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Introduction

The latter part of the 20th century has been defined by the growth and expansion of vast infrastructures supporting the movement of people, money, things and data. These generated mutual interdependencies that (re)produced social, economic and political life across the world. The COVID-19 pandemic initiated a realignment of these relationships while accelerating a different kind of movement: the penetration, diffusion and ubiquity of telecommunication technologies. During the pandemic, governments enforced “spatial and temporal immobility” by shutting their borders and instructing their populations to ‘stay at home’ (Cabalquinto and Leurs, 2022). Teleworking and digitized home environments bridged local and transnational distances allowing the homebound to explore new virtual mobilities of work, leisure and care (Watson et al. 2021, Cabalquinto, 2021).

In healthcare, innovations in telemedicine filled the void left by the shutdown of routine activity even as they raised new questions about its potential and limits. As social distancing measures took effect in most European societies in the spring of 2020, in-person consultations and elective medical procedures were rescheduled or scrapped altogether. National healthcare systems and private providers worldwide responded by increasing their reliance on telemedicine, which refers to the use of telecommunications and information technology to support or provide healthcare services at-a-distance (including: therapeutic interventions, health assessments and surveillance as well as routine administrative tasks like scheduling appointments and filling prescriptions) (Botrugno 2022; Keesara et al., 2020; Golinelli et al., 2020). In short, as bodies were rendered immobile, information and

communication technologies extended and reinforced their reach into intimate spaces hitherto reliant on face-to-face clinical encounters and in-person engagement.

This temporary immobilization affected different groups in radically different ways. Rather than in the safety of homes (equipped with internet connections), members of precarious and marginalized communities—many of them migrants, refugees and other displaced people—spent Covid-19 lockdowns in a state of arrested mobility, in temporary accommodation, camps, detention facilities and even repurposed ferries. In what follows, we engage with these shifting configurations of human (im)mobility and digital technologies, to explore how people whom the pandemic caught on the move accessed healthcare at this historical juncture in Europe. We focus on pandemic Europe because of its relatively well-resourced health systems, which are nonetheless ridden with well-documented barriers and difficulties that migrants face when accessing healthcare. At the same time, these countries seemingly understood that if public health measures were to be effective, they must include everyone, not just those eligible for healthcare because of citizenship or residency rights (Lancet Migration, 2020).

In this article, we use the term ‘mobile groups’ and ‘mobile patients’ to describe people who temporarily, permanently, or seasonally relocate from one place to another due to a variety of involuntary or voluntary reasons (Taylor et al., 2011:345). Within the healthcare, public health and demographic literature these groups are typically referred to as migrants, refugees and asylum seekers, i.e. they are conceptualized as groups through reference to their legal status. We adopt the term ‘mobile groups’ to emphasize the fact of their movement across and within borders rather than their legal status *vis a vis* the state. Focusing on mobility in healthcare is a useful and underutilized vantage point that

foregrounds the exploration of mobility inequalities rather than differential entitlements to care within static systems (cf. Adey et al., 2021; Sodero, 2020).

This paper argues for a mobilities-informed approach to social science research on healthcare and migration. It does so based on a review of two types of sources: (a) gray literature and online communications produced during and in the immediate aftermath of the pandemic (up to the end of 2022), such as non-governmental organization (NGO) reports, governmental and healthcare provider communications, health guidance websites and the like; (b) secondary sources providing early analysis and assessment of pandemic public health measures. In this way we build up a picture of how governments and NGOs adapted healthcare services to the needs of people on the move in 2020 and 2021.

We precede the discussion of this evidence with a review of selected literature on networked technologies and migrant mobilities, followed by a discussion of the status of mobile patients in national health systems in Europe. On that basis we propose our concept of “the field” where researchers can begin to apprehend and document healthcare (im)mobilities. In the second part we draw on evidence from the Covid-19 era, ultimately to show that health services throughout the pandemic took some dynamic steps to engage with mobile groups, suggesting a partial recognition of an underlying ‘sedentary bias’ in how health services are configured. This finding underscores our wider point that although health systems are generally arranged to serve settled populations and not people on the move with uncertain status, they can be reconfigured to meet the needs of mobile patients by centering their views and experiences.

