



Received: 04/07/2026 | Accepted: 20/08/2026 | Published: 30/08/2026

Healthcare Beyond Borders: Patterns and Drivers of Cross-Border Patient Mobility from Sudurpaschhim, Nepal to India

***Deepak Chandra Bhatt**

Central Department of Humanities and Social Sciences, Far Western University,
Kanchanpur, Nepal

Abstract

Cross-border healthcare is a common practice in Nepal-India border area. It is normal for people from the Sudurpaschhim Province to seek diagnostic services, specialist advice, surgical procedures, emergency care, medication, and post-treatment therapy in India. The current study explores patients' characteristics, diagnoses, preferred places of treatment, social networks, frequency and mode of travel, and barriers to continuity of care in this group. This study was conducted using exploratory sequential mixed-method design that is qualitative dominant. This study employed in-depth individual interviews of patients, caregivers, key informants (healthcare providers, pharmacists, ambulance drivers) as well as field observations and structured descriptive reports. The qualitative data were analysed thematically and descriptive statistics were generated to summarise the characteristics of patients, diagnosis, treatment facilities, routes and frequency of travels.

The discovery shows that for many border trippers it is a regular and accepted practice to access healthcare services in India. Most of them go to Indian hospitals for scheduled treatment and ask for immediate treatment in emergencies. The most frequent diagnoses are cancer, kidney disease, heart disease, neurological disorders, orthopedic disorders, complications during pregnancy and childhood, chronic disease, unresolved, and alternative opinion. The most common transit points for Kailali and Kanchanpur people are Gaurifanta and Gaddachowki respectively. The decision on which hospital to use depends on services available, infrastructure for transportation, costs, social networks and trust. The specialist accreditation system, the capacity for diagnostics, referrals, insurance claims, counselling, and cross-border coordination can be improved to decrease the informal migration for health care.

Keywords: Cross-border healthcare, medical migration, Sudurpaschhim Province, Nepal-India border, patient mobility

***Corresponding Author:**

Deepak Chandra Bhatt

Email: deepakchandra@fwu.edu.np

Introduction

The Nepal–India border is more than a political boundary. It is also an integral part of daily social and economic activities in the Sudurpaschhim Province of Nepal. Individuals frequently cross the border for work, trade, family visits, schooling, pilgrimage and to avail of different services. The Treaty of Peace and Friendship in 1950 helped establish a long tradition of people moving across the border between the two countries, and similar languages, family connections, transportation and borderless laws have made travel between the two countries common place for many communities. In Sudurpaschhim Province these traditional patterns of mobility also encompass journeys to India for medical diagnosis, specialist consultations, surgical treatment, medicine, emergency treatment and follow-up treatment.

This health mobility is particularly significant in an area where access to suitable health care facilities is determined by geographical location, scattered population, transport challenges, imbalanced distribution of health facilities and lack of specialists. There is also variation in the availability of and attitudes about the quality of diagnostic facilities that also shape their choice of treatment. The Constitution of Nepal (2015) has included health as a fundamental right, the National Health Policy (2019), and the Nepal Health Sector Strategic Plan (2023) have highlighted the issue of health access, quality of service, universal coverage and health systems strengthening. But policy intent doesn't always lead to timely and adequate care for those living in remote and border communities. The requirement for a health facility is not just about access to a health facility, but whether a

family can get the necessary care in a timely, affordable, and trusted health facility.

Whittaker et al. (2010) identifies a number of factors that influences people to seek medical care abroad, such as the variation in treatment costs, waiting times, availability of specialists, medical technology, perceived quality, institutional trust and access to specific procedures. However, these decisions are also influenced by social familiarity and migration networks in the border areas of South Asia. Likewise, in Adhikari et al. (2020), research on the healthcare needs of Nepalis who work in India during the holidays reveals that income, information, documentation, institutional support, and informal social support are all factors that might influence access to healthcare. Research in other border areas has found similar results that healthcare travel is not solely motivated by any medical needs. However, Bochaton (2015) noted that family members, friends, transport workers, former patients and others are involved in helping patients locate hospitals, make arrangements for transport, provide housing and orient them to unfamiliar healthcare systems.

The size and diversity of the healthcare sector, availability of specialist services, diagnostic facilities, teaching hospitals, private hospitals and accessibility to its population from neighbouring countries in the region is making India an important healthcare destination. The medical values travel conducted in the country have pointed out that higher affordability, specialization, advanced technology and shorter waiting time are some key factors that make India a treatment destination (Chakravarty, 2023; Gautam & Bhatta, 2020).

However, Sudurpaschhim's patients are not necessarily medical tourists. Many of them travel due to vital health concerns, emergency health needs, lack of a diagnosis or due to a lack of available services in their local area. The trips can also be a heavy burden on their families' finances and status. A better term in this context might be medical migration as opposed to elective or consumer oriented medical migration.

Bhatt's migration studies provide a foundation for understanding cross-border mobility from Sudurpaschhim to India. His research shows that the open border, geographical proximity, affordable transportation, limited local opportunities, cultural familiarity and established social networks make India an accessible destination for residents of Sudurpaschhim Nepal (Bhatt, 2015, 2018, 2023a, 2023b). These factors influence destination selection through previous experience and information shared by relatives, friends and other migrants. Extending this literature from labour migration to healthcare mobility, the present study examines how established routes, trusted networks, treatment costs, local healthcare limitations and confidence in Indian medical institutions shape patients' decisions to seek healthcare across the border.

