

# The rise of a transnational healthcare paradigm: Thai hospitals at the crossroads of new patient flows

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The rise of a transnational healthcare paradigm.  
Thai hospitals at the crossroad of new patient flows

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*In today's world, people move more, move further, and move for increasingly varied reasons such as work, studies or leisure. Seeking health care away from one's home is a part of this trend and many patients do not hesitate to cross national borders to consult a physician or get a surgical intervention. This article examines this form of mobility towards Thailand from both global and regional perspectives. This situation involves long-distance patients travelling from highly industrialized countries and closeby neighbors, such as Laotians, who may just cross the border to get treated a few kilometers away from home. Constrasting these senarios complicates the findings by studies on "medical travel" as it brings in heterogeneity and variability. There are significant differences in patients' motives, in the social implications of their cross-border health-seeking behaviours, and in the responses by health infrastructures and authorities in both the host country (marketing, regulation or even quality of care) and the patients' lands of origin (policies, intermediaries, and emerging*

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*specialized agencies). This paper takes this situation as a case study to describe and explain the rise of a new transnational healthcare paradigm.*

The opening of borders, faster information flows and increased mobility have a significant impact on health recourse and medical practices. Besides the rapid spread of diseases across national borders, transnational health also affects healthcare patterns and leads to mixed outcomes. Although there is a worldwide standardization of certain medical practices and the use of medication, disparities in health persist or even increase between economically advanced and emerging countries and the poorer nations. High-quality health care services are not available in all countries. From these disparities arise trends driven both by practitioners and by patients from around the world. Medical practitioners cross borders searching for facilities where they can practice their skills and earn a livable wage (Vaillant 2008). Patients seek hospitals outside of their own country, searching for adequate and preferable treatment. This article deals with cross-border patient mobility at short and long distance, from regional to global scale. Particular focus is given to the example of Thai hospitals located at the crossroads of new types of medical travels.

The mobility of patients on a transnational scale, described as "medical tourism", best illustrates the globalization of healthcare. The phenomenon has indeed spread worldwide and generally, but not only, involves patients originating from economically advanced countries and hospital facilities located elsewhere (Glinos *et al.* 2010). Many patients do not hesitate to cross national borders and sometimes travel thousands of kilometers in order to consult a well-known doctor or to benefit from fast, high-quality and relatively cheap healthcare services. Thailand, located in the center of Southeast Asia, has played a leading role in the emergence of this new kind of health recourse since the late 1990s. Along with India, this country receives in Asia the majority of foreign patients traveling for healthcare worldwide (Connell 2006; Bochaton/Lefebvre 2008).

In addition to the global attraction of the Thai health infrastructure, it is interesting to examine cross-border patient mobility at the regional level. In the Lao-Thai border

area, new behaviors appear related to these forms of therapeutic mobilities. A significant portion of the Laotian population is involved in this practice, which is directly connected to the recent political and economic opening of Lao People's Democratic Republic (Lao PDR). This phenomenon highlights the development gap between Laos and Thailand, and specifically the healthcare disparities between the two countries. These movements are also facilitated by the proximity and historical links between the populations living along the Mekong.

Through the study of cross-border patient mobility at regional and global scale, this article shows how transnationalism contributes to the modification of Thai hospitals' activities, and more generally to the building of a cross-border healthcare paradigm.<sup>56</sup> It is divided into three parts. The health and economic contexts, both regional and global, will be first presented to understand the factors leading to health mobility. I will then study the ways patients learn about health facilities in Thailand and how their decision is eventually acted upon. This involves the access to information and how Thai hospitals skillfully aim their communication strategies at these new foreign patients. Finally I will discuss the role this new patients' flow in shaping healthcare, and specifically the kind of change that occur in both the receiving country (Thailand in our case) and in the patients' countries of origin.

### **An effective Thai healthcare system attracting foreign patients: historical development and recent trends**

Before describing health mobility, it is expedient to present the context in which it takes place. What are the push and pull factors which attract Laotian and other international patients to Thai healthcare facilities? After introducing the attractive potential of provision of care in Thailand, I will then consider the transnational

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<sup>56</sup> The findings presented in this paper result from a doctoral project carried from 2004 to 2009 (University of Paris Ouest Nanterre la Défense and Institute of Research for Development). Household surveys were conducted in Lao PDR (2006-2007) along the border with Thailand regarding the issue of cross-border healthcare seeking behavior. Concerning the research on medical tourism, many interviews were conducted with medical professionals, marketing and operation managers of corporate hospitals, and key members of different ministers or professional organisations in Thailand (Bangkok) and India (Delhi) (Bochaton/Lefebvre 2010).

contexts between neighboring countries and globally, as well as the motives of their respective citizens-turned-patients, in order to understand the origins of these movements and identify commonalities and peculiarities in these two cases of cross-border healthcare.

