

Transnational Healthcare Practices of Retired Circular Migrants

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Transnational Healthcare Practices of Retired Circular Migrants

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Abstract

Studies on healthcare of migrants usually focus on their problems including mental health, psychosomatic complaints, assuming that they mainly use the healthcare services of the host country. As migrants may also use healthcare services in their home countries, we examine empirically the influence of being subject to different healthcare systems and services particularly focusing on the migrants' consumption of medicine. This paper contributes to the literature by specifically exploring the transnational healthcare practices of retired migrants from Turkey. Drawing on 10 qualitative interviews conducted with migrants from Turkey living in both Germany and Turkey, this paper illustrates a qualitative analysis of healthcare practices and polypharmacy – multiple medicine consumption, of migrants.

Keywords: transnational healthcare, circular migration, polypharmacy, Germany, Turkey

Transnational Healthcare Practices of Retired Circular Migrants

Başak Bilecen and Hürrem Tezcan-Güntekin

Introduction

Healthcare is one of the major pillars of social protection, which is described as ‘strategies designed to cope with the social risks arising in capitalist economies, in fields such as employment, healthcare and education, which might impede the realisation of life chances as defined in the United Nations Convention on Social Security in 1952’ (Faist et al., 2015).

Over recent years, transnational healthcare practices and services began to attract scholarly and public attention because of their being part and parcel of several, often politically induced, developments influencing social welfare, social policies and societies in general.

Research intersecting ‘migration’ and ‘healthcare’ has gained increasing attention across a wide spectrum of scholarship ranging from migration studies (Gideon 2012; Manjivar 2002), social policy studies (Dwyer 2001) to public health (Geiger and Razum 2006; Norredam et al. 2006; Razum et al. 2005). Although most of this research considers wider impacts of migration on the health of migrants usually related to mental health or psychosomatic complaints, this paper concentrates on circular migrants who live between two nation-states and organize their healthcare across borders.

As the following literature review indicates, this phenomenon has so far been mostly answered by employing perspectives that regard migration and their healthcare related practices either as an outcome of their lower socio-economic background or portraying a ‘problematic’ contour. Criticizing these confined and deficit oriented perspectives, this paper proposes a dynamic perspective arguing that migrants have simultaneous attachments not only to different nation-states, and thus, healthcare systems, but also they might have different healthcare practices. By employing the term transnational healthcare practices we refer to the socially embedded nature of health. Following the literature review, we lay the groundwork for understanding migration and healthcare arrangements between Germany and Turkey. The subsequent section introduces the research design and methods used to approach this matter empirically. The analysis section is divided into three, discussing migrants’ transnational healthcare practices, followed by a conclusion.

Conceptual Framework

Despite the growing scientific interest in migration and health, most studies on the subject concentrate on the labor migrants' 'lower' social status compared to the native population and thus the influence of their low socio-economic position in the society to their stress-related diseases (Huismann et al. 1997), mental health problems, depression (Bhugra 2003; Silveira and Allebeck 2001; Wittig et al. 2008), psychosomatic complaints (Mirdal 1985) and mortality (Razum et al. 1998). Another vein of studies concentrate on return migrants, who are composed of individuals migrated to another country for different reasons and then migrated back to their countries of origin. The research indicate that while some of the returnees arrive healthy such as those who had 'good' employment conditions as well as access and use of the healthcare services in the host country; not all returnees had the same opportunity and some of them might have adopted unhealthy lifestyles increasing the risk of non-communicable illnesses such as diabetes (Davies et al. 2011). Moreover, most of the studies are nationally oriented despite the transnational character of the phenomenon, and therefore, still little is known about how migrants negotiate their healthcare practices across borders.