We argue that the adaptations (and failures to adapt) of healthcare systems throughout the pandemic represent important first steps in the larger task of reimagining not just healthcare for mobile groups, but also how health systems grapple with the

multiple mobilities that increasingly assert themselves in and around the contemporary delivery of healthcare. Mobile technologies and the immobile infrastructures that make them possible are central to these issues. We must ask however under what conditions do they enable mobile groups to access and enjoy healthcare.

Networked technologies and migrant mobilities

Networked technology has been globally transformative and, as digital migration scholars argue, it has also fundamentally changed the experience of migration. Since 2015—when newspapers and politicians began referring to Europe’s so-called “migration crisis”—researchers documented a rise in the number of migrants using smartphones to navigate their way into Europe via Balkan and Mediterranean routes (Leurs and Ponzanesi, 2018). They asked why displaced migrants adopt digital technology and how they use it across the multiple stages of their journeys (Moran, 2022). This work focuses on the affordances made possible by mobile telephony, including call and messaging platforms, translation apps and websites, as well as social media and digital maps. Scholars document how displaced migrants use digital and social media to crowd-source information about navigation routes, crossing sites, compare smuggling services, as well as trade intelligence about refugee centers and landing sites (Alencar et al., 2019, Zijlstra and Van Liempt, 2017).

Digital technologies, in particular social media platforms, also function as emotional and mental health resources. Neag and Supa (2020) argue that the social media practices of their African and Middle Eastern research participants provided these refugee youths with a platform to process complex and multifaceted experiences of loss (e.g., of parents, social networks, ‘home’, childhood). These practices played as much a role in the grieving process

as they did in participants' ability to adjust to their new status as migrants in Europe. Others note that mobile technologies like smartphones and online channels help migrants provide and receive transnational and translocal forms of care which support health and wellbeing through the maintenance of social connections, cultural networks and social identities across distance (Cabalquinto 2020, Baldassar and Wilding 2020). Mobile technologies can also sometimes support transnational health-seeking practices. For example, González-Vázquez et al. (2015) found that recent Mexican migrants to the United States used telemedicine consultations with traditional healers to circumvent their undocumented status and address the barriers they faced in accessing healthcare. Another study found similar telemedicine health practices among Latin American migrants (whose success at accessing NHS provide medical care was variable) in London (Gideon 2011).

The above literature also points to sedentarist assumptions embedded in the delivery of healthcare, that is the built-in expectation that service users will be settled and connected within the relevant practice's or clinic's catchment. In this scenario, patient records are kept in place and tied to their home address; as much as possible, their referrals are locally managed, enabling at least in theory a smooth coordination of in and outpatient services and support in the community. A settled place to live is a key part of this puzzle, and in its absence the whole endeavor of healthcare is challenged. To set this sedentary bias in a wider context, we may recall Liisa Malkki's claim that sedentarist metaphysics embedded in language and social practice actively territorializes our framing of cultural and national identities (1992). For Malkki, sedentarist logic mobilizes a view of territorial displacement as exceptional and outside "the natural order of things", rather than as a fact about socio-political contexts that institutions must be responsive to (1992: 33). What that means for healthcare is that the mobile patient is seen as an aberration, requiring special

arrangements outside standard frameworks. Those arrangements in turn demand resources and hence may be deprioritized in conditions that are already hostile to the displaced.

In their discussion of the transnational health practices of Somali migrants in Finland, Tiilikainen and Koehn (2011) emphasize that migrants' liminal status and cultural identities inform their view of healthcare options. Their research participants engaged with healthcare practices in Somalia and Finland, in person and at-a-distance, illustrating both the constraints and fluidity of territorial boundaries as much as a systemic failure of recognition: "...physicians in the North do not consider an individual's transnational social world and are unaware of healthcare inquiries and resilient practices that span borders" (Tiilikainen and Koehn, 2011: 536).