### *The Thai healthcare system*

Thai public hospitals are currently facing difficulties with funding. Although their budgets are unbalanced, the healthcare system of the country can still be described as successful. Initially introduced in the late nineteenth century by the royal family, the health environment has taken full advantage of the country's economic growth to develop, modernize and extend to the entire population.

In 1888, King Chulalongkorn, the great modernizer of the Kingdom of Siam, built the first modern hospital, namely Siriraj Hospital in Bangkok. The foundations of the current healthcare system were then laid by Prince Mahidol (1892-1929) commonly called "Father of modern medicine and public health in Thailand" (Ellis 1936). Prince Mahidol is still widely associated with the advancements of medicine, which is a source of pride for many Thais. The national press regularly publishes special reports in memory of the Prince, describing the many medical advances made possible by him (Prince Mahidol Award Foundation 2002 and 2007). Certain private hospitals in Bangkok also use the image of the former prince as part of their marketing campaign to relate their work to the royal family: "In memory of our beloved Prince Mahidol... May the medical field continue in his footsteps" is the title of a Bangkok Hospital advertisement. Today, the royal family led by King Bhumibol Adulyadej, is still actively involved in public health projects (Chamnan 1991). The king launched mobile medical units (also called the Royal Medical Units) in 1967 to travel with him and provide treatment during official visits to remote rural areas. Modern medicine and Thai monarchy thus have strong links which provide mutual legitimacy.

In addition to the important role of the royal family in health affairs, the economic growth and the relative political stability have contributed to the expansion of

biomedicine throughout the country and to the development of healthcare provision during the twentieth century. In a similar vein as the general development of the country, the healthcare developments since 1961 have followed five-year planning cycles. The objective of the first few plans was the expansion of health coverage throughout Thailand with the construction of clinics, district and provincial hospitals. The later plans focused their attention on the installation of medical equipment in these health facilities. Finally, the last major project of the Ministry of Health was the establishment of universal health coverage in 2001. The stated goal, written in the constitution is that "all Thai people have an equal right to access the quality health services". The national health expenditures have thus followed economic trends and have increased from 2.7% of the national budget in 1969 to 8.3% in 2007 (approximately 0.4 to 1.4% of GDP) (Ministry of Public Health, Thailand 2008). Additionally, with the rapid economic growth experienced since the early 1970s, the private sector has developed significantly, initially in Bangkok and spreading later to other provinces during the 1990s. Between 1970 and 2006, the number of private hospitals increased from 23 to 344, of which 70% are located outside of Bangkok. During this entire period, Thai biomedical training enjoyed proactive government policies under the auspices of the royal family. The technical level of physicians is thus relatively high, as a significant number do part of their training abroad, primarily in the United States or Australia. Finally, even if the Thai healthcare system is good, how can the ability of Thai hospitals to attract large numbers of foreign patients be explained? Indeed, many other countries have reliable hospitals, but few have an attractive power outside their national borders. What are the local characteristics and the specific contexts which led to this situation?

### *The Asian economic crisis and the medical travel industry*

The link between the Asian financial crisis and the rise of medical travels may not be obvious at first, yet it is clear. During the 1990s, while the private health facilities proliferated in line with the strong economic growth, upper class Thais gradually turned away from public facilities, preferring private clinics and hospitals. However,

following the 1997 crisis, the majority of these wealthy patients deserted private consultations and returned to state hospitals. Many hospitals in Bangkok collapsed with the crisis, others kept their business by developing new strategies. The managers of some facilities searched for new types of patients, mainly from abroad, to fill the void. Several hospitals in Bangkok launched marketing campaigns targeting wealthy classes and expatriates living in neighboring countries. Once these regional targets were reached, the leaders of some of the largest hospitals in Bangkok pursued their plan on a global scale, giving rise to the phenomenon of international health mobility, described by them as “medical tourism”. As mentioned by Ara Wilson (2011: 134), “the internationalization of medicine in Thailand has been produced as an explicitly national project. Indeed, Thailand’s medical tourism presents a case where the nation-state has been strengthened rather than weakened through economic globalization” (Wilson 2011).