Migrants have simultaneous attachments to various geographical locales, meaning that their lives span multiple geographical borders. Transnational studies usually conduct research on resource flows between the host and home countries as well as the social, political and economic cross-border ties of migrants and their significant others (Faist 2000; Levitt and Glick-Schiller 2004). It is important to note that transnational studies do not imply weakening of the nation-states, but rather their contribution is at the methodological level by redefining the social world as composed of not only within the framework of nation-states but in which non-state actors play a crucial role too. A transnational perspective in understanding the migrants' reach to health is necessary since their lives are revolving around at least two geographically distinct contexts, and thus, two different understanding of welfare and healthcare systems. Circular mobility is particularly interesting in the context of transnational studies because it is another form of mobility in which individuals regularly go back and forth between different geographies and are exposed to both systems. According to Krumme (2003), three patterns of circular migration exist: commuting with bi-local orientation, commuting after return and commuting while staying. In the same study, Krumme argues that older retired migrants have the possibility to use locally-based resources in both countries through commuting. Similarly, Strumpfen (2012) investigated older migrants'

experiences who commute between Germany and Turkey and found out that they perceive their commuting as a resource, to be able to live in two different countries. However, still there is little known about those resources embedded in both contexts of home and host countries, particularly in healthcare.

The increasingly plurilocal nature of the lives of many requires them to deal with a wide range of coexisting different welfare, socio-cultural contexts and influences when seeking healthcare and treatment. In such situations, treatments, medical materials, ideas and beliefs are interchanged within and across a range of health and treatment networks, which might go beyond the relationship only between an individual and their doctor. Indeed, the involvement and usage of a plurality of medical approaches and medicines is documented for migrants across the globe to some extent (Assion 2004; Eichler 2008; Stekelenburg et al. 2005). Polypharmacy means consumption of plural medicines including the prescribed ones and self-medication. Usually older people who are over 65 suffer from multiple chronic diseases including diabetes, high blood pressure or cardiovascular complaints. Thus, they are treated by different physicians who prescribe different medicines for different purposes. When individuals buy their own prescription-free drugs from pharmacies, or given by their friends or family members, or take out from their medicine chests, then the risk of undesirable side effects increases due to their simultaneous consumption of various medicines. Some of the side effects include well-tolerated pharmaceuticals, unwanted drug addictions and increased risk of dizziness and related falls leading to hip fractures. According to the study conducted by Marcum and his colleagues (2012), 36.8% of older patients, who were referred to a hospital in emergency situations, were found out to take plural medicines inappropriately. Although it is quite widespread practice, polypharmacy is recently addressed as a serious concern 'because it has been implicated in drug–drug interactions, adverse drug reactions, low adherence to drug therapy, falls, fractures, visits to emergency departments, unplanned hospitalizations due to adverse drug reactions, increased health care costs, and even increased mortality' (Rohrer et al. 2013: 101). However, there is no empirical research of plural medical consumption in the context of migration. Therefore, this paper brings together migration scholarship with public health in dialogue in order to investigate transnational healthcare practices of migrants.

Healthcare Systems in Germany and Turkey

In Germany three mandatory areas of insurance are composed of health insurance, accident insurance and long-term care insurance. The healthcare system in Germany “can be characterized by predominantly social insurance-based regulation and financing combined with a high and increasing share of private healthcare provision” (Wendt et al., 2009: 86). The contributions for healthcare is paid by both the employers and the employees in the German system (see, for an extensive review Wörz and Busse, 2005). In a universal, multi-payer system, health insurance is financed by public and private insurance schemes, which is financed by contributions. All of the employees having a salary must have the public health insurance. Civil servants, self-employed and those employees who have more income than a yearly set amount threshold may have private health insurance (in 2013 = XXX euro per month). Moreover, individuals may also choose to have a private insurance in addition to the public one for certain services such as dental treatment.

The public insurance in Germany covers the main and basic healthcare, set by the Federal Ministry of Health. It is calculated on the basis of the person’s income (which is currently set to 15.5%), rather than the health condition of the person. On the other hand, private health insurance is more flexible, meaning that the person is able to choose for certain services in agreement with the insurance company and it offers additional benefits including shorter waiting lists for appointments. According to the statistics obtained through Federal Statistical Office in 2011, the majority of the insured are by public services, accounting up to 86%, while 13% is insured by private schemes, up to 13%. In addition, a very few of the working population, 0,2% have no health coverage at all, although it is compulsory. Family physician is the first contact point for a treatment in Germany. Every insured person has to have a family physician, who gives a first diagnosis and transfers the patient to a specialized physician for further treatment when there is a need.