Thus, smartphones and other mobile technologies are important tools in migratory journeys, help maintain migrant identities and can support the transition to a new life in a foreign country. As Borkert and colleagues (2018:2) argue these technologies help address some of the "highly complex information needs" and "informational precarity" (Wall et al., 2017) migrants face. This is a point that is frequently articulated by organizations that seek to support displaced people. For example, Bernadas and colleagues (2019) explored the health activism of non-profit and faith-based organizations with Filipino migrants in Japan. They found that alongside face-to-face interactions, digital media (in this case Facebook) was a key method used by these organizations for disseminating information and running educational campaigns. Such practices became indispensable during the pandemic when some migrant organizations in Italy and the UK relied on social media groups (on Facebook and Viber) as tools for monitoring the needs of their irregular and undocumented members, as well as coordinating resources and sharing information across their social networks (Vilog and Picos 2021).

Digital migration studies identify informational precarity as a core problematic migrants face as they navigate state bureaucracies and social institutions. Scholars in the field of critical border studies supplement these points in their work on ‘everyday bordering’ and its effect on the migration experience (Yuval-Davis et al., 2019). They chart the ongoing displacement of bordering practices from the guard checkpoint on the frontier, to their replication and “ubiquity” deep within the social fabric (Balibar, 2002). This body of research emphasizes the Janus-faced nature of borders: they continue to function as preeminent sites of political governance while, increasingly, also forming part of a more diffuse set of internal mechanisms and procedures designed to fix and negotiate who can access what set of rights (travel, health, citizenship, employment, education) across a wide array of social institutions. Because of its universal character and symbolic prominence, a key arena where ‘everyday bordering’ practices proliferate is the field of healthcare and the struggle over access to national health systems (Cassidy, 2018; Potter, 2018; AUTHORS, 2020). These scholars also emphasize that policy ambiguity and lack of informational clarity about who is entitled to what, function to support exclusionary health practices (Worthing et al. 2022). Although international covenants stipulate that health is a universal human right, in practice, healthcare demands resources. How those should be distributed is always contested. Direct and indirect ways of limiting access to healthcare for persons whose legal, residency and fiscal status is irregular have crept into most European healthcare systems as part and parcel of policies seeking to curb unwanted migration, “health tourism” and “drains on the system” (Ingelby and Petrova-Bendict, 2016). In this context digital technologies reveal their double edge. Indeed, an important aporia identified in the literature, which dovetails with the documented reluctance of migrant groups to access

health care on site, involves the possibility of the uses of these new technological tools for the purposes of state surveillance (Witteborn, 2021).

Mobile patients and national health systems

Mobility is a human and social capability inflected with race, gender, class and disability inequalities (Sheller, 2018). The Covid-19 pandemic exposed them, and it continues to exacerbate their impact. Above all, it illustrates how inequalities in mobility, interwoven in different sites and at different scales – local, national, international – can generate cascades of systemic failure that limit the effectiveness of states and their health systems to respond to medical crises (AUTHORS 2020). During the pandemic, the interaction of these scales produced a pattern of health disparities that affected people on the move, especially economically precarious migrants, refugees and asylum seekers (WHO, 2020). For example, the pandemic closures and shutdowns revealed the extent to which national health systems are predicated on the mobility of capital, supplies, data and humans. At the same time Covid-19 also provided new justifications for shutting down movement at the border, fusing hygienic-sanitary rationales with existing border practices and policies, that resulted in arresting the mobility of people seeking to enter Europe, often in search of safety (Tazzioli and Stierl, 2021).

The health of mobile groups is not inherently worse than that of the general population. According to the “healthy migrant” hypothesis, migrants are the *healthier* group which is seen as a decisive factor in migration (Borhade and Dey, 2018). They can also have particular and complex health needs. Some of these are linked to the availability and quality of medical care in their country of origin, while other needs are a byproduct of the

experience and accumulated duress of the migratory journey (AUTHORS 2020, Prestileo et al. 2015).