The majority of foreign patients come from economically advanced countries (Japan, the Middle-East, US, Canada, Europe). They choose to seek treatment abroad because of financial reasons, waiting periods, for comfort, or again lack of biomedical technologies in some cases. In 2004 for example, an open heart surgery costing 30,000 USD in the United States cost 14,250 USD in Thailand. Long waiting periods of several weeks or months are a significant reason for patients to seek care abroad, especially those from Canada and Britain. Finally, with the relatively recent construction and the abundance of healthcare staff (due to low pay), private Thai hospitals offer a level of comfort and quality of care hard to match elsewhere. For all of these reasons, Thailand receives the largest number of international patients, followed by India. In 2005, private hospitals in Thailand received more than 1.5 million foreign patients.

### *Development gap, geo-cultural proximity and cross-border healthcare*

The Thai-Lao border, marked by the Mekong River along most of its 1,754 km length, is characterized by major political differences as well as significant economic and health disparities. In 2006, life expectancy at birth was estimated at 72 years in

Thailand and only 61 years in Lao PDR (WHO 2008). Besides the discrepancy between health and social indicators, the two countries also differ in the type of care available on both sides of the border. While health facilities on the Thai side are attractive, Lao PDR has difficulty developing a high-quality and equally distributed primary healthcare network throughout the country. The problems and failures of the healthcare system in this country therefore push Laotian patients to seek health care abroad.

The founding of the Lao People's Democratic Republic in 1975 marked the real beginning of public health in the country. Before this, no modern and organized healthcare system existed in the country. Traditional medicine, consisting of rituals and medicinal plant- and animal part-based remedies represented the most important form of medical knowledge and therapeutic recourse. Since 1976, the number of public facilities at the central, provincial and district level has grown rapidly. However, in some areas, access to care continues to be limited due to geographical features. Despite the strengthening of the healthcare system in Laos, a number of problems persists. The doctors' relatively low level of training leads to often imperfect diagnoses (Mobillion 2010; Striegler 2005). Additionally, the extremely low salaries of doctors (between 30 and 50 USD per month) and other health workers force the majority of them to do additional work outside of the hospital, reducing their time spent in public facilities. This situation also encourages the risk of corruption within the healthcare system by encouraging hidden payments from patients to hospital staff: "Health workers charge for 'free' medicines" (Stuart-Fox 2006) is one aspect of these informal exchanges. All these elements have led to a crisis of confidence among Laotians regarding their public health system, as was observed by several authors (Hours/Selim 1997; Pottier 2004; Mobillion 2010). The combination of disappointing elements on one side and attractive elements on the other provides the context for cross-border healthcare seeking behavior, a phenomenon seen all along the Lao-Thai border. Household surveys I conducted in 2006 in several border towns<sup>57</sup> and villages showed that between 7 and 25% of

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<sup>57</sup> Several study areas were selected: in the capital Vientiane and the provinces of Bokéo, Bolikhmasai,



Laotians living in these areas have been cared for in Thai hospitals (Bochaton 2009). Whether for the treatment of road accidents, hypertension during childbirth, infectious diseases, and other problems with multiple complications, reasons for using the Thai services are multiple and expose the clear difficulties of Laotian facilities to respond to the needs of the population. This type of border crossing is more motivated by the search for quality care, rather than the possibility of financial savings as the price of care is higher in Thailand than in Laos<sup>58</sup>.

If the factors and motives differ between Laotian and international patients, there is nevertheless a similar attraction to Thai hospitals across country borders. From luxury hospitals in Bangkok to smaller facilities located near Thai borders, the healthcare system in Thailand is now at the crossroads of new patient flows.

### **Inducing border crossing by revisiting medical communication**

Compared to the use of care facilities within national borders, which follows well established treatment norms known and shared among the citizens, how do mobile patients come to choose a healthcare facility abroad? In addition to the medical reasons and/or financial motives discussed above, how do foreign patients acquire knowledge of Thai facilities and complete their journeys? How do Thai health facilities manage to be attractive and to establish their image abroad, from neighboring countries to more remote regions? By using new communication technologies and through the manipulation of physical social networks<sup>59</sup>, the Thai private medical sector develops a communication strategy turned exclusively towards foreign patients.

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Savannakhet and Champassak.

<sup>58</sup> While a consultation is free in a public Laotian hospital, it costs between 200 and 600 bahts (7 to 20 US\$) depending on the type of facility chosen in Thailand. Additionally, if one night spent in Mahosot Hospital in central Vientiane costs between 20,000 and 135,000 kips (2,5 to 17 US\$), the cost could surpass 10,000 Bahts (approximately 333 US\$) in certain private Thai hospitals.

<sup>59</sup> I use the term physical to distinguish these networks from the virtual, internet-based social networks.