In Turkey formal social policies combine public health and pension system based on employment. Up until the reform, the social security system in Turkey were composed of three different social security structures: since 1945 the Social Security Authority (SSK) was responsible for workers both in the public and private sector, since 1949 the Retirement Fund (Emekli Sandığı) was responsible for civil servants as well as since 1971 Social Insurance for the Self-Employed (Bağ-Kur). Those without any formal social security used to get ‘green card’ since 1992 for healthcare services. All of these structures used to provide services in old age pension and healthcare; however there were huge gaps in access and quality in

health services these schemes provide. For example, the public hospitals they could go were different in status and services. Hence, patients were paying themselves to get private and 'better' treatment. State contributions to the three social security schemes were marginal until the 1990s except for civil servants' healthcare related costs through the Retirement Fund. There have been recent transfers from the state budget to cover the huge deficits in those schemes and therefore the burden borne by those transfers has been pressing social security reform. Under this reform the state began to contribute to the social security system, although the contributions lag way below EU countries (see, for extensive review, Buğra and Keyder, 2006).

Under the new law 5510, effective from October 2008, health insurance, old age pensions, and social assistance have been reorganized under one umbrella and regulated by the Ministry of Labour and Social Security, and the Social Security Institution (SGK). By this reform, all social groups involving not formally employed are embraced, guaranteeing universal access to healthcare services on equal terms. For instance, individuals have the liberty to choose the type of public hospital to go to. In addition, they can go to private hospitals as long as they pay a contribution assigned based on the type of the illness, diagnosis and treatment. During an emergency case, everyone is accepted by private hospitals without contributions which was not the case before the reform. Similar to Germany, family physician system is introduced in order to screen illnesses and possible treatments before transferring patients to specialized physicians.

Research Design and Sample

The following empirical analysis is based on multi-sited ethnography (Marcus, 1995) with ten extensive semi-structured interviews with retired migrants from Turkey living in middle sized cities in Germany and in Turkey in 2013. Unlike standardized surveys, qualitative interviews offers a unique way of capturing migration experiences, processes as well as healthcare practices from the perspective of the interviewees.

Turkey has been one of the major suppliers of labor migrants in Europe beginning with the official labor recruitment agreement with Germany in 1961, followed by other countries such as Austria, Belgium, France, the Netherlands and Sweden (Abadan-Unat 2011; Martin 2012). 'According to the official records in Turkey, a total of nearly 800,000 workers went to Europe through the TES [Turkish Employment Service] between 1961 and 1974. Of these workers,

649,000 (81%) went to Germany, 56,000 (7%) to France, 37,000 (5%) to Austria, 25,000 (3%) to the Netherlands' (Icduygu, 2012: 14). In addition to labor migrants, there are other types of mobilities including family reunions, marriage migration, asylum seeking (Icduygu et al. 2001) as well as student migration (Bilecen-Süoglu 2012) from Turkey in Europe. According to recent estimates, there are currently 4 million Turkish citizens living in Europe. Of these, 80% reside in Germany (Abadan-Unat 2011). Their lives and activities have been of interest to many scholars since they form the major group of migrants in many western European countries. Although migrants from Turkey have been researched extensively, relatively little is known about their healthcare practices. Generally in the literature concerning migrants from Turkey, social protection and particularly healthcare remains as an unexplored issue (Bilecen 2013).