These mobile groups encounter national health systems that are poorly configured to receive them. Migration and healthcare research identifies a number of differences within service use and access among domestic and migrant patients. Across studies, migrants tend to use secondary, screening and outpatient specialist services at lower levels than the *host* population (Graetz et al. 2017). They also tend to have higher hospitalization rates and make greater use of Emergency care services (i.e., Emergency Rooms, Accident and Emergency services). There is a strong argument for linking these differences with structural and cultural barriers to health: studies in Italy and the UK found that Emergency care services were frequently the first (and sometimes only) contact migrants had with the national health system (Di Napoli et al., 2022, Harrison and Dekker-White, 2019). This may in part be related to the fact that for many origin countries, the hospital is the first (or only) point of access to the healthcare system, but it also speaks to these services' greater flexibility and responsiveness. For example, emergency services are always in operation and many migrants work in precarious and complex employment condition; they may need to access primary care outside regular business hours (Di Napoli et al. 2022:5). It is also a resource that helps circumvent the complexity of navigating health systems by providing a prompt resolution of an immediate need while simultaneously reducing linguistic, cultural and bureaucratic barriers (De Luca et al., 2013).

The overwhelming evidence across Europe finds that there exist significant barriers to accessing care linked to organizational issues, health literacy, language, cultural differences, as well as a lack of knowledge about existing services and benefits (Graetz et al., 2017). In addition to the complex health needs mobile groups may present upon arrival, the

social determinants of health in receiving countries, linked to poor working environments and precarious economic status, intersect to generate a “migrant health deficit” which means health status may deteriorate over time, particularly for those navigating asylum systems (Lebano et. al., 2020:1042).

The above studies also highlight the difficulties migrant patients face in securing continuity of care. In previous work (AUTHORS 2020:179) we drew on the experiences of an Italian physician working on the frontlines of Mediterranean migration who described the above dilemma as the *Prometheus syndrome*—a reference to the Greek myth in which Zeus punished Prometheus for aiding humans by chaining him to a mountain. In this case, the broad entitlement to free treatment for communicable diseases (as is the case elsewhere in Europe) also means that to be treated, in practice, the person on the move must (at least temporarily) give up the migratory journey. A continued journey through different regions and countries in Europe would sever links to the local clinic and hence the continuity of care. Like Prometheus—the migrant patient is a prisoner to their own healthcare needs.

The first point of arrival is not necessarily the endpoint of the migratory journey and migrants will continue to move until they reach a destination that *is acceptable to them*, which may involve many stops, longer stays, some setbacks and a number of reassessments along the way (Duvell, 2012). One drawback of the healthcare and migration literature is that it can tell us about access and service utilization among migrants who reached their destination, or are in refugee centers for longer periods, but it has little to say about the health needs and experiences of those in transit or otherwise “on the move” (Van Loenen et al., 2018: 82). Indeed research participants in one study looking at reception and transit centers across Europe spoke about how the desire to continue moving towards one’s

destination impacted their decision to seek care for health problems (Van Loenen et al 2018).

If migrant trajectories are non-linear and are best understood as “open spatio-temporal processes with a strong transformative dimension” (Shapendonk et al., 2020:212), then the interruption of care continuity may recur throughout individual trajectories. Exploring those trajectories, and how individuals weigh healthcare decisions against other competing imperatives emerges as one area of research. Even if we had a grasp of these decisions however, we would still understand only one part of the story, one that covers people’s struggles within exclusionary systems. Another side, and arguably one that is vital to building more inclusive healthcare, is the story of how information about the patient (diagnoses, medical history, referrals and other records) travels between different nodes of health services, who is in charge of it and in control of access to it.

Conceptualizing the field

The mobile patient may come on and off the radar of healthcare practitioners in different locations and existing research indicates that he or she is rarely effectively ‘reconnected’ to their health information across time and space. This detachment poses a methodological challenge, where “the field” consists both of the whereabouts of the patients and the (most likely virtual) whereabouts of their data. This last question intersects with concerns about the surveillance of mobile groups, the fear of which is also a recognized barrier to healthcare, as we know that for example in the UK “the government has ... pushed several data sharing arrangements within the NHS and externally with other public services,

that enable patient data from the NHS to be used for immigration enforcement purposes” (Essex et al., 2022:1).