*“Medical tourism”: a redefinition of the therapeutic experience*

Cross-border patient mobility depends on successfully informing potential patients and the promotion of the destinations includes a wide range of marketing materials such as flyers, booklets, and websites (Crooks *et al.* 2011). In Thailand, the communication developed by private hospitals reveals a constant mix between medical and recreational areas. This contributes to deeply link medical and travel experience in the users' imaginary. Consequently, if we have so far preferred the term “cross-border patient mobility” to “medical tourism”, the latter may be justified under the following development.

A virtual tour of of the largest private hospitals websites in Bangkok helps to grasp the importance of this digital platform. Each website competes esthetically in terms of access to information, illustrations and multiple choices of languages. The strong competition among the hospitals in Bangkok in order to attract more and more foreign patients is also visible on these sites. The website represents the only interface between the healthcare facility and the patient, when the patient is still at home trying to decide which hospital to use. This important step in the decision-making process comes at a time when thousands of kilometers separate the patient and the doctor, the two principal actors in this relationship. The internet site seems to enable a real communication which would otherwise be impossible due to connection time and geographic distance. It thus creates closeness between actors, despite the physical distance. The carefully designed structure of these websites shows the desire to embody an idea of closeness – continuity in the cyber world. The welcome page of the Bumrungrad International Hospital website shows the wide variety of available information and the extent of possibilities for visitors seeking care. The potential patient can exchange messages with various specialists to find one capable of treating him/her. If the terms and conditions of care are agreed upon by the physician, the visit can be organized by making an appointment. An online software provided on the hospital website gives the opportunity for the patient to

calculate in advance the cost of visit and/or surgery according to the needs. All these functions facilitate the organization of the patient visit to the medical facility and gradually transform the medical experience.

Aside from the logistical support, the website also brings the visitor into the virtual world of the hospital: it stimulates the imagination and creates high expectations. Indeed, the photographs of buildings and interior furnishings seen on the hospital sites more closely resemble a hotel than a healthcare facility and echo the expression “five-star hospital” used regularly in the press and by hospitals managers. Traditional hospital architecture, with a purely practical emphasis, is being abandoned in favor of new esthetic architectural designs, justified by their impact on the healing process<sup>60</sup>. This transformation is well underway in the Thai capital. So much so that it is sometimes confusing to western visitors unaccustomed to such a mix of styles, including the ostentatious display of modernity and design in a healthcare facility. Even the vocabulary used to describe the different areas within the facility (Lounge, Single Deluxe, Premium Atrium Suite, Sky Lobby Atrium, etc.) seems to blur the medical function of the building with the functions of relaxation, comfort and luxury instead. Philippe Bachimon (2001) writes about the “creation of desire for locations or the renewal of locations through tourism” to describe the impact of leisure activities on the sites visited. This assertion seems quite transferable to our case study. The hospital, as a spatial entity, is indeed re-created through medical tourism, with its new norms and expectations.

In addition to the Internet, which makes distance irrelevant and features hospitals in a new way, the international press has also played an important role in promoting private hospitals in Bangkok to potential foreign patients: “Sea, sun, sand and surgery” (Moorhead 2004 in *The Guardian*) or “A little sightseeing, a little face-lift” (Donehy 2006 in *Los Angeles Times*) are some of the sensational titles used by journalists to describe the phenomenon of medical tourism. This development strongly emphasizes changes in the field of health and its marketing.

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<sup>60</sup> See studies on “therapeutic landscape” (Gesler 2005) or “therapy by design” (Gesler *et al.* 2004).

Moreover, with the expansion of the medical tourism industry, a growing number of agencies, sometimes exclusively specialized in this field, have emerged to inform about tourism opportunities, treatment options, and to assist interested patients with selecting hospitals abroad, visa applications and other paperwork. These companies often take part to trade shows and other promotional events designed to attract potential patients (Crooks *et al.* 2011). The Thai government takes an active role in promoting medical tourism including the sponsorship of these events: for example, the Tourism Authority of Thailand (TAT) supports for the first medical and wellness trade fair in Thailand (September 11 to 14, 2012), with over 100 companies from more than 20 countries in Bangkok.

### *The role of social networks and their manipulation*

Apart from international mobility, what other communication strategies are used by Thai hospitals towards potential patients in the Lao PDR? Advertisements in Laotian newspapers or on billboards in Vientiane show an obvious presence of Thai hospitals in Lao PDR. However, according to the surveys I conducted, advertising has little impact on the decision to be treated across Mekong River or on the choice of which healthcare facility to visit. Out of 55 respondents, only 2 mentioned the possibility of having been indirectly influenced by advertising. In reality, strategies of cross-border patients are mainly guided by word of mouth between family members, neighbors and other acquaintances. Throughout the decision-making process including logistical and financial considerations, the patient's social network significantly influences the treatment itinerary. Physical social networks are therefore a powerful analytical tool for understanding the production of cross-border movements (Bochaton 2009).