Contrary to other research focusing solely on all types of migrants' access and use of host country healthcare services, older, retired migrants who live in their country of origin more than 3 months are chosen as the target group of this study for two reasons. First, circular mobility increases the opportunities for migrants to be exposed to two different healthcare systems. The time frame makes a difference in health practices, for example, return visits may take up to one month during which migrants can take all the necessary prescribed medicine with them. However, when the duration of circular movements increase, then the need for prescribed medicine and medical doctor visits may become compulsory, which then gives us a better insight about their healthcare practices. Second, because the concept of circular mobility usually do not include older generations, even though 'lifestyle migration' of pensioners from Western to Eastern countries can also be studied as a form of circular mobility. Usually circular mobility is attributed as a characteristic of seasonal workers, who go to another country for a certain amount of time and upon completion of their work they return to their home countries or where they are based such as in farming and construction industries. However, older generations increasingly engage in circular mobility since they are retired and no longer engaged in formal paid work they can be away from the host countries for longer periods of time in a year. In the case of our interviewees, for instance, most of them invested in their hometowns, they bought houses and would like to spend longer time periods in Turkey.

The sampling strategy is based on snowball sampling. Both of the authors first contacted their personal contacts in Germany and Turkey, and then asked the interviewees for referrals to other contacts in both countries. During the selection procedure special attention is paid to minimize biases arising due to this strategy to achieve a sample as heterogeneous as possible in terms of their length of stay in Turkey, region of origin, age and gender. The interviews

took place both in middle sized cities in Germany and in Turkey. In total 10 interviews were conducted, with 6 women and 4 men, with an age range from 64 to 71. All of the interviewees arrived Germany during the first official recruitment phase either as labor migrants or as their spouses. Seven of the interviewees were married, two were living separately and one was widowed. All of the respondents had at least one child, and one grandchild and all of them were retired with public healthcare insurance from Germany. 8 of them had primary school education and 1 of them had junior high school education; whereas 1 of them was illiterate. All of the interviews were conducted in Turkish, the interviewers' and the interviewees' native language. The names of the interviewees are fictitious in order to secure their anonymity as promised. All transcribed verbatim and analyzed in accordance with qualitative content analysis (Mayring 2000). Through this way of analysis, we examine latent meanings, themes and patterns in transcribed interviews about the respondents' health and healthcare practices.

Medicine use between Germany and Turkey

All of the interviewees indicate that they take medicine regularly for their healthcare including diabetes, cardiovascular diseases, high blood pressure, thyroid or cholesterol, which are the most common diseases in our sample. They take at least three different prescribed drugs on a regular basis. The phenomenon of polypharmacy in old age has been documented by writers on gerontology, from Ziere et al. (2005) to Clyne et al. (2012); however there are some interesting patterns. As explained by Hatice, who arrived in Germany in 1972 with her husband together and now living separately, consumes daily plural drugs. For her, this situation is normal in her age. In her words:

'Until now I was taking 3 different drugs since a very long time, then it has been 4, and in March when I was hospitalized due to my complaints in my heart, 2 more have been added to the list. But you know in our age, it is normal, all my friends take more than 3.'
(Hatice, 66)

This normalized pattern of plural drug consumption is a major topic among interviewees in their daily interactions. Conversations with their friends in their spare time was also mentioned by interviewees like Hatice did. Those conversations extend beyond their reciprocal home visits to meeting in cafés outside or in the waiting room of their doctors'. Most of the interviewees commented that their social activities outside their homes with friends revolved exclusively around the Turkish speaking community and healthcare is one of the most frequent topic they talk about. It seems that migrants were pulled towards to their ethnic community in sharing their health and related issues. Language has a crucial influence in their

practices. Speaking in their native language perceived like a break from the everyday stress of communication in a foreign language. Moreover, emotionally language gives them the comfort of their 'home', a feeling of relief perhaps.

Moreover, some of the interviewees mentioned that they watch informative programs in the television with Turkish broadcasting in Germany, in which medical doctors are invited and give talks about certain issues everyday. For instance, Leman said this is very typical to older generations to watch those programs because they are at home and have time, and talk about their health, medical doctors, and drugs they are taking.

