

Health and Borders Across Time and Cultures: China, India and the Indian Ocean Region Special Issue: Introduction

Beatriz Carrillo García, University of Sydney, and Devleena Ghosh, University of Technology, Sydney, guest editors

This special issue of *Portal* brings together papers examining the intersection of health and borders. In this analysis health is understood not only as the absence of illness, but also as knowledge, as a right, and as the pursuit of identity and self-transformation. Similarly, borders here are used as both physical and mental constructs. As Michael Pearson—in this issue—tells us, medical connections and exchanges have been a constant in human history. However, over the last few decades the process of globalisation, which has seen a growing number of people moving across national boundaries, has made medical exchanges and migrations not only more extensive but has also presented new challenges for the ways in which we understand and regulate public health, health rights, and identity. Charis Thomson (2011: 205) has described medical migrations as ‘part of the very fabric of the transnational world order,’ which she sees as the reason behind the current political but also theoretical importance of medical travel.

On the one hand, health has increasingly become a private good that can be sold and bought in the global market; while on the other hand, the right to be healthy is also increasingly being recognised not only as an inalienable human right but as a precondition to the fulfilment of all other rights. Grounded within the existing global

trade system and the inequalities that underpin it, the commercialisation of health services have presented national health systems around the world with both challenges and opportunities (Leng & Whittaker 2011). The commercialisation of health related 'goods' and the retreat of the modern state from this traditional area of intervention implies a certain inequity in the way in which such health 'goods' are distributed. The temptation for the corporatized health institutions of emerging economies to capitalise on state subsidised medical infrastructure to earn huge profits has been documented by many scholars (Godwin 2004, for example). According to them, such practices shift medical resources from the global south to the global north, creating an asymmetric dualistic system of healthcare where the poor are left to the care of traditional practitioners or inadequate public health services or have to eschew treatment altogether while the rich can afford the high-end medical technology and state-of-the-art infrastructure.

The articles in this special issue were originally presented at a workshop on Health and Borders in China, India and the Indian Ocean Region, organised at the University of Technology, Sydney (UTS) in October 2009. Both the workshop and this special issue represent a multidisciplinary effort that looks at health from a social science perspective through historical, socio-economic, and cultural approaches. They are also concerned with the health inequities across and within national borders, due to economic imperatives, changing technologies and environments. The articles in this special issue explore lessons learned and new ways of understanding health across international and internal borders, with specific reference to the cases of India, Australia, Hong Kong and China, Pakistan, and Thailand. They are concerned with three main themes:

- The triumph of biomedical practices over traditional medicines; and the incorporation of biomedical practices and technologies (under the premise that technology is value free) into traditional medicines, which have in turn undermined the practices of the latter.
- A recognition that medical migration can provide opportunities for vulnerable or less well-off social groups to access better care; while at the same time recognising that without appropriate planning and regulation the commercialisation of health services and human organs and tissue can actually be to the detriment of health care services for local populations.

- The ways in which medical tourism—and cosmetic surgery tourism in particular—represent part of a new makeover culture in which identity seeking (through bodily transformations) is tied up with economic imperatives and global health markets.

The special issue starts off with a historical account of the medical connections and exchanges that took place during the early modern world between Europe and Asia. Using the example of Portuguese Goa (nowadays the smallest state in India, but also the state with the highest income per capita in the country), Michael Pearson gives us a rich and detailed account of the context and nature of the medical exchanges that took place between the 15th and 18th centuries CE. Pearson's main argument is that during that early modern period—given the strong reliance of European medical texts on Latin, Arabic, Greek and Hebrew medical knowledge—there was much commonality in the medical practices recommended by European medical writers with those of the East, and no one system was perceived as being more effective than any other in curing disease.

Pearson does tell us, however, that some diseases were considered to be geographically determined, and they were thus thought to be curable only by using local medical knowledge. And yet the prevalence of some diseases across Asia and Europe spread the idea across Europe of potential universal remedies, which would eventually become the foundation of the early markets in medicinals (Cook 2011). For Pearson this was symptomatic of the rise of 'scientific' western medicine from the late eighteenth century, emerging in the context of western imperialism and mercantilism and which were to dramatically change medical relations between Europe and Asia where any notion of commonality was abandoned.