The existing literature on Nepal-India mobility has mainly been dedicated to the study of labour migration, livelihoods, remittance incomes and vulnerability of migrant workers. Much less focus has been placed on patients who cross the border to access health care, especially patients coming from Sudurpaschhim Province. This is an important gap as the routes patients travel, the people who help them, which hospitals they choose and the number of times they make the trip, can point to the way households actually react

to the absence of health services. These also reveal the process through which the informal social network can progressively serve as an unofficial referral system for Nepali patients to access healthcare providers in India.

Drawing on a concept of health care strategies rather than labour migration and commercial medical tourism, this study focuses on the daily health care practices of patients and caregivers in a remote border area in the far west of Nepal. It aims to highlight how common households rely on conventional migratory pathways to cross borders in situations where domestic health care is seen as lacking, unpredictable or challenging.

The primary objective of this article is to explore the trend of cross-border health care migration from Sudurpaschhim Province to India. Specific focus is placed on categories of travellers, health issues for which they are travelling, emergency and planned travel, destination, the routes and places of transit, social and institutional supports, regularity of travel and continuity of care. The study also examines the ways in which familiar routes are slowly transformed into health care corridors, and how recurrent cross-border travel can contribute to a continuous treatment journey, rather than a one-off experience of health care travel.

Understanding Cross-Border Healthcare Mobility: Access, Push-Pull Factors, and Social Networks

The article is based on three interrelated concepts that help us appreciate why patients from Sudurpaschhim come to India for healthcare: barriers to accessing healthcare, push-pull factors, and social networks. These views together help to shed light on why patients cross the border and what kind of

border they choose and how. Healthcare is interpreted in this context as a more than just being close to a hospital or health facility. The important thing to patients is that they get the right care, at the right time. This encompasses the ability to consult with specialist physicians, secure accurate diagnostics, prescription of medication, referral, cost of treatment, communication and trust in the health care facility. If a health facility is physically there, but patients do not feel they will be able to get the expertise, diagnosis or treatment they need in a timely fashion, or confidently, they may go elsewhere.

The push pull analysis can be used to understand why certain patients choose to travel to India for treatment. Lee's (1966) migration framework states that people choose to move depending on what makes them want to migrate from one location to another and what makes them want to move to the other location. There are common push factors in Sudurpaschhim, such as lack of specialists, uncertainty about the diagnosis, difficult geographical conditions, delays in treatment, poor referral systems, and lack of trust in some local services. Concurrently, Indian healthcare centers could have allure due to patients' perception of higher density of specialists, increased level of diagnostic services, faster diagnosis, reputation of the hospital and proximity from border districts.

These decisions are not, however, solely based on comparisons of health facilities directly. They also are influenced by what patients hear and learn from others. What a family has experienced, what is said about doctors and hospitals by neighbours, and what they remember about the hospitals and doctors they have been in before, as well as community perceptions, can have a significant impact on what hospital or doctor is seen as reliable. In

this respect, health care decisions are medical and social. Migration networks are of special interest in the study of cross-border healthcare mobility. Patients don't usually make such trips independently. Current networks can offer information on doctors and hospitals, arrange transport, explain where to go when the treatment is in progress, and offer practical assistance during treatment. Massey et al. (1993) believe that migration networks mitigate the uncertainty and risks of migration by linking new migrants with individuals who have previous experience at the destination.

Sudurpaschhim is a region with longstanding relations with India, both labour and family, which have established familiar paths and links for health care. Previous studies on mobility Nepal – India have emphasised the intimate links between mobility across the border and household strategies and social relations (Bhatt, 2024). This study builds on this knowledge and reveals the role relatives, former patients, pharmacists, local health workers, ambulance drivers and other transport actors can play in assisting patients to navigate the health journey. These connections become medical pathways over time and create a medical pathway between communities in Sudurpaschhim and their healthcare providers across the border.

Methodology

Research Design and Study Area

This research work was designing exploratory sequential mixed method with a higher priority was given to qualitative research. In addition to the structured descriptive information, qualitative information was collected to support and organize the qualitative findings. This was appropriate as healthcare mobility across borders is not only

about actual mobility, but also about personal decisions, uncertainty, trust, financial concerns and experiences that influence the choices of patients (Creswell & Creswell, 2018; Creswell & Plano Clark, 2018).

The fieldwork was carried out mainly in Kailali and Kanchanpur districts of Sudurpaschhim Province. The districts were chosen as they are crucial transit areas for patients going to India for treatment. Gaurifanta in Kailali and Gaddachowki in Kanchanpur are two of the major border crossings used by patients. Other notable places to stop include Dhangadhi, Attariya and Mahendranagar where patients can visit local health facilities and/or pharmacies, seek advice, arrange transport, contact family members or collect money to move on to the next stop, or prepare for the onward journey. When patients' treatment journey ran through these routes, they were also included from other hill and mountain districts of Sudurpaschhim.