The pandemic, and the new refugee movements that got under way before the pandemic fully receded, heighten the need for a fundamental rethinking of the role(s) of mobility in these systems. In other words, these crises force us to rethink what we call ‘sedentary healthcare systems,’ that is health systems designed on the assumption that they serve settled populations (Kaspar et al., 2019; AUTHORS 2020). Within the European Union, this ‘sedentary’ bias is illustrated by the fact that despite the commitment to freedom of movement in the Schengen area, proof of legal citizenship and/or permanent residency in a member state is a basic requirement within European health and social insurance systems for accessing healthcare—whether based on an insurance or a universal health care model free at the point of access. This is a problem not just for highly mobile and marginalized populations, but for some European migrants as well because increased levels of mobility in the latter group have disrupted the clear alignment between citizenship, place of residence and of employment (Probst 2023). Indeed, Stan (2015) noted that Romanian migrants in Ireland working in low-wage or informal sectors of the economy often struggled to meet the “ordinary residence” condition for accessing free healthcare services. Within the UK studies have illustrated that a key barrier for migrants, members of the Travelling community and people experiencing homelessness in accessing care is the unwillingness of GP offices to register them without proof of address, despite the fact that there is no NHS requirement to provide proof of identity, address or immigration status for registration (Sweeney and Worrall 2019).

As we note above, the sedentary bias in health systems is not just the cause of formal or informal barriers to care but is also reflected in the range of dominant socio-

cultural assumptions and competencies embedded in the delivery and practice of healthcare. The experience of being a migrant is a liminal status that is constrained by, but not necessarily limited to, territorial boundaries. In part, as we have seen, this is because information and communication technologies directly support the maintenance of multiple border-spanning forms of identity and meaning.

Thus, rethinking sedentary healthcare systems requires a grasp of what healthcare looks like from the *point of view* of the mobile patient (Lebano et al., 2020). From this vantage point, the coherence of these systems, their responsiveness and their use value is not necessarily national, static or fixed. Rather, these systems are parts of a vast health assemblage spanning multiple countries. It consists of national health systems which retain significant formal entitlements to healthcare for migrants, even if in practice access is graded, unequal and complicated. There is also a wide-ranging complex of situated initiatives staffed by local practitioners, volunteers and advocates who respond to the specific health needs and problems of access unique to these populations. Under which circumstances is it possible for people on the move to navigate these systems? How can the pursuit of health fit within the time-horizon(s) of migratory journeys themselves? Where (in terms of place, immigration processes, and destinations) an individual is in the migratory arc is an important factor in determining both access to and the utilization of healthcare structures. In other words, a migratory journey is also a health journey.

Evidence from lockdowns: crisis, mobile patients and digital health

The question then, is how to map this vast mobile health assemblage? How might we follow research participants as they move through these differential scales and

infrastructures? And what role can digital resources which, as we noted above, have been identified as indispensable tools in migratory journeys and important aspects in maintaining continuity and community among migrants, play in both charting these trajectories and helping migrants make these health journeys intelligible and viable? In what follows we describe a number of Covid-19 era initiatives that provide a useful starting point for this conceptual reorientation. These encounters and initiatives in the international healthcare assemblage unfold in the mediated space where members of mobile groups renegotiate the terms and conditions of face-to-face recognition, while at the same time both adapting to and resisting the digital tools rolled out during the pandemic. They struggle for resources in overstretched systems while remaining vigilant of state surveillance and immigration control. From the perspective of research, this space constitutes the multi-sited field, encompassing sites like the clinic, the NGO, the mobile app interface, the community hub and other venues where health-related conversations and health-seeking behaviors unfold—all of them raising their own methodological and ethical challenges.

