Accessing health services in India: Experiences of economic migrants returning to Nepal.

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Research article

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Abstract

Background

Migration to India is a common livelihood strategy for poor people in remote Western Nepal. To date, little research has explored the degree and nature of healthcare access among Nepali migrant workers in India. This study explores the experiences of returnee Nepali migrants with regard to accessing healthcare and the perspectives of stakeholders in the government, support organizations, and health providers working with migrant workers in India.

Methods

Six focus group discussions (FGDs) and 12 in-depth interviews with returnee migrants were conducted by trained moderators in six districts in Western Nepal in late 2017. Another 12 key persons working in the health and education sector were also interviewed. With the consent of the participants, FGDs and interviews were audio-recorded. They were then transcribed and translated into English and the data was analysed thematically.

Results

The interviewed returnee migrants worked in 15 of India’s 29 states, most as daily wage labourers. Most were from among the lowest castes so called-Dalits. Most migrants had had difficulty accessing healthcare services in India. The major barriers to access were the lack of insurance, low wages, not having an Indian identification card tied to individual biometrics so called: Aadhaar card. Other barriers were unsupportive employers, discrimination at healthcare facilities and limited information about the locations of healthcare services.

Conclusions

Nepali migrants experience difficulties in accessing healthcare in India. Partnerships between the Nepali and Indian governments, migrant support organizations and relevant stakeholders such as healthcare providers, government agencies and employers should be strengthened so that this vulnerable population can access the healthcare they are entitled to.

Background

The number of Nepali who migrate to India to work continues to grow each year, in part due to the ease of crossing the open border between Nepal and India and the relative affordability of traveling there. Reliable information on cross-border mobility is not available as there is no proper reporting system, but estimates suggest that 1.6 million Nepali work in India as seasonal laborers [1]. Most perform jobs, mainly as
restaurant workers, factory workers, security staff, drivers, domestic workers, agriculture workers, porters, miners, rickshaw pullers, and Indian government civil servants [2].

A systematic review on health and health care of internal migrants in India suggests that migrants are at high risks of diabetes, hypertension, malaria and HIV [3]. Three studies on internal migrants in India reveals that migrants are at risks for an obesity, diabetes, hypertension, skin problems, back pain and chest pain [4–6]. Some studies have documented that Nepali migrants in India are vulnerable to many health problems, including infectious diseases such as the Human Immunodeficiency Virus (HIV), tuberculosis (TB), and malaria [7, 8]. They tend to experience poorer access to healthcare than does the local population [9, 10]. Promoting safer and secure working environments for all workers, including migrants is the priority of UN's Sustainable Development Goal [11] and the timely use of personal health services to achieve the best health outcomes. However, there is little evidence regarding the degree and nature of the healthcare access of Nepali migrants in India. This sub-study is part of the larger research on “Health Vulnerabilities of the Cross-border migrants from Nepal”. The larger study had collected data from 751 survey respondents or returnee migrants. The aim of this qualitative study, then, was to explore, from the perspective of cross-border migrants and related stakeholders, the health-seeking behavior and the barriers experienced by Nepali cross-border migrants in accessing health services in India.

**Methods**

**Study design**

The study was based on (a) focus group discussions (FGDs) with migrant workers; (b), interviews with migrants who declined to participate in FGDs; and (c) key informant interviews (KIIs) with relevant stakeholders.

The study was carried out in six districts—Achham, Doti, Kailali, Kanchanpur, Banke and Surkhet—in Western Nepal between 2017 and 2018. Six FGDs, one in each district, were carried out. Each FGD was attended by 6–8 male returnee migrants [12]. In addition, 12 interviews were conducted with migrants who did not want to talk in a group setting. Finally, 12 KII were conducted with two participants from each district. The FGDs and interviews were facilitated by skilled qualitative researchers in late 2017. Semi-structured FGDs and interview tools were designed to explore issues related to the accessibility of health services, health-seeking behavior and barriers to access to healthcare in India.