Participants and Sampling

Purposive and snowball sampling techniques were used to identify participants. These methods were deemed suitable as they are not centralized, but rather cross-border medical travel occurs in a fragmented, non-recorded, and informal manner. Participants were therefore chosen because of their direct experience of or knowledge about the cross-border healthcare mobility.

The study involved travellers from Nepal (patients), caregivers of the patients, family members, local health workers, pharmacists, local community and institutional informants, and transport and ambulance workers. An attempt was made to represent participants from different age groups, gender, socio-

economic status, districts, health status, places of arrival and treatment experiences.

Having various groups present helped to give a wider view of the healthcare journey. Patients reported on their history of illness, why they traveled, their choice of hospital, their experiences of treatment, and follow-up care. The caregivers expressed the practice and cost of accompanying patients. Health workers and pharmacists expressed their opinions on local services, referral practices, and patients' decisions; and ambulance and transport workers gave information on the common routes used and travel arrangements. Wider community and institutional perspectives were added through the key informants.

Data Collection

Data collection was carried out using in-depth patient interviews, caregiver interviews, key informant interviews, a structured descriptive survey, field observation and field notes. Interviews with patients raised issues around the history of illness, choices of treatment in India, sources of information, choice of hospital, route of travel, treatment experience, cost considerations, emotional issues, satisfaction, and follow up care. Caregiver interviews were centred on functional concerns including transportation, housing, finances, communication with health care providers, access to medications, emotional support and disturbance of family routines.

The key informants were health workers, pharmacists, ambulance drivers, local representatives and others who knew about the cross-border health care practices. These accounts assisted in understanding the information patients get, make referrals, arrange travel, and get through the border.

Field observations were made around hospitals, pharmacies, diagnostic centres, ambulance services, transport points and border areas. The researchers gained insight into the organization of cross-border health care mobility in everyday practice by making these observations. Structured descriptive data was also gathered on patient demographics, types of illness, destination of care, frequency of travel, sources of hospital information, general cost categories and satisfaction. In addition, health policies, planning documents, institutional reports, and the relevant literature were examined to contextualize the field findings related to access to health care and migration.

Data Analysis and Ethical Considerations

Thematic analysis was used to analyse the interview material and field notes, using the approach outlined by Braun and Clarke (2006). The analysis was focused on the recurring themes such as reasons for seeking care in India, choice of destination, routes crossing the borders, diagnostic uncertainty, social and professional support, repeated travel and continuity of treatment.

The structured information was analysed descriptively and summarised into groups of patients, categories of illness, destinations, routes, how often they travelled and common difficulties reported. The aim of these quantitative aspects was to aid the qualitative analysis, and not to give statistical estimates for the population level.

All ethical principles were observed in the study. It was voluntary, informed consent was obtained and confidentiality and privacy was kept. Participants had the option of not answering any question and refusing to participate in the study. There was no

requirement for personal identifying information for analysis. All experiences in the study were analyzed from a social-science and public-health perspective, and were not intended to make a clinical assessment or decision about individual treatment.

Results

Cross-Border Healthcare as an Everyday Strategy

The one thing which is very clear from the study is that travelling for health care to India from Sudurpaschhim is not an uncommon occurrence. It's a routine process for many families for a diagnosis, expert guidance, surgery, medications, emergency care and post-care. The pattern was not only followed in the border districts of Kailali and Kanchanpur but also among patients visiting the hospitals from the hill and mountain districts of Baitadi, Darchula, Dadelhdura, Doti, Achham, Bajhang and Bajura. These households often view India more as another healthcare option, rather than a foreign place that they have to travel out of the way for.

Patients went across the border for urgent and planned medical care. Emergency trips were often for extreme cardiac symptoms, neurological emergencies, accidents with significant injuries, acute abdominal symptoms and obstetric complications that needed immediate specialist attention. Planned trips were more likely to be associated with chronic disease management, suspected or confirmed cancer, kidney and heart disease, orthopedic issues, reproductive health issues, child health issues, further investigation of the illness, second opinion, medicines, or follow-up after previous treatment. Emergency and planned travel are important. It demonstrates that cross-border healthcare is both an

alternative service in emergency situations and is integral to longer-term household coping mechanisms for illness.

Many patients did not travel directly to the Indian hospital, but instead traveled there after being referred by their local health care providers. Many patients traveled to an Indian hospital after a referral from their local health care providers. Many trips were done in sections. The patients may first go to a local clinic and then to a district or provincial centre, and so on, till they reach a border crossing and finally the Indian hospital. Thus, the role of the places like Dhangadhi, Attariya and Mahendranagar was much more significant than that of transit points. These sites were utilized by families to find further medical advice, to consult with the pharmacist, to call family members, arrange transportation, collect money, and determine next steps in their journey. For older patients, those who are very ill and/or caregivers, these steps may be an additional physical, financial, and emotional burden when seeking healthcare.

Different Patients, Different Healthcare Needs

All the patients were from different backgrounds and medical conditions. They encompassed those with chronic conditions, those who needed surgery, those who wished to have advanced diagnostic testing or second

opinion, those having complications during pregnancy, children needing specialist services, elderly having multiple health issues, and patients with cancer, kidney and heart disease, neurological and orthopedic diseases. The other noticeable group were those who were not happy with their previous treatment, or were not sure of the diagnosis they already had. They had a tendency to cross the border in search of better clarity and reassurance, rather than a confirmed need for a specific procedure.

