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Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border

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ABSTRACT

Drawing upon research conducted on cross-border patients living in Laos and seeking care in Thailand, this paper examines the important role played by social networks in patients' decision-making and on the itineraries they choose to seek treatment on the Thai side of the border. Due to the vastly contrasting situations between the two countries in terms of healthcare supply, and considering Laotians' increasing demand for high quality healthcare, a number of them have managed to satisfy their needs by combining cross-border treatment with the use of the healthcare facilities provided by their own country. This study consisted first of household surveys conducted in five border areas (2006–2007) in Laos in order to quantify and map out cross-border healthcare-related travel patterns. Afterwards, interviews were conducted with cross-border patients (55), Laotian and Thai medical doctors (6), Thai social workers (5), and officials working in public institutions (12). While socioeconomic and spatial factors partly explain cross-border mobility, patients' social networks significantly influence treatment itineraries throughout the decision-making process, including logistical and financial considerations. The social networks existing at different geographical levels (neighbourhood, regional and global) are therefore a powerful analytical tool not only for understanding the emergence of these cross-border movements but also for justifying them in an authoritarian political environment such as Lao PDR's.

1. Introduction

Sisouvanh is the head of a family living in a village located 20 km from the Thai border (Champassak province, south of Laos). This rather poor family of rice farmers is composed of a Lao husband, a Thai wife and 3 children who simultaneously suffered from severe fever in 2006. Since the parents did not have the necessary resources to take their children to hospital, Sisouvanh asked a friend working at the district health office for advice. The latter advised them to provide blood tests whose samples he handed over to a colleague at a nearby laboratory in Laos. As the results were positive for malaria, he then advised them to go directly to a Thai hospital called Silithorn Hospital located 20 km from the border. Since the family did not have a car, their friend asked a cousin living in a nearby village to lend them his car. Upon crossing the border, they did not have border passes for legal entry into Thailand but a customs officer (an acquaintance of Sisouvanh's friend) and the husband's nephew working at the border police both allowed them to cross into Thailand without any official documents as it was an emergency case. Once in Thailand, the family received a loan roughly equivalent to 40 Euro (2000 Thai Bahts) from the wife's sister who then called the husband's father living in the US for a donation of 200 US$. Finally, in order to complete the payment of the hospital bill, the husband's uncle provided the family with a loan of approximately 300 Euro.

The situation of Sisouvanh's family is not unique but is part of the growing phenomenon of cross-border health mobilities from Laos to Thailand. Thai healthcare facilities are often discussed in the context of medical tourism and transnational mobility (Wilson, 2011; Bochaton, 2013). The phenomenon of medical tourism, whose origins date back to pilgrimages (Gatrell, 2011), occurs today when patients decide to travel across international borders in order to receive medical treatment and is generally depicted as involving patients from economically advanced countries and hospital facilities located in less developed countries such as India, Malaysia or Thailand. Discussion tends therefore to be focused on Western patient-consumers covering long distances to get medical treatment in developing countries but without taking into account travels of some “desperate ‘medical tourists’, such as those from Burma or Yemen, moving at considerable personal cost” (Connell, 2013: 5) or formal cross-border institutional transfers such as those within the European Union (Glinos et al., 2010). Medical

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tourism definitions therefore appear narrow and need to be "expanded into 'a wider, more diverse and more nuanced phenomenon'" (Glinos et al., 2010: 1146) as "international mobility for medical care is more diverse and complicated, notably in its cross-border and diasporic component" (Connell, 2013: 2).

Many medical tourism destinations equally involve cross-border intra-regional medical travel originating from neighbouring countries. "Cross-border patient-consumers are responsible for generating the consistent volume that produces impressive-looking figures" in Malaysia (Ormond, 2013a: 94) as well as in Thailand where "89% of the foreign patients treated in 2002 were local expatriates or Asian nationals" (Lautier, 2008: 109) from Myanmar (Maung and Walsh, 2014) and Laos mainly. Intra-regional medical travels occur on all continents: for example, more than 80% of overseas patients in Tunisia come from Libya (Lautier, 2008) and international patients who went to Singapore for medical treatment in 2005 came mostly from neighbouring countries, especially Indonesia (52%) and Malaysia (11%) (Khalik 2006 in Connell, 2013). Flows also take place along the US/Mexico (Brown, 2008; Horton and Cole, 2011; Dalstrom, 2013), the Cambodia/Vietnam border (Pocock and Phua, 2011), and in South Africa (Crush and Chikanda, 2014). The general lack of access to medical diagnosis and treatment along with issues related to high costs or delays in treatment produce these growing temporary movements of people seeking healthcare across borders (Lunt and Carrera, 2010).

In the context of the Lao-Thai border, medical travels involve today a significant portion of the Laotian population and are directly connected to the recent political and economic opening-up policies pursued by the Lao People's Democratic Republic (Lao PDR). This phenomenon also highlights the development gap between Laos and Thailand, and is facilitated by proximity and by historical links between the populations living along the Mekong River.