**Study participants**

Participants were defined as “Nepali returnee migrant workers aged 18 years and over who had lived in India for at least six months for the purpose of work”. Key informants included representatives from health facilities, local government offices, and NGOs/INGOs working on migrant issues, HIV/AIDS and other health issues.

**Data organization and analysis**
All FGDs and interviews were audio-recorded, transcribed and then translated into English and saved in electronic files. The researchers independently reviewed the transcripts and translated versions. Transcripts were then cross-checked with the original recordings before they were analysed using a thematic approach [13].

**Ethical consideration**

The study protocol was approved by the Nepal Health Research Council (Ref no: 888) and informed consent was obtained from all participants prior to the FGDs and interviews. A Nepali-medium ‘participant information sheet’ provided participants with information about the study and outlined the researchers’ commitment to participants’ privacy and the confidentiality of the information collected.

**Results**

Findings are presented under four themes: (1) accessibility, (2) perceptions, (3) affordability of healthcare services in India and (4) barriers to accessing those services. Each theme is discussed below and relevant quotes are presented in support.

- **Accessibility of healthcare in India**

Access to healthcare impacts one's overall physical, social and mental health status as well as quality of life. The FGD, KII and in-depth interview (IDI) participants reported having had mixed experiences using health services in India. Most generally agreed that health access depends on where a migrant lives, the nature of the company he or she works for, the intelligence of the employer, the level of income earned and local transportation facilities. About half of the KII participants mentioned that Nepali migrants struggle to get health services because they lack the proper certification:

> It is difficult for migrant workers to access health services at government hospitals if they don't have an aadhaar card (KII with the chair of a rural municipality in Achham).

An aadhaar card is an identification number provided to all people who live in India for more than 12 months, regardless of their citizenship. The aadhaar programme, which is the largest biometric identification system in the world [14], gives every cardholder easy access to various government benefits and services.

Another reason provided for limited access to healthcare was participants’ unfamiliarity with the locations of services and their struggle to make effective decisions. As one teacher pointed out:

> Many Nepali migrant workers do not access hospitals because they feel hesitant and they are unfamiliar with the system (KII with a school teacher in Kailali).

Some participants did, however, speak positively about facilities in India:
Yes, there are government hospitals as well as private clinics. There are no problems to speak of regarding access to health services (FGD in Banke).

The health center in my place was good. It used to issue tickets even over the telephone (FGD in Surkhet).

- **Perceptions of healthcare in India**

Participants were asked how healthcare workers responded to returnee migrant workers when they sought treatment at health facilities. The majority of respondents had a positive attitude towards health service delivery in India. The participants felt that they had been treated fairly at Indian healthcare centers. Nonetheless, a few FGD participants expressed a fear of maltreatment and some reported having encountered discrimination. A typical positive view is as follows:

They say nothing bad to patients who go to receive treatment. They do as much as they can; otherwise, they refer them to other places (FGD in Doti).

One interviewee was less positive about health workers in India:

We are always afraid. We wonder if we will be given the wrong injection or have some organ taken out of our bodies (IDI with returnee male migrant in, Doti).

A participant who had had a health problem recalled the following experience:

I suffered from illness in India. I was admitted to the hospital. I received good treatment. I did not feel discriminated against for being a migrant laborer. I had heard that they behave differently to the people with look like janajatis but I have not faced such a situation so far (IDI with returnee male migrant in, Surkhet).

In contrast, one KII participant shared that Indian health workers do, in fact, treat Nepali workers fairly:

Indian health workers do not discriminate between Nepali and Indian nationals (KII with a health post in-charge in Achham).