The mobility patterns were among the most complicated due to chronic illness: treatment was sometimes conducted for months or even years. Patients with diabetes, hypertension, kidney disease, heart disease, respiratory illness, arthritis or neurological diseases usually started their treatment in the local area. Some families however opted for further treatment in India when symptoms persisted, when experts were called in, or when there was some doubt as to the diagnosis. Patients travelled for specialized orthopedic, abdominal, cardiac, neurological, gynecological, urological surgeries, and more. For many, surgery was not enough. The patients re-presented for wound reviews, physiotherapy, medication, follow-up examinations or to the same specialist. Likewise, patients with an undiagnosed disease typically came for special tests and interpretation.

Table 1

Major Patient Categories and Typical Cross-Border Care Needs

<i>Patient category</i>	<i>Typical care needs</i>
<i>Chronic-disease patients</i>	Long-term medicines, specialist review, laboratory monitoring, repeated consultation, and follow-up

<i>Surgical patients</i>	Orthopedic, abdominal, cardiac, neurological, gynecological, urological, and other specialized procedures, including post-operative review
<i>Diagnostic and second-opinion patients</i>	Advanced investigations, specialist interpretation, and clarification of uncertain or unsatisfactory diagnoses
<i>Women with obstetric or gynecological complications</i>	Emergency obstetric care, reproductive-health assessment, surgery, blood services, or neonatal support where required
<i>Children requiring specialist care</i>	Pediatric diagnosis, specialist consultation, pediatric surgery, and management of congenital or chronic conditions
<i>Older patients with multiple conditions</i>	Multi-specialty assessment, chronic-disease management, and caregiver-supported healthcare navigation
<i>Cancer, renal, cardiac, neurological, and orthopedic patients</i>	Specialist treatment, advanced diagnosis, procedures or surgery, and repeated follow-up

Note. These categories summarize patient profiles identified in the study and are not mutually exclusive.

Health Conditions and Reasons for Seeking Care in India

Conditions that prompted patients to travel included undiagnosed symptoms, serious chronic or life-threatening illnesses. The uncertainty of diagnosis was a common theme in many interviews. Some patients were already on the first few visits to various providers in Nepal but still did not have a clear conclusion of their illness. In these cases, traveling to India was frequently considered a means of getting more specific investigations, specialist interpretation or a more certain diagnosis.

Treatment for some families was preceded by the need for a reliable diagnosis. Patients with suspected or confirmed cancer travelled for biopsy, chemotherapy, radiotherapy, surgery, second opinion and follow up. Nephrology consultation, dialysis and longer-term care for chronic kidney disease (CKD) was sought by

people with kidney disease. Patients with cardiac disease were referred for investigations (e.g., ECG, echo and angiography) and specialist treatment and surgery. Neurological patients typically required a CT scan, MRI, neurologist consult or neurosurgical treatment, and patients with orthopedic problems travelled for fractures, trauma, spine and joint issues, surgery, and for other orthopedic conditions. Maternal and gynecological conditions were complicated pregnancies, reproductive-health problems, and gynecological procedures. Specialist diagnosis, surgery and management of chronic or congenital conditions were visited by children.

The cross-border healthcare patterns show that there is no single disease or treatment that is associated with cross-border care. Rather, it reacts to a wide variety of healthcare needs, from clarifying a diagnosis to ordering medication to very specialized intervention.

Table 2***Common Health Conditions Leading to Cross-Border Healthcare Mobility***

<i>Health condition</i>	<i>Common reason for travel</i>
<i>Cancer-related illness</i>	Biopsy, chemotherapy, radiotherapy, surgery, second opinion, and follow-up
<i>Kidney disease</i>	Nephrology consultation, dialysis-related care, and chronic kidney disease management
<i>Heart disease</i>	ECG, echocardiography, angiography, cardiology consultation, and surgery
<i>Neurological illness</i>	MRI, CT scan, neurology consultation, and neurosurgery
<i>Orthopedic problems</i>	Fracture and trauma management, spine or joint care, and surgery
<i>Gynecological and maternal problems</i>	Complicated pregnancy, reproductive-health assessment, and gynecological surgery
<i>Child health problems</i>	Pediatric diagnosis, specialist consultation, and pediatric surgery
<i>Chronic diseases</i>	Medicines, monitoring, repeated consultation, and follow-up
<i>Undiagnosed illness</i>	Further investigation, diagnostic clarification, and second opinion

Note. The categories summarize conditions described through patient interviews and key-informant accounts.

Choosing Where to Go: Nearby Towns and Larger Medical Centres

Patients were not directed towards any particular destination. Some went to the local Indian town, others far distances to the larger medical centres. Khatima, Pilibhit, Pithoragarh, Sitarganj, Rudrapur, Bareilly, Lucknow, Delhi and Dehradun were the many places mentioned. The selection of the destination was determined by multiple factors: seriousness of the illness, financial ability of the household, the need for treatment, transport availability, previous experiences of family or friends, recommendations from trusted individuals,

and level of specialization patients thought they required.

