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Critically reflecting on Loh's "Trends and structural shifts in health tourism"

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In this May's issue of *Social Science & Medicine*, Loh (2015) Trends and structural shifts in health tourism: Evidence from seasonal time-series data on health-related travel spending by Canada during 1970–2010. *Social Science & Medicine*, 132, 173–180) provides a temporal analysis of one mode of health service import, "health tourism", by Canadians, 1970 to 2010. Using national balance of payments statistics ([BOPS], data produced by the Canadian government that estimate the value of imported and exported goods and services) Loh analyses trends in health services purchased by Canadians abroad over the past forty years. In so doing, Loh asserts that 1995 marks a "structural shift" in the cycle and volume of health tourism by Canadians, coinciding first with the signing and implementation of the General Agreement on Trade in Services (GATS), an international trade agreement that liberalizes global trade in services, and also a period of low private investment in Canadian medical facilities.

While Loh seeks to address a substantial and persistent (quantitative) gap in our knowledge of how health tourism is operating, we contend that his analysis is flawed, thereby limiting its overall validity and applicability. Chiefly, his apparent misunderstanding of key features of the Canadian health system as well as his conflation of broad health related travel data with the specific practice of *medical tourism*, confound the intended take home messages of the paper. Below, we provide what we see as four limitations in Loh's argument and call for stronger conceptual clarity in exploring medical tourism to avoid contributing further confusion to an already muddled conversation. We begin with the introduction of a more stringent and contextualized definition of medical tourism, the phenomenon Loh's analysis aims to measure.

1. What is medical tourism?

Medical tourism is the private movement of patients across national borders for the purpose of accessing medical care (Connell, 2015). Patients are travelling to a growing number of countries around the world to access procedures such as orthopaedic and cardiac surgeries, unproven interventions (e.g., stem cell treatments), and reproductive services (Lunt et al., 2011). Some patients are motivated to go abroad for medical care because costs are high in their home countries while others do so because the procedures they wish to access are illegal or (relatively) unavailable at home (Crooks et al., 2010). Alternatively, patients who rely upon publicly financed health care systems may seek care abroad due to long wait lists (Crooks et al., 2010). Due to the dual lack of comprehensive reporting from the private health care sector and lack of public surveillance of patient movements, reliable flow numbers of this phenomenon are not available. However, industry reports suggest that the global medical tourism industry takes in billions of dollars in annual revenues (e.g., Purdy and Fam, 2011).

Health tourism, on the other hand, represents a meta-category that captures both medical (e.g., surgical, diagnostic) and non-medical (e.g., spa therapies, holistic care) health-related care accessed abroad. It is essential to clearly operationally define such mobilities; other global health care mobilities are sometimes conflated with medical tourism both in industry and academic reporting, which ultimately muddies the dialogue about medical tourism flow numbers, their associated economic value, and the equity impacts of these inbound and outbound flows in destination countries and patients' home countries. For example, when patients are referred to health care providers in other countries by their home health care systems as part of formal cross-border care

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arrangements, they are not engaging in medical tourism and instead are undertaking out-of-country care (Runnels et al., 2014). Similarly, when vacationers become ill or injured abroad and require emergency medical care, they are not medical tourists as the purpose of their travel was not to seek care. Finally, expatriates accessing care in the country in which they live are not medical tourists as the care they receive is not their primary purpose for relocating.

2. What is our interest in medical tourism?

We are health services researchers based in Canada, the geographic focus of Loh's analysis. We have, collectively, published a substantial catalogue of scholarly work on Canadians' involvement in medical tourism and on the impacts of Canadians' pursuit of medical tourism abroad on Canadian health service providers. We have interviewed and surveyed former Canadian medical tourists (e.g., Cameron et al., 2014; Snyder et al., 2014), Canadian medical tourism facilitators (e.g., Johnston et al., 2011), and Canadian doctors and health and safety professionals (e.g., Crooks et al., 2013a, 2015; Johnston et al., 2012, 2013; Runnels et al., 2014; Snyder et al., 2012, 2013). We have conducted literature reviews, structured scoping reviews, website reviews, and media reviews all pertaining to Canadians' involvement in medical tourism (e.g., Crooks et al., 2013b; Hopkins et al., 2010; Penney et al., 2011; Snyder et al., 2011). Some of us were involved in the development of an informational tool aimed at providing guidance to Canadians considering travelling abroad as medical tourists (Adams et al., 2013). As a result, we feel confident in our capacity to comment on the analysis presented in Loh's paper. In the sections that follow, we propose four significant limitations of the work that call into question the validity of the design and subsequent results.