- **Affordability of healthcare in India**

A number of returnee migrant interviewees stated that most Nepali migrants visit government hospitals and health centers but that some go to private hospitals. Migrants make choices about the hospital they visit depending on how much they can afford. Nepali migrants may receive limited support from the companies they work for to cover the cost of healthcare. For example, a returnee migrant worker said this about the sharing of expenditure:

We have to bear costs ourselves. If a company is well-established, it also bears part of the cost of health treatment for its employees but in the majority of cases, we have to pay for ourselves (IDI with a returnee male migrant in Surkhet).
Similarly, another returnee added:

*Ninety-five percent of Nepali brothers and sisters pay for health services on their own. Only in five percent of cases do employers bear the health expenses of their workers. Health services in government hospitals are cheap but those in private hospitals are expensive and not affordable for all Nepali migrants (IDI with a returnee male migrant in Achham).*

Since a small company is less likely than a big one to provide insurance coverage or cover the cost of healthcare during an illness, migrants employed by small companies are less likely to get health services in India. Some companies are very supportive:

*If companies are good, they support their workers. For example, one diamond company insures the health of its employees. If workers claim medical expenses, the insurance company pays them. Not all companies provide insurance facilities, however. (IDI with a returnee male migrant in Kanchanpur).*

Indeed, in a few cases FGD participants mentioned that they had received financial support from their employers for medical treatment in India:

*When my rib broke while I was working, my company bore the cost of my treatment. (FGD in Surkhet).*

*When I fell sick, my employer paid for me (FGD in Banke).*

**Barriers to accessing healthcare services in India**

Despite the above reports of easy access to healthcare in India, some FGD participants commented that they had faced a number of barriers to accessing and using health services. These included financial problems, language barriers, discrimination and lack of knowledge about the location of health services. The comments below are typical.

*If you have money, you can get the medicine nearby; if you don’t, you can’t (FGD in Banke).*

*It is more difficult to seek health services in India than in Nepal due to the language problem and unfamiliarity with the location of health services (FGD in Achham).*

*Indians dominate Nepali people, doctors neglect us, Indians cut queues, and hospitals and doctors charge high fees (FGD in Surkhet).*

Other challenges to accessing healthcare services mentioned by several returnee migrants included the lack of information, overcrowding in government hospitals and not getting time off work from their employers for treatment:

*We do face different setbacks. First, we don’t have enough money to get treatment in advanced hospitals. When we don’t have an aadhaar card, officials don’t admit us. Our citizenship papers aren’t useful for accessing health services (IDI with a returnee male migrant in Doti).*
If you are sick, there is no one to take care of you. Even if friends and relatives live nearby, they cannot give you time as they are busy at work. If someone takes care of a friend, he will be scolded by his boss for not working (IDI with a returnee male migrant in Kanchanpur).

A number of key informants highlighted that language barriers, delayed receipt of salaries and the passiveness of individual migrants also prevent migrants from seeking healthcare services:

In India, migrant workers have to bear the cost of treatment on their own. Not getting paid on time also affects their treatment since they have to take a loan to pay for health services (KII with a local representative in Surkhet).

Nepali migrant workers cannot express their problems effectively. Unlike their Indian counterparts, they hesitate to mention their problems and hide their illnesses. Thus, their treatment is not effective (KII with local representatives in Surkhet).

Discussion

To the best of our knowledge, this is the first study to explore the healthcare-seeking behaviours of cross-border migrants, including their use of healthcare services and the barriers to accessing those services that they face. We found that access to healthcare is related to the kind of employer or company a person works for and the insurance coverage they are provided. Our findings suggest that it is less likely that a small company will provide insurance coverage and cover the costs of healthcare during an illness than a big company. Thus, migrants employed by small companies are less likely than those employed by big companies to get health services in India.

Like this study, a previously conducted exploratory study of Nepali migrants working in the Middle East and Malaysia highlighted that healthcare access depends on company size and the generosity of employers [15, 16]. Lee and colleagues [17] and Joshi et al. [18] also confirm our finding of our study: Indian, Bangladeshi and Myanmar migrants in Singapore and Nepali migrants in the Gulf countries had similar challenges to accessing health services as they lacked health insurance.

Many participants reported that not having an aadhaar card was one of the key barriers to accessing healthcare services in India [19]. As many Nepali work in India as seasonal migrants and stay for less than six months, they are not eligible for one. Obviously, many migrant workers did not know that it is not mandatory to have an aadhaar card to access healthcare services in government health facilities in India. In fact, migrant-related organizations facilitate easy healthcare access for those without aadhaar cards.