Consultations, medicines and routine diagnostic services, orthopedic problems, child health concerns, minor procedures and follow-up were commonly sought in nearby destinations, such as Khatima, Pilibhit, Pithoragarh and Bareilly. This appeal was quite similar to distance appeal, familiarity appeal, transport appeal and affordability appeal. These trips were portrayed as a trip to the local town, by some families. However, when the disease was looked upon as serious, complicated and advanced specialist treatment, Lucknow, Delhi and Dehradun were more frequently cited. Families were

more likely to be directed to these larger medical centres if they had a history of cancer, kidney disease, cardiac disease, neurological diseases, major surgery, and unresolved diagnostic issues.

Formal referral as a basis for choice of hospital was seldom the only basis. A family may choose Bareilly as a place for recovery if a member of their village had recovered there, Lucknow as a place of recovery if a relative had lived or worked there, or Delhi because they believed that they would be able to get a second opinion at a well-known centre and that it would be serious enough to warrant that move. The clinical need was thus one factor in the decision. Additionally, trust, personal experiences, stories of successful treatment, family contacts, and affordability were also important, as were knowledge of travel routes.

Border Routes, Transit Points and Informal Guidance

The two Border Crossings of Gaddachowki (Kanchanpur) and Gaurifanta (Kailali) were of particular importance for the medical journeys in this study. People from Kanchanpur and the

neighbouring hill districts would frequently make their way to Gaddachowki for treatment enroute to Khatima, Pilibhit, Haldwani and Bareilly. Gaurifanta is commonly used by the patients of Kailali and the people from hill districts travelling from Dhangadhi to Bareilly, Lucknow and Delhi. It has thus turned these crossings into special border points. They are part of long-term healthcare corridors that were built over a longer period of time, in the context of Nepal-India movement.

Some patients started their journey with a hospital in mind, others got advice from drivers, pharmacists, local health workers, relatives, or other patients who had been on a previous journey. This process meant that people who were not actually involved in the referral system may have also become valuable sources of information about health care. Medical labour migration could then be facilitated via existing labour-migration channels, family ties and transport infrastructure. Knowing about a road, town, hospital or a contact person made a medical journey otherwise unknown easier to organize.

Table 3

Major Routes of Medical Travel

<i>Route or transit point</i>	<i>Main users</i>	<i>Common onward function or destination</i>
<i>Gaddachowki</i>	Patients from Kanchanpur and adjoining hill districts	Khatima, Pilibhit, Haldwani, and Bareilly
<i>Gaurifanta</i>	Patients from Kailali and hill districts travelling through Dhangadhi	Bareilly, Lucknow, and Delhi
<i>Dhangadhi, Attariya, and Mahendranagar</i>	Patients arriving from hill, mountain, and Terai areas	Consultation, transport arrangements, gathering money, contacting relatives, and seeking referral advice

Note. The routes summarize the healthcare-mobility corridors described and observed during the study.

Repeat Travel and Continuity of Care

Not all patients were traveling on a regular basis. Others travelled only once, mainly for diagnosis, for emergency treatment or minor surgery, or to get a second opinion. Some people made multiple trips, particularly those getting treatment for cancer, kidney disease, heart disease, neurological disorders, chronic conditions, or older people taking medications for a long period of time or following surgery.

Burdens associated with repeated travel arose far beyond the cost of care. Each subsequent follow-up may require transportation, feeding, lodging, diagnostic testing, medications, caregiver time and loss of household income. Continuity of care was inextricably linked with the ongoing problem of families' mobility for these families.

The cross-border journey was not always a success in India. Without this change, the original journey would be a part of a longer pathway of healthcare if patients continued to receive reviews, medicines and additional investigations from the same specialist.

This also identified an important discontinuity in the health systems. Others came back to India due to a lack of mechanism for transferring medical records, coordinating follow-up, or getting post-treatment guidance from an available provider nearer to home they had a trust in. The number of journeys thus implies more than crossing the border simply. Frequent travel may also reflect the effectiveness—and ineffectiveness—of various aspects of a patient's care.

Table 4

Frequency of Medical Travel and Continuity Burden

<i>Frequency pattern</i>	<i>Common patient category</i>	<i>Main continuity burden</i>
<i>One-time visit</i>	Diagnosis, minor surgery, emergency care, or second opinion	Immediate expenses, travel stress, and pressure to make quick decisions
<i>Repeated follow-up</i>	Cancer, kidney, cardiac, neurological, and other chronic conditions	Long-term financial and emotional burden, caregiver time, and repeated travel
<i>Regular medicine or review visit</i>	Chronic disease and post-surgical patients	Continued dependence on Indian providers and transport routes
<i>Emergency repeat visit</i>	Patients experiencing sudden deterioration or complications	Unexpected financial pressure and urgent cross-border coordination

Note. The frequency categories are based on the descriptive patterns identified in the study.

Discussion

Beyond Medical Tourism: Healthcare Travel Driven by Need

This study highlights the need to rethink cross-border healthcare mobility as not exclusively driven by medical tourism. Medical tourism typically refers to the deliberate choice of a healthcare destination based on an individual's perception of the relative advantages and disadvantages of different options. Factors such as price, technology, waiting lists, and quality of care often influence such decisions (Chakravarty, 2023; Gautam & Bhatta, 2020).