Being aware of how information is spread through intermediaries, actors from private Thai hospitals or insurance groups develop strategies to infiltrate the Laotian community in order to occupy a more prominent role in social relations which would

accompany their visual presence. Between medical pretext and disguised door-to-door selling, certain cross-border patients (especially those living in the border towns and even more so in Vientiane) receive home visits from doctors and administrators from some private Thai hospitals near the border. These visits serve two purposes. First, they allow the doctors to monitor patients with chronic diseases or those recovering from operations. Second, they allow the doctors to maintain contact with the most regular Laotian patients. Some are even met with an elaborate bouquet of flowers or with small gifts bearing the hospital logo. The most loyal patients are occasionally invited in small groups to a restaurant. In this way, the groups of private hospitals intend to extend the relationship with their patients outside a purely medical context, and thus create a climate of confidence. By reversing the itinerary – the hospital *comes* to the patient, rather than patients going to the hospital – the hospital administration establishes a new form of relationship between patient and care-giver. The impact of these meetings, albeit not widely in used yet, is as real for the patients visited as for their family and friends, who will surely hear about the event later. The visit will not go unnoticed by neighbors, who may discuss it between themselves.

I also observed that the Laotian shopkeepers, who represent a solid patient base of the Thai border hospitals, were a targeted group of these visits. These individuals possess a growing economic power which allows them to be treated regularly in Thailand. They also benefit from their strong personal connections, gained through their positions, which have great influence in the shaping of social networks. By visiting the shopkeepers, the private hospital managers are well aware of their ability to reach a larger portion of Laotian society: shopkeepers have numerous interactions with the population, and therefore possess an extended social network. Even more so than shopkeepers, Laotian doctors and pharmacists are in the best position to advise their patients to seek treatment in Thailand. Several factors, observed and learned through interviews, allow me to believe that certain agreements exist between Laotian medical personnel and private Thai actors. For example, some border hospitals seek to build relationships with doctors in Vientiane by offering visits to their facilities. These visits allow the doctors to become aware of the different

services and equipment available in these hospitals. These trips are not organized with the intention of training the healthcare staff. Instead, they take advantage of the healthcare disparities on each side of the border and try to encourage Laotian doctors to send their patients to Thailand for medical tests which aren't available in Laos. As there is no formal policy between the two countries regarding this issue, the agreements between Thai hospitals and certain Laotian doctors are hidden. According to one doctor from Mahosot Hospital in Vientiane, "we suspect that there are corrupt doctors". Similarly, a Thai insurance company (Ayudhya) whose office is located discreetly in the outskirts of Vientiane includes Laotian medical staff in its team. The right hand of the Thai representative of this company is indeed a pharmacist and owner of a large pharmacy opposite the Mother and Child Hospital in the centre of the capital. Her husband is a physician responsible for performing health reviews of future subscribers. Even if the insurance company is not obviously visible within Vientiane, it is supported by a network of Laotian healthcare professionals. This network represents the most effective and credible method of distributing information among Laotian patients.

The building of good relations between Thai hospitals and Laotian doctors and the contribution of Laotian healthcare professionals who represent a health insurance company in Vientiane are examples of the power of private Thai organizations. These examples illustrate well the ways in which these groups adapt their methods of communication with potential patients in a foreign country. Private hospitals in Thailand therefore target social networks to expand their influence in Lao PDR. Their strategy consists of having their name marketed by the Laotians themselves and not only through booklets or other advertising media. The force of social networks is shown in the emergence and self-organization of cross-border care (Bochaton 2009). The skill of the private hospitals consists of taking advantage of these networks.

To reinforce and increase patients' flows from the Lao PDR and around the world, private Thai hospitals located either in Bangkok or near national borders develop

specific, although different in form, communication strategies which gradually transform the function of the hospital in Thailand and strengthen its commercial potential. As we will see now, the various forms of cross-border healthcare presented in this article transform not only Thai hospitals but also health systems in the patients' countries of origin.