3. Limitation one: lack of definitional clarity

At the outset of his paper, Loh provides a brief definition of health tourism as "embodying the activities of consumers travelling abroad for health services and medical procedures" (Loh, 2015; pg. 173). Health tourism is an enormously broad category, and – as pointed out above - encompasses travel for complementary as well as alternative medicine, spa therapies, and biomedical interventions (Connell, 2015). With the exception of Loh's conclusion, where the full spectrum of 'soft' to 'hard' care is opened up, it is clear that his paper is intended to examine *medical* tourism specifically. This is underscored by the datasets used and his focus on biomedical interventions. Further, most of his sources are drawn from the medical tourism literature and not the broader scholarship on health tourism. That said, looking at the methodology and sources of data that inform the creation of the Canadian BOPS employed by Loh, it appears there is *no measure* that actually captures the value of privately purchased medical services by individual Canadians while abroad as they are not surveyed about their purchases of services upon re-entry to the country nor are unmediated service imports of private households measured in any other way (Canada Border Services Agency, n.d.; Statistics Canada, 2015a). As such, we ask: is it even possible to look at medical tourism-related (let alone the broader meta-category of health tourism-related) trends using this particular data set? We are not currently convinced that it is. Loh provides an incredibly limited overview of the BOPS, one that does not effectively argue for the fact that these data can serve either as a direct measure of or a proxy for Canadians' private pursuit of intentional medical care abroad via the global medical tourism industry.

4. Limitation two: what exactly does the BOPS capture?

In our own review of the Canadian BOPS (Statistics Canada, 2015b) we are left with significant questions about what it does and does not capture. As we point out above, we are not convinced that *all* the health-related travel captured in BOPS is medical tourism, one of Loh's chief assumptions. Instead, our review of the BOPS and also the data that Loh reports leads us to believe that this dataset also integrates health services provided to Canadians abroad that are formally insured, and thereby likely to be medical emergencies, routine care accessed by expatriates, and formal cross border care agreements between Canadian health insurers and care providers abroad. In other words, the BOPS appears to integrate multiple types of intentional and unintentional international health care mobilities in the single 'health-related travel' variable. It is thus impossible to tease apart medical tourism from these other mobilities without gaining access to the data at a finer granularity than what Loh has used. Because Loh attempts to link his findings about trends observed between "health tourism" and the Canadian health care system, it is essential that he be able to distinguish between these different types of mobility because each has different health system origins and implications. Because it is not possible to do this, his attempts to link his findings to funding and structural changes in the Canadian health care system to Canadians' pursuit of medical tourism abroad is not supported.

5. Limitation three: mischaracterizations and misunderstandings

We assert that the claims Loh makes in his paper are not well supported. As an example, Loh claims in the introduction to his paper that "Canada is among countries with the highest spending on health tourism" (Loh, 2015; pg. 174). This claim is not referenced and comes as somewhat of a surprise. While the table provided does show Canada as the highest total spender on health-related travel services (however, see related comments, above), there is no rationale provided for the countries against which it is contrasted, nor are the examples of spending adjusted for population or income. The countries included likely represent very different health traveller profiles, again returning to the issue of what kind of health-related travel expenses they are incurring with regard to elective or necessary medical care financed out of pocket or with the assistance of internationally portable health insurance.

With regard to the financing of care in Canada, Loh inaccurately characterizes Canada's health care system as a unified whole. While the federal government finances a significant portion of its citizens' care via transfers to its provinces, Canadian health care is administered and financed on a provincial or territorial basis (Sutcliffe, 2011). Medicare is in effect 13 separate health care systems that differ in terms of treatments that are covered and their capacity to deliver them (Daw and Morgan, 2012; Sutcliffe, 2011). This is significant as any totalizing claims about the overall capacity or functioning of the Canadian health system, such as those made by Loh throughout his paper, neglect the significant provincial or territorial differences that are likely influencing what procedures Canadians are travelling for and why. Furthermore, Loh's characterization of the Canadian health system as perennially beset by wait times draws from non-peer reviewed sources produced by the Fraser Institute, a think tank well known in Canada for its reputation of producing ideologically driven research (McLevey, 2014). Indeed, the wait time rankings created by the Fraser Institute are not produced using rigorous quantitative data capable of representative results, instead relying on a survey of specialists self-reporting their perceptions of wait times in their own practices (Barua and Fathers, 2014). While wait times for medical care are a

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