However, many of the study participants were not in a position to make dispassionate calculations and trade-offs between the competing healthcare destinations. Several respondents indicated that their illness was severe or diagnosed in an unclear manner. For some households, receiving cancer treatment, kidney dialysis, or heart surgery in India was the only viable alternative. This underscores the role of necessity in motivating cross-border healthcare migration. As such, it is important to distinguish between demand driven by individual preferences and the need for specialized treatment, diagnostic investigations, or second opinion. Cross-border mobility can thus help to identify the missing piece of the current care pathway that patients and families are looking for, even if health facilities are formally present.

Border Corridors: part of the Healthcare System

Gaddachowki, Gaurifanta, Dhangadhi, Attariya and Mahendranagar became crucial components of the 'movable infrastructure' of healthcare. They are not just geographical. These are locations where patients and

families come together to keep going—with funds, information, transportation, guidance, referrals, and social connections. From this point of view, a healthcare corridor is not just a road between one hospital to another. A series of locations and connections in which families engage to make decisions and arrange care.

This is similar to broader studies indicating that geographical location and social ties can facilitate cross-border migration for healthcare services (Bochaton, 2015). It also brings an additional dimension to the study on Nepal–India mobility. Routes that have been used for work, trade, kinship and other social transits are also being utilized to gain access to health services. Routes that have been used for employment, trade, kinship and other forms of social transits are also being utilized to gain access to health services in the history. Bhatt (2024) highlights how Nepal-India mobility is interwoven in socio-cultural relationships and household strategies. The study findings demonstrate how familiar migration routes could be used to pursue treatment opportunities.

Social Networks as Informal Referral Systems

Few families traveled to healthcare services on their own across borders. Others, such as relatives, former patients, pharmacists, local health workers, ambulance drivers, and transport workers, played a significant role in the choice of hospital, route, and destination. They provided practical answers: Where shall the patient go? What hospital would you be familiar with? What are options for the family to get there? Who is at the destination? What would be the cost of the trip? Where do they go? This is very similar to Massey et al (1993) network perspective that involves established

social networks that lower risks, costs and uncertainties of migration. These formal systems of patient navigation and referral have limitations, as reflected in the importance of these informal networks. Relatives' or previous patient advice may be very valuable as it is available and trusted. It could also be based on personal experience, lack of information, commercial considerations or recommendations that do not necessarily align with the patients clinical needs.

The lack of such mechanisms can generate disparities, as those without strong social networks or access to reliable informal advice often find themselves at a disadvantage when attempting to navigate the formal referral system. Such findings are consistent with those of Adhikary et al. (2020) on healthcare-seeking behaviour among Nepali migrants in India. Information, trust, and support play a particularly vital role in facilitating cross-border healthcare migration.

Diagnostic Trust and the Geography of Confidence

One key finding of this study was that many healthcare journeys started with a lack of diagnosis. Often patients and their families would wish for “proper tests”, another specialist's opinion or a better explanation following previous consultations that failed to convince them of answers. Diagnostic trust is a key element of healthcare mobility. The ability to access a local health facility may not be sufficient if patients are not confident that their local health facility can provide a reliable diagnosis, explain the condition sufficiently, or refer to a specialist that is available. The geography of healthcare is, therefore, a geography of confidence, too.

Many patients were linked with the idea of a serious or complicated disease with the necessity to go to a bigger or more renowned medical centre. Uncertainty and limited confidence at the place of origin and greater specialization and certainty at the destination (Lee, 1966). These perceptions do not necessarily reflect objective data that one institution or health system delivers better clinical services than another. However, people's trust and competency perceptions impact actual decisions. Health-system improvement efforts should not only focus on access to care, but also on patient trust in the diagnosis, communication, referral, and continuity of care.

Repeat Travel and the Challenge of Continuing Care

One of the aspects that occurs beyond a single trip to seek healthcare is repeated journeys. Ongoing investigations, medicines, specialist consultations or procedures were needed for patients with cancer, kidney disease, cardiac conditions, neurological illnesses, chronic diseases and post-surgical needs. The mobility of patients across borders poses challenges not only at first contact with the healthcare system, but also as measures for treatment and follow-up, responsibility and continuity can extend beyond one system to another, as Whittaker et al. (2010) explain. The results obtained from Sudurpaschhim bear this concern.

This study confirms this viewpoint, particularly in relation to the experiences of stroke patients in New Zealand who reported difficulties accessing post-discharge support and follow-up care services. The study participants from Sudurpaschhim largely shared similar experiences, as reflected in their comments on the burden of repeat travel.

This would benefit by better continuity of care and rather less travel, even if every advanced medical service is not immediately available in Sudurpaschhim. This gap may be addressed by documentation of discharge, improved referral records, patient-held medical information, counselling, teleconsultation (where appropriate) and trusted arrangements for follow-up in the province.

Policy and Practice Implications

The findings bring several implications to the healthcare planning in Sudurpaschhim and to Nepal's aim of equitable healthcare and universal health coverage.

First, the capacity of specialist services and diagnostics must be further strengthened at provincial or regional level. The significant factors for patients seeking to cross the border for serious illness were uncertainty of diagnosis and serious illness. The areas of prioritisation identified in the study are cancer diagnosis and referral, kidney care, cardiac care, neurology, orthopedics, maternal and paediatric specialist services, emergency care, imaging, pathology and co-ordinated care of chronic diseases.