### **From the country of origin to the host country: an ambivalent impact**

#### *On money and brain-drain in Thailand*

The effects of cross-border patient mobility on the Thai health system are far from uniform. Other than the financial impact, the management of foreign patients also drives large restructuring which can, among other things, influence the professional choices of medical staff and the care of local people. From a financial point of view, transnational health-seeking practices allowed a certain number of private hospitals in Bangkok to recover from the Asian financial crisis of the late 90s. This industry niche now represents a major earner of foreign currency. In a similar manner, the fact that Laotians began using trans-border care contributes to the dynamism of the private Thai hospitals located near the border. Indeed, the prices for foreign patients are 10% higher in these facilities. The example of a private hospital I have studied and which was located just across the Mekong from Vientiane confirms this situation: 50% of the patient base is coming from Laos, making this hospital significantly dependent on its neighbor. Generally, private Thai facilities greatly benefit from admitting patients from just across the border, as well as very far away. However, large numbers of Laotians also seek health care in public hospitals. For these facilities, the cross-border circulations can sometimes represent financial burden contrary to the incomes made by private facilities.

Regardless of this cross-border phenomenon, the public healthcare sector in Thailand is going through significant internal structural problems, including maintaining a balanced budget. Universal coverage, established in 2001, has proved

to be incredibly costly<sup>61</sup>. In 2004, the debts incurred by district hospitals surpassed one billion Bahts<sup>62</sup> and those from provincial hospitals were almost 300 million Bahts. From a regional perspective, the North and Northeast of Thailand, both zones bordering Laos, face the worst budget problems. 40% of public hospitals in the North and 45% in the Northeast of the country ran a negative balance sheet that year (Ministry of Public Health 2008). In this context of diminishing resources, the cross-border health-seeking behavior of Laotians becomes a touchy subject, especially when these patients cannot afford the costs and thus benefit from free treatment by the hospital. While this situation is not very common, the cross-border health-seeking is misperceived as a fiscal burden on public hospitals in Thailand. This misperception is even stated by the national media: “Non-Thais prove burden to border medical services” (*The Nation* 1996). The effects of cross-border healthcare on Thai facilities are differentiated and produce mixed reactions according to the parties concerned. Discreet control measures and restrictions in the public sector compete against the strengthened influence of private hospital groups across the Mekong. These actions have opposite effects, between an increased separation and a progressive blurring of the border.

Transnational health-seeking trajectories, especially of the international type, also indirectly affect the structure and organization of the Thai healthcare system. The phenomenon of Thai doctors leaving the public sector for jobs in private hospitals began in the 90s with the growth of the private sector. This trend could very well increase with the success of “medical tourism” and the promise of high salaries. Also, the return of economic growth and to some extent the influence of medical tourism on local practices has changed the behavior of the Thai upper class, which after progressively abandoning private consultations after the crisis is now using them again. Data from the Thai Ministry of Health show that the public healthcare system was strengthened by 1,188 new medical graduates in 2006. However, 777 public

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<sup>61</sup> The reason for this problem lies in the inadequate per patient payments given to hospitals and the financial burden of this measure. Indeed, fees paid by patients qualifying for special assistance (low income people, student, war veterans) amount to 30 Bahts regardless of the medical procedure done.

<sup>62</sup> 1 US\$ = 29,8 Bahts (October 2010)



medical doctors also resigned that year (Ministry of Public Health, Thailand 2008) which explains why certain small health facilities including health centers have been abandoned by physicians. To avoid too large of a misappropriation of medical personnel to the private sector, the Thai ministry allows public sector doctors to work part-time in private hospitals or private clinics. In 2003, a survey revealed that two-third of public-sector doctors have secondary employment in a private facility, allowing them to increase their income by more than 100%, but at the expense of quality service in the public sector (Herbreteau 2007). Although this is not the only factor, therapeutic travel increases the demand for qualified healthcare professionals in the private sector, which accelerate the flight of doctors towards this sector. A real competition is occurring in Thailand, regarding the redistribution of medical human resources with the private healthcare sector being reserved for foreign patients and the public sector for Thai patients (Pachanee 2006). Similarly, we can now fear a new form of segregation within healthcare facilities. Bangkok Hospital, a large private hospital is a good example of this with its two recently built buildings, one serving only international patients, the other serving only domestic.

### *Some effects in the patients' countries of origin*

The patients' countries of origin are also impacted by the departure of some of their nationals. The implications differ between each country and require specific discussions according to the countries involved, their geocultural proximity with Thailand and patients' motives.