Pearson's article reminds us of the hierarchies of knowledge set up by post-Enlightenment philosophies which re-natured certain medical traditions (for example the transformation of the Arab physician Ibn Sinna into the Latin Avicenna) and purified the doubts out of Western scientific medicine, thereby creating hegemonic discourses of health and well-being that have dominated the world in the last century. For example, Isabelle Stengers, amongst others, have traced the exclusion of hypnotism as a 'medical' practice to two French commissions of 1784–1785, one headed by Lavoisier. Hypnosis was declared to be a product of the imagination, hence not science.

More than a century later Freud would also exclude hypnosis from his practice (Chertok & Stengers 1992).

Scholars such as Stengers (2000) argue that European science and medicine converted the narratives ('stories') of science into ones that are different from other stories because of the demand that 'inventions' become 'discoveries' that can be tested or are replicable in a laboratory. Thus medical science must submit to tests that cause health narratives to lose their fictive status and become detached from specific individuals and places. But, as the social studies of science and medicine have shown, such tests involve creating and stabilizing networks of social relations and practices. European medicine's faith in its own scientific objectivity thus led to certain experiences and ideas being privileged and others (especially those from non-European cultures) ignored or relegated to the realm of 'traditional' or 'alternative' medicine. European philosophies of knowledge therefore created and still reproduce a set of social relations and cognitive structures which shape current knowledge and the conditions of human existence (Stengers 2000).

Those discourses ring through Mary Garvey's paper, which outlines the issues faced by practitioners, educators and students of Chinese medicine in Australia. Garvey argues that Chinese medicine may be at risk of losing its distinctiveness as a medical practice through the current attempts to align it with Western biomedical perspectives in order for it to 'fit' within existing mainstream medical curricula and regulatory practices. While agreeing that Chinese medicine is a diverse practice even in China, where it has undergone revisions and reform throughout its long history, she argues that by excluding Chinese medicine's strong cultural bases and eclectic diagnostic practices—which do not conform to western scientific testability, in that their efficacy cannot be established through the isolation of each of its practices—from the curriculum and the practice will result in its outright integration into biomedical practice.

The paper by Bernard Yam deals with the issue of health inequities and entitlement across a particular border—that between Hong Kong and mainland China—which divides one people (the Chinese) through differentiated citizenship rights. The article maps the incidence of mainland Chinese expectant mothers who go to Hong Kong to give birth there, not only to take advantage of the superior medical services available in the island but also for their children to gain access to the entitlements available to

children born there. The pressure exerted on Hong Kong's hospitals from the increasing number of these cross-border births was doubly challenging given that obstetric and midwifery departments had been downsizing as the island experienced a downward birth rate during the 1990s. Local protests against the cross-border births eventually pushed the Hong Kong Hospital Authority, in cooperation with authorities on both sides of the border, to introduce a new obstetric package, which effectively barred non-local women from giving birth in the island. Yam acknowledges that while effective from the point of view of the Hong Kong authority, the prevalence of last-minute hospital admissions and the high health risk faced by those women crossing the border needs to be addressed and further investigated.

Continuing on the theme of health inequities and the commodification of health services, the third paper by Dominique Martin examines Pakistan's recent attempts to stop unregulated cross-border organ trafficking. The commodification of the body for medical purposes and the financial transactions that surround this process have ranged from the free/forced selling of body parts such as corneas and kidneys to paid gestational surrogacy. Again, the transfer of corporeal potential and resources from the global south to the global north points to a form of neo-imperialism that is virtually imposed through the necessities of poverty and the demands for profit. The dark history of transplant tourism in Pakistan demonstrates the hazards of unregulated cross-border markets in human organs. Martin examines the impact of Pakistan's 2007 *Transplantation of Human Organs and Tissue Ordinance* and the sustained efforts of transplant professionals and societal groups led by the Sindh Institute of Urology and Transplantation, to show how organ trading has been effectively discouraged, while gradually giving way to a program of self-sufficiency in organ transplantation that is more equitable and non-exploitative. Martin stresses that the case of Pakistan highlights the need for countries to protect their own organ and tissue providers who may be vulnerable in the global healthcare market.

The final paper of this special issue brings to the fore the complexities of an expanding flow of medical migrations. In Meredith Jones's account, for those undergoing cosmetic surgery overseas this represent much more than an opportunity to take advantage of cheap medical services (in facilities of comparable or even better quality than those available in the global north) and tourist deals, but is part of a journey of self-

transformation and identity seeking. This for Jones is part and parcel of a new makeover culture that collapses cultural change (identity seeking) and economic imperatives on to global health markets, epitomising Thompson's (2011) point that medical migrations have indeed become an integral part of our transnational world order.

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