Second, establishing trustworthiness of the patient should be viewed as an aspect of health-system strengthening, not just an institutional image issue. Patients should be given clear information on their diagnosis, why they need a referral, what specialists are available, likely waiting times, expected cost of the referral and what treatment options are available. When medicines and diagnostic services are available and accessible, referrals are transparent, quality assurance systems are in place, communication is respectful, and there are meaningful systems in place for

patients to voice complaints, this can all affect the patient's confidence in local services.

Third, there is a need for improved formal patient-navigation and referral assistance in border districts. Today, several patients have already requested information from a pharmacist, ambulance driver, transport person, relatives and previously treated people from India. Formal services could complement these networks, supporting them by providing accurate information on referral processes, documents, emergency transportation, insurance coverage, medical records, and follow-up needs.

Fourth, continuity of care needs to be emphasized. The Health Sector Strategic Plan highlights enhancement of systems and equitable service delivery in Nepal (MoHP, 2023), yet what is a unique challenge for patients following treatment in India is linking treatment received across the border with following treatment at home. Provincial hospitals, local health services, patient-held records and telemedicine connections (where possible) and advice on when another trip to India is really needed could be introduced.

Fifth, the full cost of medical mobility should be taken into account and not just hospital costs. Some initial consultation or procedure may seem inexpensive but repeated trips include travel, accommodation, food, investigations, medicines, care taker's costs, working days missed. A greater responsiveness of health insurance coupled with referral-based support and appropriate social-protection mechanisms may diminish the financial strain on affected households. Policy should not always be to prevent patients from accessing health care in India. Cross-border care can still be feasible and useful in many situations including

emergencies and very specialized treatment. A more realistic objective is to reduce unnecessary financial and physical barriers, maximize the information provided to patients and minimize avoidable reliance, and ensure patients who do cross the border are supported before, during and after treatment.

Finally, the role of continuity of care as a driver of cross-border healthcare migration has important implications for treatment and follow-up care in the local health system. While the Health Sector Strategic Plan for Sustainable Development emphasizes the importance of equity and access to healthcare, patients who received treatment abroad often found themselves in need of continued care without the support of an integrated system. Provincial hospitals and healthcare facilities should invest in developing patient-held records, appropriate post-treatment follow-up methods, and teleconsultation opportunities, as well as engaging in meaningful dialogues with local treatment providers. Similarly, health institutions should acknowledge the necessity of repeat treatment journeys and consider their impact on patients' overall well-being.

Policy Recommendations

Based on the study findings, it is recommended that:

1. specialist healthcare services and diagnostic facilities be developed at the provincial level;
2. healthcare institutions invest in building patient trust by providing high-quality, reliable, and accessible care;
3. formal patient navigation and referral support services be developed;

4. healthcare facilities enhance the continuity of care for patients returning from treatment abroad;

5. the financial burden of medical mobility be reduced to ensure financial protection for the affected households.

The ultimate goal of this agenda should be to reduce inequity in healthcare access while encouraging patients to make informed decisions regarding their treatment options. It is equally important to develop responsive health insurance programs and referral support services.

The open border policy between Nepal and India means that formal bilateral coordination is required to address the needs of cross-border healthcare migrants. In particular, emergency response mechanisms, ambulance services, documentation support, and post-treatment follow-up services could be explored.

Limitations

The results of this study should not be extrapolated to all the regions of Nepal-India border. Most of the fieldwork was conducted in Sudurpaschim Province including Kailali–Kanchanpur corridors. Patients who had traveled through these districts were also included if their treatment journey included these districts.

The cross-border medical mobility is also mostly unorganized and fragmented, and there is no complete sampling frame, nor is it easy to obtain a reliable estimate of the amount of cross-border travel for medical services. To this end, the study is primarily concerned with the identification of patterns, experiences and decision-making processes instead of estimating the prevalence of cross-border

medical travel. Some data, especially treatment costs, dates, hospital procedures, and repeat journeys were subject to participants' memory. This information is therefore considered as household level information and not as independently audited records.

A clinical comparison of the quality of health care services and/or treatment outcomes of hospitals in Nepal and India was also not conducted as part of the study. The primary evidence were not Indian hospital records. Perceived quality, diagnostic reliability, hospital reputation and trust, do not refer to the objective ranking of individual hospitals or national health systems, but rather to the way the patients understood and experienced the quality of the healthcare options.

Conclusion

Healthcare mobility across the border between Sudurpaschim Province and India has become a part of the social fabric of the region and for many households, essential. This encompasses all emergency and planned trips, all types of medical conditions, Indian towns close by, significant medical cities, and single and recurring travel. The Gaurifanta and Gaddachowki border crossings are key healthcare corridors of Kailali and Kanchanpur. Dhangadhi, Attariya, and Mahendranagar are also significant intermediate places where families consult, arrange transport, reach out to relatives, fund the treatment, and make the decisions regarding the destination of treatment.