The sustained increase of patients' mobility in recent years is beginning to cause concern to doctors and dentists in some highly industrialized countries. They fear a huge diversion of patients from the national health structures and therefore adverse financial consequences on the current system. In addition to structural effects, the phenomenon raises concern of the quality of care for the patients as well as the medical consequences which could result from surgical procedures (Turner 2012). Some articles available in the press highlight the dangers of medical tourism, sometimes excessively. For example, the paper titled "Les horreurs du tourisme

médical” (“The horrors of medical tourism”) published in a French weekly magazine called *Marianne* (Saporta 2006) solely underscores the potential negative effects, using shortcuts, identifying medical tourism with organ trafficking and its rapid international spread. However, the transnational practice of patients also represents an advantage for private insurance companies. With rising costs, busy healthcare systems and an aging population, it becomes increasingly attractive for some companies to cover the travel and medical expenses of their clients to be treated in Thailand, instead of in Europe or the United States. More and more American insurance companies include coverage of medical procedures performed abroad in their contracts. Some even have direct agreements with hospitals in Thailand or elsewhere. Finally, in addition to the actual effects of medical tourism in the countries of origin of the patients, the phenomenon opens the door to similar trends in other forms of personal services. How far is the transfer of skills in healthcare possible? In a similar manner, retirement houses have been built in Thailand to accommodate Japanese retirees as well as wheelchair accessible welcome centers designed to greet people coming from some Scandinavian countries. It is not known how each other’s interests will be reconciled in the near future and which unique organizations will be made from the use of this healthcare disparity.

Lao PDR shows a very different profile, due to the geo-cultural proximity and the development gap between the two countries. I will focus on this country for the remaining of this section as this kind of situation is largely overlooked in transnational studies and in the literature on cross-border healthcare specifically, and therefore requires more scrutiny. As described above, the search for quality medical care is the main motive of Laotian patients who cross the border to receive treatment in Thailand. These movements reveal the political failure of the Laotian government to provide high quality infrastructure to the entire population throughout the country. Moreover, these forms of health mobility arise within a complex historical framework and in a context where Thailand largely dominates the economic and cultural exchanges. Beyond the medical issue, healthcare seeking behaviors thus cover a political dimension that leads health officials and the public sphere of the Lao

PDR to use specific actions to try to slow the flight of the patients (ironically, many of the high-ranking officials go to Thailand for treatment), showing the growing influence of Thailand in Laotian society. One aspect of the Laotian reaction is to criticize the border-crossing practice through a variety of channels. Whether in the discourse of the members of the Ministry of Health or in newspaper articles, movements towards Thailand are often portrayed as a fad: "Doctors at Mahosot Hospital are concerned that patients who choose to go for treatment in Thailand are merely following fashion instead of good medical advice" (Xayxana 2005). Here, the patient is not seen as searching for quality care, but rather portrayed as a casual consumer. This portrayal aims to discredit the patients who cross the border to Thailand, and thus alleviates the political obligations of the Laotian government by not meeting the needs of these individuals. Moreover, the fact that cross-border health-seeking behavior removes, in a way, patients from the Laotian national health system is seen as an unpatriotic in the eyes of the party: "Lao people should help the Lao economy by using the local medical services (...). Economic development in Laos is still the duty of Lao people" (*Ibid.*). The loss of accountability of political bodies in Lao PDR continues and individuals seeking care pass from the status of "consumers" to that of "culprit". The financial argument regarding the transfer of money to Thailand and the supposed loss to the Laotian economy is at the heart of the criticism.

Despite these perceptions and these discourses, the departure of many Laotians to Thai hospitals stimulates awareness regarding the need for progress and drives the actions of some Laotian healthcare actors. Healthcare facilities in Laos appear to imitate the functioning of their neighbor's establishments through the purchase of new equipments and the construction and the rehabilitation of infrastructures. The underlying idea is that if the Laotian hospitals can look like Thai hospitals, more Laotian patients who might otherwise have sought treatment in Thailand might stay in their country for treatment. New medical facilities and equipment illustrate the will of the Laotian government to compete with Thailand in order to escape today's unequal relationship. However, the desire to acquire medical equipment sometimes leads to absurd situations, which are also maintained by international agencies. In a

hospital in Vientiane, a CT Scan was only used by two patients per day. Does this situation really justify the acquisition and installation of this machine, which is also available elsewhere in Vientiane? The question of repayment is not an issue here as this was a donation from the Japanese International Cooperation Agency. The acquisition of medical products in Laos follows neither a medical nor an economic logic. When we know that hospitals in Laos have trouble obtaining new medications and maintaining stable supplies, the pertinence of the decisions and the agreements reached between Laotian authorities and international funders appears questionable.