'I talk to my friends about my health. I would say usually to my friends because they are also in a similar situation. They take at least 3 drugs doctors gave them like me. When we get together we talk about our doctors and the drugs we are taking. I mean when you are old, health becomes your main concern and you talk about it to feel better. It makes me feel better to see that I am not the only one living with a lot of drugs everyday.' (Leman, 69)

Most of the interviewees compare their situation to their spouses or peer groups. When they also realize that their peers or spouses also consume plural medicines regularly, they also feel supported and relieved that they are not the only ones taking many drugs as Leman's example illustrates. Her statement represents a common view of older migrant generations and point us to that individuals do not like to consume many drugs and it is considered as problematic, but they have to because of their poor health conditions. Most of the drugs the interviewees have to take regularly include drugs against cardiovascular diseases, which alert us to the most common type of complaints is about heart and stress related.

When asked about their use of other drugs in addition to the prescribed ones, two patterns can be identified. One group, mostly composed of men say that they do not take any other unprescribed medicine at all either because they know that it is not good to do so. As Ali states:

'No, no, I don't take such other things, you know, there might be side effects. And it is also forbidden you know. I only take those medicine given by my doctor.' (Ali, 65)

Moreover, some of them belonging to that group do not want to pay for additional medicine. For instance, Leman, has been operated two times on her knee joints due to meniscus tears and related complaints afterwards in Germany. When asked if she uses medicine against osteoporosis, she says that she eats dairy products because her doctor did not give a prescription for that, so she never considered to buy one, to get a test for it or ask for prescription. It is also important to mention here is that in German healthcare system some of the medicines are not covered by the public healthcare benefits and the full price of osteoporosis

medicine is usually paid by the patients themselves. Thus, the combination of costs and the fact that the doctor as the authority do not see that medicine is very necessary leaves Lemman in a difficult situation. Because one of the unwanted consequences of polypharmacy due to cumulative effects of different and not coordinated active pharmaceutical ingredients, that it can lead to a higher risk of falls. Particularly in old age risk of fall is extreme, causing to hip fractures, unwanted operations, and thus, longer hospitalizations and care taking. Therefore, it is very important for older migrants to be informed properly about their drugs and their compliance should be achieved.

Those in the second group, on the other hand, state that they take some unprescribed medicine but they do not consider those medicine as ‘real’ medicine because they are usually composed of paracetamol or painkillers. As Naciye states:

‘If it is not necessary I try not to take any other medicine because I take enough. But sometimes I only get Aspirin, Vermidon or Novalgine (painkillers) from the pharmacy.’
(Naciye, 71)

Because the interviewees are not well informed about the pharmaceutical ingredients of their daily medicine, they think that taking a paracetamol or a ‘simple’ pain killer would not do any harm. However, through consumption of different remedies they could suffer from different side effects such as dizziness or sight disorders which might again result in increased risk of falls. Moreover, polypharmacy can also be extremely problematic especially for those who has dementia as it causes a higher risk to deteriorate the cognitive capacity. Or equally likely, those who use sedatives such as neuroleptics might be seriously affected by multiple drug use.

‘I cannot live here without there’ – Formal and informal health care

In order to overcome multiple complaints, our interviewees consume prescribed plural drugs on a regular basis and sometimes unprescribed ones. However, not much is known in the literature about how they arrange their consumption across borders when, for example, they leave Germany to live in Turkey for the half of the year or sometimes even more. All of our interviewees have public healthcare insurance from Germany and do not have a second insurance from Turkey. They all stated that when they need to access and use any healthcare related services in Turkey, they show their German insurance cards and can be treated in

both public and private hospitals in Turkey. All of them stated that they go to their family doctors in Germany¹ regularly and the family doctors prescribe the medicine. When they say to their doctors that they are going to Turkey, then the doctors prescribe for longer periods of time and the patients buy them in Germany and take them to Turkey. When asked if they run out of their regular medicine, they usually told that someone from their family arranges for them. For instance, Leman, who has been in Turkey since 6 months stated that her medicine for her heart condition was almost finished and she ordered it from her daughter-in-law who was luckily going to Turkey at that time to have holidays. She also added that:

‘Even if she [her daughter-in-law] was not coming here, I could have found my medicine in Turkey. For example, my sister’s husband is a retired medical doctor, who is now working in a private hospital, I would have asked him for prescription. Perhaps their name is different but the doctors here [Turkey] look inside and give me the same one.’ (Leman, 69)

When asked about how her daughter-in-law could have brought the needed medicine to her, she replied:

‘We all go to the same family doctor, she is very nice [...] she knows everyone in my family, so she [daughter-in-law] asked her to write me my medicine, that’s it.’ (Leman, 69)

Therefore, family ties play an extremely important role in organization of the healthcare of migrants across borders. Family members in Germany can bring or in some instances they gave the medicine to post or other family members in Turkey can assist in finding ‘good’ doctors as well as prescribe the medicine themselves. Although formally it is arranged between two countries through insurance systems, still informal ties are very important to realize those formal arrangements.

Another way to continue their prescribed medicine is to go to family doctor in Turkey and let them find the same medicine or an equivalent. Because some of our interviewees live longer than 6 months in Turkey, they chose a family doctor in Turkey as well. Indeed it is a good practice to have some professional regularly checking their health; however, two medical doctors in two countries with different medical approaches do not have any contact besides

¹ In Germany, *Hausartzsystem* (family doctor system) has a central role. If an individual needs a medical assistance as legally insured, s/he can go to any doctor whom s/he trusts and entitled to treatment as the public health insurance foresees. The family doctor is the first stop to screen and discuss with the patients the next treatment steps and advises on treatment decisions as well as the selection of hospitals and specialized doctors.

their patient, who can or cannot inform one or the other. Therefore, the patient is left as the only actor connecting different medical approaches might not necessarily benefit from that situation as expected.

Therefore, the common pattern of medicine use is arranged between two countries formally and informally in a way that the main healthcare system referred to is Germany. Turkey is considered to be the second one since they are not insured there. As Naciye says:

‘I cannot live here [Turkey] without there [Germany].’ (Naciye, 71)

The interviewees still feel connected to Germany through formal ties, healthcare insurance in this specific case. When they have an emergency or ran out of their prescribed medicine by their doctor in Germany, then they use the healthcare services in Turkey. As opposed to the findings of the study conducted by Lee and her colleagues (2010), we found out that migrants from Turkey in Germany choose to go to primarily to their family doctors in Germany, get their prescriptions and operated in Germany. Lee and her colleagues (2010) they found out that Korean immigrants in New Zealand use the healthcare services of Korea, especially for surgeries, since they can directly go to specialists in Korea and the hospitals are ‘better’ in Korea in terms of best quality of doctors, faster services, trust, familiarity and affection. However, formal health insurance schemes play the major part in this finding. Our interviewees have lower socio-economic background, dependent on their insurance and they would not be able to pay a surgery in Turkey themselves if their health insurance would not pay. Therefore, even if they would like to get a surgery in Turkey, unless it is an emergency, they would run the risk of not being reimbursed by their German health insurance upon their return to Germany.

‘I feel better in Turkey’ – Healing effects of life in Turkey

Most of our interviewees told us that they feel better when they go back and live in Turkey longer periods, so that they do not need to take some of their prescribed medicine given by their family doctors in Germany. They usually talked about how their daily lives change in Turkey that they live in houses with gardens in the countryside – as opposed to their flats in cities in Germany – where they can grow their own fruits and vegetables and take care of themselves much more diligently choosing what to eat and what not to eat. In addition, they said that they can afford ‘better’ products, meaning that grown in natural environments without pesticides and genetically mutated seeds. They pay special attention to their food and health. As Fatma said:

'I don't go to doctors in Turkey because I never needed. I pay attention to what I eat here [in Turkey], I do sports, I try to go to walks with my neighbors.' (Fatma, 64)

They also stated that they are much more active physically in Turkey. Some of them work in their gardens long hours, or they go to longer walks or swim with their friends. Our interviewees stated very frequently that physical activity makes them feel better. For example, in Önder's words:

'Because I work in my garden in Turkey everyday, I loose weight. When you loose weight, you become lighter and feel better. The singing in my ears [Tinnitus] stop. When I am in Germany it comes back again because I have a sedentary life. Whenever I start this sedentary life, the singing in my ears come back and much more than before.' (Önder, 67)

However, when Önder's Tinnitus 'stops' in Turkey he does not take his medicine because he thinks that he does not need a medicine anymore and he does not inform any of his doctors about that situation which could cause disruptions in his medical care and might have long-term side effects such as he describes that having worse sensation of noise, often as ringing or roaring in the ears. Tinnitus is often believed to be caused by longer exposure to loud noise and from taking various prescription or non-prescription drugs.

Moreover, social life is perceived to be better in Turkey. Especially Naciye told throughout the interview that for her it is very important to have higher spirits, surrounded by friends and family. In Turkey all of our interviewees feel comforted by their social circles through regular and spontaneous home visits, chatting and sharing their daily lives with their neighbors and extended family members. In Kemal's words:

'Of course in Turkey we are much more social. I see my brothers in the village, brother-in-laws, grandchildren when they come for their holidays. It's great spending time with my grandchildren. At this age, what can I ask for more? It is about fondness of your family, your children, grandchildren surrounding you. When I am with them, I feel very healthy again.' (Kemal, 69)

Those family and social ties are play a central role in the lives of the elderly has been long acknowledged (De Belvis et al. 2008; García et al. 2005). However, what it surprising is that they stop taking their medicine especially those related to psychosomatic complaints when they are in Turkey and feeling 'better', which might interrupt their healing process. For example, Levent said:

'I have bronchial asthma, I take a medicine for that. In Germany I take it every morning and every evening. In Turkey I take it once a day, either in the morning or in the evening, and sometimes I forget to take it. Sometimes I even do not take it in Turkey, it does not affect me.' (Levent, 70)

All of our interviewees used at least once in their lifetime a prescribed medicine for psychological complaints. Some of them were still using when we interviewed them; however, they all mention that they stop taking especially those medicine related to psychological symptoms because they feel naturally cured in Turkey and decide themselves not to take their regular drugs without any consultation.

Conclusion

While the research on migration and health mainly concentrates on the migrants' access and use of the healthcare systems in the host countries, the research on transnationality focuses on migrants' and their networks connections. Thus, in this article, we look at older migrants' healthcare practices across borders to understand the ways in which they organize their healthcare.

This article contributes to migration and public health literatures on two aspects. First, putting these two research domains into dialogue with an interdisciplinary perspective, we could see when older migrants engage in circular mobility in their retirement organize their healthcare across borders. We empirically demonstrate that migrants rely on the host country's healthcare system, and while they live in their country of origin, due to formal arrangements between two countries, they can use the healthcare services there as well. But we show that they mainly rely on their doctors in Germany and their prescriptions. In an emergency situation occurs, or when they ran out of their medicine, then they go to the doctors and hospitals in their country of origin.

Second, based on our empirical evidence, family doctors in the countries of immigration and emigration should be better connected. Because as our evidence suggested, some of the older migrants felt 'better' when they live in their country of origin, and they stopped taking their prescribed medicine; however without informing their doctors. It would be better if medical doctors could have accessed to the patients' personal health history and the medications they are on for an informed decision on their prescriptions. After all, the doctors in Turkey might not be properly informed by the patient especially if the patient has dementia or the

doctors in Germany are not properly informed about their patients' stop their medication which might affect the health of circular retired migrants in an unwanted way.

Polypharmacy in the context of health will continue to be a serious and persisting issue. Much of the data on this may reflect the cultural and health backgrounds of migrants as much as the circulatory conditions in which they are living, but the consumption of plural medical remedies should be treated carefully. Therefore, more need to be done to ensure that older migrants and their doctors in both contexts should be well informed. In this respect the social and cultural features of medicine use probably deserve further attention.

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