The results of the study indicate that distance and treatment cost do not fully account for medical mobility. Handled the patients' decisions are influenced by diagnostic uncertainty, perceived availability of

specialists, trust in institutions, family and community advice, transportation accessibility, past treatment experiences, and long-standing social networks. In many contexts, gaps in formal referrals and patient-navigation systems are filled by so-called informal actors, including relatives, previous patients, pharmacists, local health workers, ambulance drivers and transport workers.

If follow-up is repeated, then there's a third level of the problem. The diagnosis or treatment process, which starts with one in-country consultation, can become a long-term cross-border process with multiple consultations, medicines orders, investigations and post treatment review. This continues to place financial, logistical and emotional pressures on patients and their families.

The policy response should therefore not be based on the belief that discouraging all treatment in India is a good policy. Cross-border health care may continue to be valuable, especially in times of emergencies and when highly specialized services are needed. The more practical priority is to minimize unnecessary dependence and make the mobility of the necessary nature more safe and less cumbersome.

Improvements to specialist and diagnostic services in Sudurpaschim, improving referral and counselling services, making health insurance and financial protection more responsive, strengthening trust in local health care institutions and building up mechanisms for provision of continuity of care after discharge could have a significant impact. Practical coordination between Nepal and India is also significant as cross border healthcare is already an integral part of life for many communities in the border regions. A valid starting point for health planning in

Sudurpaschhim region of Nepal is to take medical mobility into account as a lived reality in health care provision.

Acknowledgment

The author is thankful to University Grants Commission (UGC), Nepal for financial support for this research under Small RDI Grant (Award No. SRDIG-81/82). This assistance helped to finish the study. The author also gratefully acknowledges everyone who contributed their time, experiences and support during the research.

References

- Adhikary, P., Aryal, N., Dhungana, R. R., Kc, R. K., Regmi, P. R., Wickramage, K. P., Duigan, P., Inkochasan, M., Sharma, G. N., Devkota, B., van Teijlingen, E., & Simkhada, P. (2020). Accessing health services in India: Experiences of seasonal migrants returning to Nepal. *BMC Health Services Research*, 20, Article 992. <https://doi.org/10.1186/s12913-020-05846-7>
- Bhatt, D. C. (2015). Socio-economic dimension of migration in Far Western Nepal. *Nepalese Journal of Development and Rural Studies*, 12(1–2), 23–32.
- Bhatt, D. C. (2018). Status of labour migrants and their families in Far-Western Nepal. *AMC Journal*, 1, 86–95.
- Bhatt, D. C. (2019). Missing migrants and their families in Sudurpaschhim Province. *Anusandhan Vatika*, 8(3), 1951–1962.
- Bhatt, D. C. (2023a). Embarking on a journey: A comparative study of selecting ideal migration destination among Nepalese and Indian labor migrants. *Journal of Engineering Technology and Planning*, 4(1), 60–71. <https://doi.org/10.3126/joetp.v4i1.58442>
- Bhatt, D. C. (2023b). Why do labour migrants cross their border? A comparative analysis between Nepal and India. *Journal of Tikapur Multiple Campus*, 6(1), 143–159. <https://doi.org/10.3126/jotmc.v6i01.56373>
- Bhatt, D. C. (2023c). Working environment and benefit differences in Indo-Nepal labour migration. *Far Western Review*, 1(2), 46–69. <https://doi.org/10.3126/fwr.v1i2.62110>
- Bhatt, D. C. (2024). Socio-cultural dynamics of cross-border labour migration between Nepal and India. *KMC Journal*, 6(1), 331–355. <https://doi.org/10.3126/kmcj.v6i1.62366>
- Bhatt, D. C. (2025). Across the border: Push-pull dynamics and the lived experiences of Nepalese labour migrants in India. *KMC Journal*, 7(2), 193–209. <https://doi.org/10.3126/kmcj.v7i2.83446>
- Bochaton, A. (2015). Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border. *Social Science & Medicine*, 124, 364–373. <https://doi.org/10.1016/j.socscimed.2014.10.022>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Chakravarty, D. (2023). *Health care beyond boundaries: Evolution of medical value travel in India*. Federation of Indian Chambers of Commerce and Industry.
- Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.

- Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE Publications.
- Gautam, P., & Bhatta, K. (2020). Medical tourism in India: Possibilities and problems of alternative medical treatment. *International Journal of Health Management and Tourism*, 5(3), 181–207. <https://doi.org/10.31201/ijhmt.634092>
- Government of Nepal. (2015). *The Constitution of Nepal*. Government of Nepal.
- Government of Nepal. (2019). *National Health Policy 2019*. Ministry of Health and Population.
- International Organization for Migration. (2018). *Research on the health vulnerabilities of the cross-border migrants from Nepal*. IOM Nepal.
- Lee, E. S. (1966). A theory of migration. *Demography*, 3(1), 47–57. <https://doi.org/10.2307/2060063>
- Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A., & Taylor, J. E. (1993). Theories of international migration: A review and appraisal. *Population and Development Review*, 19(3), 431–466. <https://doi.org/10.2307/2938462>
- Ministry of Health and Population. (2023). *Nepal Health Sector Strategic Plan 2023–2030*. Government of Nepal.
- Whittaker, A., Manderson, L., & Cartwright, E. (2010). Patients without borders: Understanding medical travel. *Medical Anthropology*, 29(4), 336–343. <https://doi.org/10.1080/01459740.2010.501318>