One common understanding of crisis relates to its generative qualities. Crises are frequently depicted as turning points against which actions are pursued and decisions made. Covid-19 was no exception; it spurred innovations across the field of healthcare as governments were forced to temporarily confront some of the structural barriers to healthcare access in the name of public health. In the UK, a series of mobile and pop-up interventions (e.g., Nightingale hospitals, walk-in vaccination centers, and mobile vaccination units) sought to manage the spread of the virus and alleviate hospital pressures. Many of these innovations illustrate the point that healthcare systems have the capacity to be more responsive to the unique needs of mobile and migrant populations. A number of countries besides the UK (including France, Ireland, the Netherlands and Finland) provided

full access to vaccinations without the requirement to prove residency or present identification (Slootjees 2021:15-16). Portugal temporarily regularized most foreigners and provided them with free access to the national health system. Municipalities like Berlin temporarily extended anonymous and free access to ambulatory care to undocumented migrants. Others apportioned part of their city budgets to temporarily cover the costs migrants would incur in accessing the healthcare system (Slootjees 2021, PICUM 2020).

Material interventions had a significant effect on broadening access to healthcare systems but the widespread acceleration in telemedicine adoption held the most transformative potential. According to the healthcare literature, the benefits of telemedicine include its lower economic cost (as compared with traditional services) as well as its capacity to broaden access. Interventions ranged from Covid-19 patients followed at home by telecare programs as in the hard-hit Italian region of Lombardy (Bernocchi et al. 2022) to the routine adoption of virtual consultations by general practitioners in Germany, where nine out of 10 physicians began offering the service during the pandemic (von Weinrich et al. 2022). Some countries like Switzerland, where before the pandemic 44 percent of emergency room walk-ins consulted with their doctors via a telehealth platform before leaving the house, expanded their range of telehealth services beyond triage and primary care (Omboni et al. 2022).

The United Kingdom was no different: one study found that 90 percent of GP appointments and 46 percent of nurse appointments were done remotely in April 2020 (Murphy et al. 2021). In Scotland, between March and June 2020, the number of video consultations went from 330 to 17,000 per week. For the rest of the UK (Wherton et al. 2021), in the months immediately before and after the start of lockdown, remote consultations went from 30 percent to 89 percent. Similarly, text message use by GP

practices tripled between April and July 2020, revealing specific advantages for engaging with migrant patients: some doctors used online translation tools such as Google Translate to communicate with patients in their language (Knights et al. 2021).

However, innovation has its limits. With the announcement of lockdown in the UK, GP surgeries and other healthcare services shifted to remote consultations using video, telephone, email and text messaging for important routine activity as well as limiting face-to-face appointments to only when absolutely necessary. The NHS also postponed all non-urgent elective operations from April 17th for 12 weeks. Doctors of the World (DOTW) UK (an NGO that aids excluded people by providing medical care, information and support) followed suit moving from face-to-face consultations to a telephone assistance and free advice line (DOTWUK 2020). This closure of drop-in clinics had a dramatic effect on the number of service users and consultations. For example, the average monthly number of consultations went from 170 before the pandemic to 50 during the crisis (Lessard-Philips et al., 2021:7, 12). In some cases, the shift to telemedicine sharpened the effect of existing technological disparities linked to socioeconomic factors. Clients reported lack of phone or internet credit, as well the inability to access a phone, printer or computer as significant impediments. Others found the process of registration daunting, as it often required complex technological interactions between different devices:

They ask you to go on the website, fill out the form, sign it, and then send it back to them, so they can register you. I mean, I don't have a scanner, I don't have printers, then how can I download it, scan? Or, if I can do it online, like an electronic signature, most people don't know how to apply that. You need a computer. You can't do that on your phone. So, those forms, for example, are not accessible at all for many people. (Migrant 9) (Knights et al., 2021: 587).

Clearly it is not the case that *all* migrants lack access to digital devices or Wi-Fi connection points (Marler 2018). However, access to smartphones or Wi-Fi does not necessarily mean that these devices have sufficient speeds and permit bandwidths necessary for video conferencing and other data intensive tasks. For example, many vulnerable groups supplement unreliable data connections with access to the internet in other spaces, such as public libraries or other community sites with free Wi-Fi spots (Ramsetty and Adams, 2020, AUTHORS 2022). The pandemic forced the closure of these spaces, while increasing the number of individuals in a household that needed to use digital devices and access to the internet thereby further compounding access problems (McMullin, 2021). A similar point was made in a recent report on access to primary care services for Traveller and Roma communities during the pandemic: these nomadic communities in the UK (another mobile population, albeit not necessarily cross-border) display stark differences in terms of access to the internet (38 percent of Romany and Traveler people had a household internet connection compared with 86 percent in the general population) and digital literacy (over 50 percent do not feel confident using digital technology) with the general population (Mitchell and Garrett 2021). In 11 out of 19 GP practices contacted, patients were denied primary care because the practice refused to register patients unable to use their online registration facilities. In another study, primary care staff provided informal workarounds for registered patients who were digitally excluded (like older patients) by completing online consultations on their behalf over the phone or in person (Turner et al. 2022) but this was ad hoc and multiplied administrator workloads.

