience

- How do the people know about you?
  Friend / word of mouth / promotion / internet / word-to-mouth / contact person

- Why do people come to Delhi for treatment?
  What is their situation (in their country)?
  healthcare facilities / technologies / training / prices / availability / quality

- What similarities and differences do you see between the situation in the country of origin of your ____ (clients, patients, customers…) and the situation in India?
  - their countries vs. Delhi
  - healthcare system / treatment/ quality/ availability /costs/ waiting time

- Can you describe the needs or wants of your ____ (clients, patients, customers…)?
  - Medicine: med. treatment / diagnosis / special care / consultation
    quality / price / trustworthiness / participation or tailored
  - Participation: tailored offer / complete arrangement / decision-making / travel
  - Location: geographical distance / culture / language / religion /
    infrastructure / political stability
  - Services: visa assistance / travel and accommodation / airport pick-up / presence on site / tourism
  - what else ____?

- How do you know about the ____ (clients, patients, customers…) needs and wants?
  - ask question / feedback form
  - (internal) studies / exchange with other facilitators

- Can you describe the questions or doubts that your ____ (clients, patients, customers…) have considering medical travel to Delhi?
  - questions / apprehensions
  - medicine / location/ services/ communication / culture / city
  - quality / hygiene / doctors credentials / costs / experience or evidence
  - rumours / stories

IV – practices of mobilisation and role as intermediary

- Can you describe how you get in touch with ____ (clients, patients, customers…)?
  How is the contact / communication?
  - mail / telephone / Skype / face-to-face conversation
  - ways to approach somebody/ rules of conduct
  - mutual understanding / misunderstanding
  - people involved in communication/ role of interpreters

- How do you build trust with ____ (clients, patients, customers…)?
  - difficulties / strategies
  - counteract doubts / apprehensions
  - convincing / reasoning/ promotion

- Can you describe the role of a medical travel company / facilitator in mobilising / convincing people to come to Delhi for medical treatment?
  What would happen if there are no medical travel companies / facilitators?
  - particular strategies/ promotion/ lines of reasoning
  - persuasive appeals / images / messages
  - difficulties without

- How do you perceive your position of being between ____ (clients, patients, customers…) and healthcare provider?
  - Most appropriate term: intermediary/ mediator/ facilitator/ agent/ broker
  - mediate/ negotiate between?
  - culture / language / religions
  - emotional aspects

V – end of the interview

- indicate end – would you like to add anything from your side?
- express thank / tell what happens now/ what do I do with data/ citation/ further contact

11.3 Personal declaration

I hereby declare that the submitted thesis is the result of my own, independent work. All external sources are explicitly acknowledged in the thesis.

_____