With regard to the cost of health during their illness in India, the majority of participants in both FGDs and interviews stated that they themselves paid to see a private doctor or return to Nepal for long-term treatment if the case was serious. These findings are similar to those of a study conducted among Chinese migrants in Singapore, which found that most of the interviewed migrants paid to see a private
doctor or return to China for long-term treatment completely on their own [20]. The high cost of medical treatment for basic health services is also well documented in the literature [19, 21–23].

Our analysis of the FGDs and in-depth interviews conducted in this study identified unfamiliarity with locations or health system in India as a reason for limited health access among migrants. Similarly, Karim and Diah [21] highlighted that Bangladeshi migrant workers in Malaysia had poor access to healthcare because the health system in Malaysia was unfamiliar to them.

In the present study, among the reasons migrants were dissatisfied with the quality of health services in India were difficulty in communicating with medical staff, discrimination and delayed treatment. A few migrant workers in our study were not confident in Hindi or otherwise failed to understand the language used during their consultation. Other studies, too, have identified language as a barrier to accessing good-quality healthcare [20–21, 24–26].

Discrimination, too, has been reported elsewhere: two studies on minority populations in US and a study on immigrants in Spain also highlights that these groups experienced discrimination within healthcare settings [24, 27, 28]. Another in-depth study conducted in Thailand found that Sub-Saharan African migrants living in Bangkok experienced high level of dissatisfaction with the services provided by health professionals [29].

In contrast, some studies report that migrants received good-quality health care whilst working abroad [20, 31]. Possible reasons for this improvement include the lifestyle changes and health benefits that accompanied them which some migrant workers in the US experienced.

The key limitation of this study is that it did not collect qualitative data (FGDs and interview) from returnee female migrants. Since the study not being able to conduct in India meant returnee migrants were approached in their respective home districts this will have resulted self-selection bias. Also, the study was conducted in only six of Nepal’s 77 districts and only with returnee migrants, its findings might not be representative of the experiences of migrants in other districts or who are still working in India. More specifically, the data in this report excludes the healthcare perspectives and experiences of cross-border migrants who fail to even attempt to access healthcare providers.

**Conclusion**

Nepali migrants in India face considerable challenges in accessing primary healthcare services. Factors that limit their access include the limited healthcare services available in the vicinity, employers’ small size and limited finances, language barriers, the lack of an aadhaar card, discrimination and low and delayed pay.

Nepali migrant-related organizations in India can play a crucial rule in disseminating information to Nepali migrant workers about accessing health care services in India. They can also facilitate dialogues both with healthcare service providers to minimize any existing barriers, including those stemming from
language problems, as well as with employers (mainly in the formal sector) to ensure that workers are provided with health insurance coverage.

**Abbreviations**

AIDS
Acquired immunodeficiency syndrome
FGD
Focus Group Discussion
GTN
Green Tara Nepal
HIV
Human immunodeficiency virus
IDI
In-depth Interviews
INGO
International Non-Governmental Organizations
IOM
International Organization for Migration
KII
Key Informant Interviews
NGO
Non-Governmental Organization
NHRC
Nepal Health Research Council
TB
Tuberculosis
UN
United Nations

**Declarations**

**Ethics approval and consent to participate:**

Ethical approval was obtained from the Ethical Review Board of Nepal Health Research Council (NHRC). A written informed consent was obtained from each respondent before data collection. Participants were informed about their voluntary participation and ensured the protection of privacy and confidentiality.

**Consent for publication:**

Not Applicable.
Availability of data and materials:

The transcripts used to support the conclusions of this article are available from the corresponding author on reasonable request.

Competing interests:

The authors declare that they have no competing interests.

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Authors’ contributions:

PA conceptualized the study, analysed the data, interpreted the findings and prepared the first draft. RK, RRD, NA and PRR interpreted and provided input for preparing the first draft of the manuscript. PS, EvT, BD, GNS, PD, MI and KPW reviewed and revised the final draft of the manuscript. All authors read and approved the final manuscript.

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