Besides the context and among the various factors that influence cross-border medical travels to Thailand, I will first examine how the role of the socio-economic profile of the Laotian patients is quite significant. The influence of spatial knowledge, understood as the numerous crossings and the frequent use of cross-border transportation, will be also considered. But as «social ties and networks play a crucial, and too frequently unacknowledged, role» (Lunt et al., 2014: 35), I will emphasize how patients' social networks influence treatment itineraries throughout the decision-making process, including logistical and financial considerations. As described in the case of Sisouvanh's family, the social network involved in the cross-border journey consists of 8 people distributed over three distinct geographical areas: local area, cross-border area and distant country. Close-at-hand and distant factors both impact families' therapeutic itineraries, with a specific type of support provided at each level. This paper will therefore explore the functioning and importance of multi-scalar social networks as a means to offset households deficits in terms of economic and spatial capital.

The paper first contextualises the medical travels taking place along the Lao-Thai border followed by a discussion on the role of intermediaries and social networks based on a review of the studies conducted on international and regional medical travels. After a presentation of the methods, I examine (i) some facts and data about medical travels from Laos to Thailand, (ii) the role played by economic resources and spatial knowledge and finally (iii) how social networks support the movements of cross-border patients lacking these resources.

2. The Thai-Lao border: development gap and ambivalent relationship

The Thai-Lao border – materialized by the Mekong River along most of its 1754 km course – underlines major political differences as well as significant economic and healthcare disparities. In 2011, while life expectancy at birth reached 74 years in Thailand, it was barely 68 years in Laos. The two countries also differ in terms of healthcare available on both sides of the border. While health facilities on the Thai side are attractive, Laos faces challenging problems in developing a high-quality, evenly-distributed primary healthcare network throughout the country. In some areas, access to healthcare continues to be restricted due to geographical challenges. Although the healthcare system in Laos has improved over the last decade through international assistance, problems still persist. Laotian doctors' relatively low level of training often leads to imperfect diagnoses. Malfunctioning healthcare facilities have led to a growing crisis of confidence among Laotians regarding their public health system (Hours and Selim, 1997; Pottier, 2004; Mobillion, 2010).

Besides the discrepancies observed in health and social indicators, cross-border travels must also be considered in light of the ties between the two countries. Although Laos and Thailand have a common cultural, religious (Theravada Buddhism) and linguistic background, the two countries are often described as "*enemy brothers*", which emphasizes the ambivalent nature of their relationships.

Originally composed of small separated principalities (*müang*), Laos was unified for the first time in 1353 by Prince Fa Ngum. In 1827, Thai neighbours destroyed the city of Vientiane and its population was moved to the right bank of the Mekong, the *Isan* area (northeast of Thailand). According Ngaosyvathn and Ngaosyvathn (1994), this attack and the subjugation of local populations have given rise to a hatred of Laotians towards Thai. Before this event, no chronicle reports such resentments between the two neighbours while after 1827, many documents found in Thailand and Laos highlight a resentment against the aggressors.

At the end of the nineteenth century, the arrival in Indochina of the French and the British led to great changes in the territorial organization of the area as the Mekong River became a political border. The current borders of Laos date from the French colonization and for some experts «Laos might best be described as a quasi-nation, having emerged from maps drawn by European colonialists rather from a sense of territoriality and nationhood among united people» (Jerndal and Rigg, 1999: 36).

After the independence of Laos in 1954 and during the 60s, the relationship strenghtened between the Royal Laotian government and Thailand. But the proclamation of the Lao People's Democratic Republic (2 December 1975) and its socialist orientation marked a new break in Lao-Thai relations. Lao PDR formalized its "special relationship" with the Communist Party in Vietnam and a declaration of friendship was signed in February 1976 (Stuart Fox, 1980; Dommen, 1982). From 1975 to the late 80s, the border between Laos and Thailand was closed and relationships were conflictual. But the failure of collectivization led Laotian leaders to gradually release the economy in the mid-80s (New Economic Mechanism in 1986) which drives to the reopening of the border with Thailand. In November 1988, the visit of the Thai Prime Minister Chatichai Choonhavan in Vientiane and his statement «turning Indochina from the battlefield to a market place» marked a political shift in the relations of the two countries. Border areas become the new dynamic centers of the Indochinese peninsula: «Thailand's borders have transformed from backwater culs-de-sac to areas whose vibrancy is created by the very fact of their spatially transitional status. Northeastern Thailand is transformed in the GMS (Great Mekong Subregion) discourse from economic backwater to geographical centre or crossroads of the regional economic powerhouse» (Hirsch, 2009: 129).

The reconciliation initiated by the two countries is also embodied in the construction of infrastructures facilitating cross-