Digital exclusion was a barrier to telehealth services and it made migrants more vulnerable to misinformation about the virus (Bastick and Mallet-Garcia, 2022). These vulnerabilities manifested themselves in terms of poor access to digital technology or limited digital literacy, a set of disparities prominent among socio-economically precarious and medically disadvantaged populations. For example, a key concern for these groups was simply getting timely, up-to-date information and guidance about how to protect themselves from COVID-19. Many of the barriers to health vulnerable and migrant populations routinely face were exacerbated when ported into digital spaces. One report on migrants and other vulnerable populations in England during the pandemic highlighted that besides the issues already noted (e.g., cost of access and ability to find relevant information on government websites), guidance and recommendations were written in English and in a way that was difficult to understand for non-native speakers or individuals with low literacy levels. Translations into other languages were selective and often delayed. Finally, because outreach and drop-in support services, as well as other informational sites and resources like community meetups and social networks were closed, effective avenues for the dissemination of relevant knowledge to protect one's self from the virus was cut off (DOTW, 2020).

Sweden's experience provides an important contrast to the above case and illustrates what rethinking health interventions from the point of view of the mobile patient might look like. In April 2020, a number of healthcare centers in large Swedish municipalities (including Stockholm, Gothenburg and Norrköping) supplemented existing national telephone assistance lines with so-called "corona lines" staffed by healthcare workers from diverse cultures and fluent in a range of languages (Arabic, Somali, Tigrinya/Amharic and Persian/Dari). These professionals provided a range of telemedicine

services, including information on: how to protect one's self from the virus, triage of those with respiratory symptoms, as well as advice on home care, individual and community hygiene. These telephone response lines were part of a broader, targeted set of initiatives involving multilingual pamphlets, producing videos that were shared on Facebook community groups and other social media platforms, as well as posters placed in community centers (Sweden famously chose not to "lock down" society). The explicit goal of these efforts was to enhance the availability of up-to-date information about the virus among migrant communities, themselves seen to be a part of the population particularly at risk (Valeriani et al., 2020).

The contrast between the UK and Swedish cases is instructive. Both are illustrative of the "sedentary bias" inherent in national health systems discussed above. In many countries, when telemedicine solutions were introduced shortly after the global recognition of the pandemic's scale in early 2020, many of these innovations were grafted onto existing health systems that were oriented towards serving the needs of settled populations. Indeed, the greater flexibility and responsiveness of the Swedish example serves to underscore the point that the "corona lines" were initiatives put in place to circumvent or supplement existing services provided by the national health system which was known to have failed in its efforts to reach a migrant subset of the population that was particularly vulnerable and frequently excluded. These insights are relevant not just to future public health emergencies but to the wider field of healthcare delivery. For example, one of the key roles telehealth played throughout the pandemic was that it allowed patients already within the health care system, and with normal access to primary care, to maintain a degree of care continuity with their doctor when in-person visits were no longer feasible. Digital portals also facilitated other routine but pandemic-impacted, administrative tasks like refilling

prescriptions or scheduling appointments (Chang et al., 2021). Yet again, these innovations when grafted onto existing pre-pandemic health service configurations work to magnify disparities rather than mitigate against them largely because they presuppose registration within (and trust of) the system, digital access to and literacy of national health portals, as well as a degree of bureaucratic competence.

