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Trends and structural shifts in health tourism: Evidence from seasonal time-series data on health-related travel spending by Canada during 1970–2010

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A B S T R A C T

There has been a growing interest in better understanding the trends and determinants of health tourism activities. While much of the expanding literature on health tourism offers theoretical or qualitative discussion, empirical evidences has been lacking. This study employs Canada's outbound health tourism activities as an example to examine the trends in health tourism and its association with changing domestic health care market characteristics. A time-series model that accounts for potential structural changes in the trend is employed to analyze the quarterly health-related travel spending series reported in the Balance of Payments Statistics (BOPS) during 1970–2010 (n = 156). We identified a structural shift point which marks the start of an accelerated growth of health tourism and a flattened seasonality in such activities. We found that the health tourism activities of Canadian consumers increase when the private investment in medical facilities declines or when the private MPI increases during the years following the structural-change. We discussed the possible linkage of the structural shift to the General Agreement on Trade in Services (GATS), which went into effect in January, 1995.

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1. Introduction

Health tourism, embodying the activities of consumers traveling abroad for health services and medical procedures, is becoming an increasingly notable way of health care delivery around the globe. While capturing much attention from the popular media, (Kumar, 2009a; Kurlantzick, 2007; Rosenthal, 2013; Surowiecki, 2012; Yang and Liu, 2012) health tourism has also become an important topic in the public policy forum (Haley, 2011; Lunt et al., 2015; Pocock and Kai Hong, 2011; Reisman, 2010). For countries on the demand side of health services abroad (with outbound patients), health tourism provides a way to relieve the shortage of health services in the domestic market. The increasing volume of health tourism activities, however, often yields growing concerns about patient safety and legal issues related to malpractice, given that the legal responsibility has not always been clearly defined between patients, health insurance agencies, and foreign health service providers (Crooks and Snyder, 2011; Hanefeld et al., 2013; Mitka, 2009; Samir and Karim, 2011; Turner, 2010). International medical travel can also influence domestic political and social changes (Ormond, 2015). For destination countries (with inbound patients), health tourism gains popularity due to the revenue and the broader economic impact generated through such activities and the opportunity to bolster domestic medical care standards (NaRanong and NaRanong, 2011; Turner, 2010). However, a lucrative health tourism sector may also distort national health care system with a negative impact on the access to health care for domestic consumers (Whittaker et al., 2010).

Due to the widespread impact of health tourism, there has been a growing need from the health system planning and policy-making perspective to better understand the nature of the trend in these activities (Chen and Flood, 2013; Cohen, 2012; Crozier and Martin, 2012; McMahon and Thorsteinsdottir, 2010). It is important to have a better understanding of what the determinants of health tourism are and in what way they have shaped the trend. Unfortunately, the rapidly expanding literature of health tourism offers mostly theoretical or qualitative discussion regarding, but lacks the much needed empirical evidences due to the paucity of reliable data (Connell, 2013; Hanefeld et al., 2015).

In this study we explore the quarterly health-related travel spending series from 1970 to 2010 in the Balance of Payments Statistics (BOPS) maintained by the International Monetary Fund (IMF) as a measure for health tourism. Combined with data from

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other sources including World Development Indicators (WDI) and the OECD Health Data (OECD Health) as covariates, the health-related travel spending data are analyzed in time-series models to assess the association of a country's outbound health tourism activities with domestic health care market conditions, using Canada as an example. Our analysis accounts for potential structural changes in the trend in health tourism, a consideration motivated by the observation of the changes in the stereotypes of health tourists and the medical procedures sought abroad. The timing of the structural break is identified using a procedure suggested by Franses and Vogelsang (1998).

This study uses Canada for two reasons. First, Canada has a relatively long history of engagement in health tourism and has been in the lead in terms of the volume of health tourism activities. In the BOPS database, Canada has the longest stretch of seasonal data dating back to 1970. The long period of data coverage allows us to have a clearer view of the presence of any structural changes. Second, during the study period, Canada's national health care system went through frequent adjustments in capital investments in health care and variation in the medical price index (MPI) under the same national health insurance system (also known as Medicare). It makes the Canadian data more ideal for identifying the impact of changes in the domestic health care market conditions without the complexity of a large scale disruption in the system, which often leads to unstable estimates in an empirical analysis.

Our analysis identified a structural shift point which marks the start of an accelerated growth of health tourism and a flattened seasonality in such activities. We also found that the health tourism activities of Canadian consumers increased when the private investment in medical facilities declined or when the private MPI increased during the years following structural-change. We offered a possible explanation of these structural changes and discussed the contextual factors.