In addition to the transformation inside the Laotian hospitals, there is also momentum towards healthcare privatization<sup>63</sup>, justified to counter Thai influence and to “improve health care in Laos and reduce the number of people crossing the border to Thailand for treatment” (Somsack 2007). When I asked a senior party official during an informal meeting in Paris what were the strategies proposed by the government to improve the healthcare systems in Laos, he answered that “the government [had] the desire to allow room for the private sector so that the population does not leave for Thailand.” Cross-border healthcare mobility is at the center of government thinking; it creates a political environment conducive to the development of a private healthcare sector. The current healthcare project only seems to consider the wealthy class of Laos who seek private medical care, at the expense of the great majority of the Laotian population who cannot afford any option other than public services. These developments may very well exacerbate unequal access to care.

The transnational flows have varying impacts according to the patients’ country of origin. This heterogeneity is important to stress once again. The reception of international patients in Thai facilities is largely based on economic factors and is seen as either a financial gain or burden to Thai hospitals. Conversely, these movements are perceived in the countries of origin as a political or social issue. The

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<sup>63</sup> The Ministry of Health in Vientiane wrote a decree in 1998 to allow foreign investors to build private hospitals. This text, initially valid only in Vientiane, will involve all major Laotian cities in the near future.

proximity and complexity of relations between Laos and Thailand make this cross-border mobility a political issue, the consequences of which can be observed in the political realm, as well as healthcare facilities. Alternatively and while they certainly pay attention to medical tourism, geographical distance and lack of close relationships between distant countries and Thailand do not lead authorities to rethink their health system. Although it is often presented in the news, there is still a long way before the medical tourism industry really challenges health policies in regions like Far-Eastern Asia, the Middle East, Europe or the US. This being said, some actors in the health sector in these locations, such as insurance companies, are beginning to take advantage of the situation, especially given the difference in costs. Ultimately, cross-border patient mobility has not yet led to a concerted international agreement between the various actors. What has occurred instead, has involved minor adjustments according to the logic of each group involved.

How, then, should we understand transnational healthcare? Is there a new paradigm at play? This could be the next challenge for the states, which will have to find a new frame matching patients' flows and the organization of national health systems.

## **Conclusion**

Today's transnational flows of patients illustrate an increasing world-wide interconnection in a field, that of healthcare, which was until then largely confined to national borders. "Healthcare consumers everywhere are becoming more individually responsible for their own health behaviours and treatment decisions" (Kearns / Barnett, 1997). Among these treatment decisions, some may include a hospital located thousands kilometers from home. Taking Thailand as a case study (perhaps also transferable to other contexts), this paper has shown that hospitals are now at the crossroads of new types of patients flows and see their functions redefined. The hospital environment, its interior design and communication strategies are thus gradually transformed. All this contributes to transforming the perception of hospitals in the patients' imaginaries.

The emergence of new forms of “healthcare territoriality” that allow therapeutic recourse to take place outside the territory of origin transforms international legal, political, economic and medical environments. More than interconnection, we should indeed speak of interdependence between countries. From the finding of a dependant relationship of Lao PDR towards Thailand in terms of supply and quality of care, this article has also shown that dependency can also exist in the opposite direction: Thai private hospitals located near the border receive large payments from Laotian customers, which explains the invasive strategies developed in Laos to attract more and more of these patients. This is also true at a global scale: patients living afar save time and money by coming to hospitals in economically emerging or developing countries. These facilities, and by extension the host country, are very keen to receive foreign patients, and consider this new health niche with the utmost importance. The question to ask, therefore, is: how long will it take for international rules to be drafted and implemented to address this situation?

This study of cross-border patient mobility at the regional and global levels is an invitation for health geography to shift its focus from the nation-state as the conventional unit of analysis in order to be able to tackle the complex issues brought about by globalization processes. By going beyond the nation-state, it is then possible “to explore the complex scenarios that emerge from the dialectic interaction of descendant nation-state and ascendant transnational spaces” (Robinson 1998). This would help to frame what I call a new transnational healthcare paradigm – in which the role of national boundaries and policies on therapeutic recourse is dramatically diminishing – and its consequences on the territorial dimensions of health care. This rising paradigm does not discard the role of the nation-state in health affairs. It should instead allow for a consideration of health issues at the crossroads of new territorial assemblages. From a political perspective, these new territorial assemblages are thus based on a combination of decision-making capacity shared among public and private stakeholders, nationals and foreigners, formal or informal players, each with their own logic and their own territorial base. The national level is

overwhelmed, and global forces generated by globalization give rise to process of interaction between various institutions and bodies. In the context of globalization, a transnational healthcare paradigm is then necessary to catch the complex imbrications between the different actors playing on health issues at various territorial levels.

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