Finally, it is important to note that although many of the telemedicine innovations described above focused exclusively on the delivery of healthcare, these services do not exist in a vacuum. The work of NGOs and other organizations is crucial in bridging cultural, bureaucratic and linguistic barriers to accessing healthcare for migrant groups. Here the experience of some NGOs supporting migrants during the pandemic is instructive. Many of the integration services (e.g. language classes, advice on housing and education, interview training, cultural activities) offered by these organizations whose clients are newly arrived migrants and refugees have an important in-person, face-to-face dimension. Moving those services online was not just logistically complex, but technological mediation also affected the degree of service user engagement, shifting user comfort and trust in the process itself (McMullin, 2021). When viewed as part of the larger ecosystem of migrant support, healthcare, whether delivered remotely or in person, likewise remains dependent on trust and a willingness to engage in the first place.

Conclusion: healthcare and mobility beyond the Covid-19 pandemic

This essay has sought to achieve two things. Firstly, we set out to propose a mobilities-informed approach to social science research on healthcare and migration, as a useful corrective supplementing more traditional frameworks that explore access to

healthcare through the prism of status, entitlement and the realization of the right to health. Secondly, we engaged with evidence gathered during the Covid-19 pandemic that suggests that when confronted with a public health emergency, health systems have the capacity to be responsive to the needs of mobile groups. We have argued that these efforts could become more successful if they grew out of a recognition of what we have called healthcare's 'sedentary bias', and if they aimed to transcend it. National health systems are configured to serve settled populations. They are not designed for people on the move, whose residential, immigration and fiscal status is uncertain. However, as we have sought to show above, this bias can be alleviated when health interventions are rethought from the point of view of the mobile patient.

As in other spheres of life during the Covid-19 lockdowns and restrictions, healthcare resources were mobilized to shift many routine services online, spurring an acceleration of developments in telemedicine. While hospitals were at and beyond capacity caring for a steady flow of Covid-19 patients, and emergency and other essential services like maternity wards operated in the shadow of burdensome restrictions, primary care and many specialist consultations were conducted remotely, over the phone, video and mobile apps. This also extended to healthcare-related bureaucratic tasks, such as the registration of new patients. The rollout of these practices intersected with the phenomenon of digital exclusion, making healthcare partly or completely out of reach for those without the means or ability to connect. People without fixed residency or otherwise on the move constitute a subset of the digitally excluded, and this exclusion may only be partial or temporary. But that does not make it less significant. Where interventions in healthcare were designed specifically to overcome the barriers that affected those groups, as in the case of the "corona lines", they were promising. Where digital solutions were grafted onto the existing healthcare

infrastructure, leaving the underlying sedentary bias intact, problems of access, distrust, cultural and language barriers manifested themselves similarly as in the case of face-to-face services. In these circumstances, overstretched, often NGO-led initiatives designed for mobile patients were forced to grapple with the needs of those whose unaddressed health problems mounted.

The insights into the problematic functioning of telemedicine during the pandemic, combined with the more general observations on healthcare's sedentary bias, its effects on mobile patients and the risks it presents to public health, lead us to call for qualitative research that asks and answers questions about the scope for action and change. This work must take a holistic view of the field, encompassing the clinic, its record-keeping and record-sharing practices, the mobile app and the infrastructure that underpins it, and any other place where health is pursued and discussed. In this multi-sited field we should also not forget the state which, as Cabalquinto and Wood-Bradley (2020) have argued, is highly capable of supporting migrant needs through digital and platform technologies when sufficiently motivated. Building on work in digital migration studies, critical border studies and mobilities research we must rethink fieldwork further, by integrating online and digital research, as it has been developed during the pandemic (with the unmediated sociality of participant observation and other creative and participatory methods, which enable us to "to vault out of silos and leap over boundaries" (Kara 2015, 3). In this way, after Covid-19, fieldwork in health and mobilities should explore the affordances of telemedicine and its limits, the manifestations of digital exclusion, the production and circulation of digital patient records, and the changing relevance of the unmediated, face-to-face encounter. In the 21st century marked by multiple crises, we all belong to populations in need of systemic

responses to our health needs. As such we would all be better served by systems built to recognize our heterogeneous relationships to mobility.

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