The rest of the paper is arranged as follows. Section 2 provides an overview of the global trends in health tourism, while Section 3 gives an overview of the domestic health care market in Canada and highlights the potential factors of demand for health tourism by Canadian consumers. The data and methodology are described in Sections 4 and 5. Section 6 and 7 present the results and conclusions.

2. Global trends in health tourism

Based on a growing number of popular press reports and existing industry or country case studies, many postulate that the rising trend in health tourism is a global phenomenon. A recent study, however, shows that the growth in health tourism in the last decade is not a universal phenomenon but rather uneven across countries with the volume of health tourism activities becoming more polarized between the high- and the low-usage countries (Loh, 2014). Consequently, a better understanding of what the determinants of health tourism are is needed.

The growth of health tourism can be linked to a number of factors. From the demand side, the unavailability or inaccessibility of health services in the domestic market is the major driving factor. Health tourism seems to have gone through a major change in recent decades in terms of the type of services sought and the demographics of consumers. Until recent decades, health tourism has been characterized by affluent patients from developing countries traveling abroad for health procedures that are unavailable or of lower quality in their countries of residence (Achouri and Achour, 2002; León, 2002; Widiatmoko and AGani, 2002). This type of medical tourism continues to grow, especially within the Global South (Crush and Chikanda, 2015). During recent decades, however, rising numbers of patients from developed economies seeking medical services abroad for cost-saving or avoidance of long wait lists appear to have shifted the average profile of medical tourists (Connell, 2015). These changes could be attributed to the rapidly worsening medical inflation (e.g., in the US, see Cebula (1998) and Riggs et al. (2012)) and the increasing wait time for major surgical and therapeutic treatments at home (e.g., in Canada, see Barua et al. (2010)). The new types of health tourists form a niche market, which foreign countries with cost advantages over home countries in producing these health services (e.g., Thailand, Malaysia, and India) can tap into (Bookman and Bookman, 2007a; MacReady, 2007).

On the supply side, an increasing number of countries have been aggressively developing a health tourism sector to meet the needs of patients from targeted countries or regions. Many supplying countries carved their markets around a specialized subset of health services (such as cosmetic surgery, reproductive care, dental care, organ transplants, hip replacement, and even heart bypass surgery) while few others attempted to provide a one-stop shopping experience by offering a more balanced mix of services (Hamlin, 2012; Ramachandra, 2011; Schiano and Rhodes, 2010; Siva, 2011). In most of these countries, governments took an active role in promoting health tourism and creating financial incentives for health care providers to meet the international quality standard (Bookman and Bookman, 2007b; Kumar, 2009b; Reisman, 2010).

Another factor which may have influenced the increasing health tourism activities is trade liberalization. The most notable international service trade agreement in the recent decades is the General Agreement on Trade in Services (GATS), which went into effect on January 1, 1995. It was a major attempt of the World Trade Organization (WTO) to liberalize trade in services, with health services being one of the two specially targeted areas (the other being education services). In the GATS framework, the supply of services is categorized into four modes: cross-border delivery of services (Mode 1), consumption of services abroad (Mode 2), commercial presence of suppliers (Mode 3), and presence of suppliers as a natural person (Mode 4) (Chanda, 2002). Health tourism, which involves consumers crossing borders to obtain medical treatment, falls into Mode 2. Since the GATS commitment is legally binding, a country needs to be highly certain about the consequences and implications before committing the health service sector (Smith et al., 2009; Woodward, 2005). Full commitment consists of providing full market access and national treatment for the particular mode without any restriction. National treatment means that citizens of foreign countries are granted the same rights and privileges of national citizens. Around the time when GATS went into effect, 38 countries made full commitment to liberalize trade in medical and dental services, 21 countries committed to liberalize trade in midwife and nurse services, and 31 committed to liberalize trade in hospital services under Model 2 (Secretariat, 1998). By 2009, the number of countries that made full commitment to the above sectors rose to 49, 24, and 50, respectively (Adlung, 2010). The effect of GATS on the volume of health tourism activities is unclear due to the lack of empirical studies.

3. Health tourism by Canadians

Canadian patients have been actively involved in health tourism in the last few decades. Canada is among countries with the highest spending on health tourism. Table 1 summarizes the annual health-related travel spending and its share in personal travel spending in 2000, 2005, and 2009 for a selected list of countries. From 2000 to 2009, the health related travel spending by Canada rose from US$213 million to US$366 million dollars. With the health-related travel spending as a share of personal travel spending constantly above 1.5% for all years, Canadians also travel for health reasons

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