



## Offshore Hospitals Take on the U.S. Health Care Market

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By David J. Gibson, MD

"You're Going WHERE for Surgery?"  
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Perhaps the biggest inhibitor to innovation in health care is lack of competition. The predominant business plan for the American health care market has been hegemony. Hospitals seek to become regional monopolies and dictate pricing to insurance companies. Doctor groups seek monopolistic contracts with hospitals for services. Laboratories seek monopolies with doctor groups. All of this works when the consumer is deliberately excluded as a variable from the market equation.

Actual competition based on price, objectively measured quality and innovation is an alien concept. But winning by forming monopolies is about to change.

Global competition is emerging in health care. A growing number of high-quality health care facilities in developing countries have begun catering to "medical tourists" from the United States and other countries. The Indian government has publicly encouraged medical tourism by offering one-year extendable medical visas, organizing exhibitions to showcase Indian hospitals, and creating a list of recommended hospitals to attract foreign patients.

Most health insurers are aggressively adding low-cost, international facilities to their networks. This expansion is expected to become commonplace by 2009, just as high deductible consumer directed health plans (CDHPs) become the predominant model for group health markets across the country.

State legislators in West Virginia and Colorado have introduced bills offering incentives to state employees to take advantage of the costs savings of overseas medical care. In February 2007, West Virginia Rep. Ray Canterbury (R-Greenbrier), with nine co-sponsors, introduced House Bill 4359 "establishing a system to reduce the cost of medical care paid by the Public Employees Insurance Agency by providing incentives to covered employees to obtain treatment in low cost foreign health care facilities accredited by the Joint Commission International." <sup>1</sup> In Colorado, Representative Spencer Swalm introduced a similar bill, HB07-1143.

Specifically, the Canterbury bill offers state employees these incentives for medical care abroad:

- Waiver of all co-payments and deductible payments;
- Payment of round trip air fares for the covered employee and one companion;
- Lodging expenses in the foreign country for the companion for the length of the treatment or procedure;
- Lodging expenses in the foreign country for the covered employee and the companion for not more than seven days of convalescence after the treatment or procedure;
- Payment to the covered employees hiring agency for seven days of paid sick leave,

- which are not counted against the employee's accrued sick leave; and
- Rebate up to 20 percent of the cost savings directly to the covered employee.

It is unclear whether these bills will become law this year, but we do know that their legislatures are taking it seriously. The WV Legislature invited PlanetHospital to the Charleston statehouse to present a proposal for administration of such a policy.

### The Attraction of Offshore Care

Uninsured patients and those with CDHP health plans are becoming more attracted to high-quality health care that is up to 80 percent less expensive than the cost for the same service in the United States. For example, heart surgery can easily cost more than \$50,000 in the United States. The same surgery, often with better outcomes data, might only cost \$10,000 in India, \$12,000 in Thailand or \$20,000 in Singapore. These prices frequently include round trip airfare and four star hotel accommodations for the family.

One conservative estimate in Health Affairs suggests \$2 billion in savings if a fraction of Americans went overseas for one of 16 different procedures that the authors believe are easily tradable.<sup>2</sup> Table 1 provides an overview of the competitive pricing in the market.

Table 2 lists a few of the hospitals currently competing in the international market. These hospitals have fully computerized and networked hospital information systems, and digital radiology department. They each have 24/7 telemedicine services. Each offers world-class amenities and delivers the highest ratings for customer service and patient satisfaction.

The numbers of travelers and size of the industry are growing every year. Medical tourism grossed an estimated \$60 billion worldwide in 2006. A report by McKinsey & Company predicts this will increase to \$100 billion by 2012. In 2007, 750,000 Americans are expected to travel abroad for health care. By 2010, this figure is estimated to increase to 6 million.<sup>3</sup>

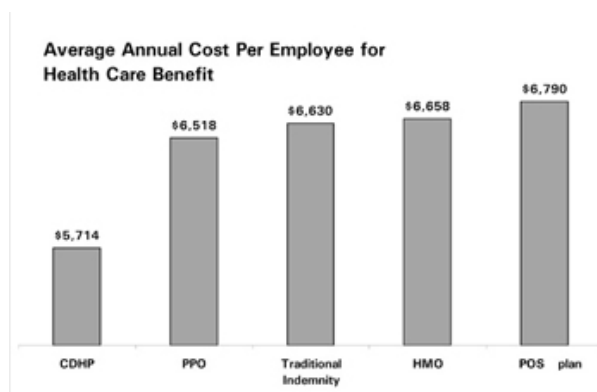
Travel agencies that specialize in packaging medical tours for patients and their families are one of the leading growth elements in the travel industry.<sup>4,5</sup> The growing online directory of options and patient travel can be found at: [www.medicaltourism.com](http://www.medicaltourism.com).

As patients with high deductible health insurance are exposed to the true cost of health care services, we anticipate an explosive growth in foreign competition for high cost goods and services in America's health care marketplace. So far, domestic providers have dismissed this trend. Unable to compete on price, they are becoming progressively exposed to superior outcomes data from foreign competitors.

How quickly will the defined contribution health insurance product, predicated upon the beneficiaries' financial exposure, expand in the group health market? Table 3, taken from a recent Mercer study, demonstrates the likelihood of employers offering CDHPs to their employees in 2007 or 2008.

Large employers who have offered CDHPs to their employees are experiencing significant savings. The accompanying graph demonstrates the average annual cost per employee for the various types of health plans on the market.

CDHPs delivered substantially lower cost per employee than either PPOs or HMOs in 2006. CDHP averaged \$5,770 per



employee, compared to \$6,616 for HMOs and \$6,932 for PPOs (but just \$6,019 for PPOs with comparable deductibles of \$1,000 or more). The average CDHP cost is 5.3 percent higher than last year's average cost of \$5,480. It should be noted that CDHP cost includes the employer account contribution and that many of the new plans added in 2006 were HSAs<sup>6</sup>, which do not require an employer's contribution. Cost rose more rapidly for both PPOs and HMOs - 7.0 and 6.5 percent, respectively

While too early to evaluate the long-term impact of consumer-directed health plans, it appears their cost trend is running about 2.5 percentage points below cost trends in HMOs and PPOs. A consensus is developing among health care economists: CDHPs will likely become the predominant form of group health insurance over the next few years.

If the consumer is exposed to the true cost of goods and services, the monopoly strategy that has predominated for the past half century will no longer work. Instead, American providers will have to compete in the high-end service market that is rapidly developing?

Two variables will require attention. The first is the quality of the service provided. American providers have generally resisted objective measurement and stratification reporting of outcomes data. That must change.

### **Quality of Service**

Medical tourism ceased to be a futurist's fantasy and became a practical reality in 1999, when the Joint Commission on Accreditation of HealthCare Organizations (JCAHO) launched its international branch, Joint Commission International (JCI). Chicago-based JCI has accredited over 100 hospitals in 23 countries.

JCI standards for hospitals include assessing quality of patient care, efficiency and best practices of management, patient safety standards, outcomes data and improvement across key functions. Criteria for JCI accreditation are considered as rigorous as those for US hospitals seeking JCAHO accreditation.

Furthermore, as is demonstrated in Table 4, many of these facilities are affiliating with some of America's leading academic medical centers for patient care, medical education and research. The schooling, training and board certification processes for physicians and surgeons at these hospitals are comparable to those in American medical centers. Generally, the surgeons and physicians on staff have trained in the United States or Europe, with many holding licensure within the United States. In 1974, 97 percent of medical school graduates in both the U.S. and the U.K. were Caucasian. By 2000, this had dropped to 74 percent. Of the 26 percent made up of ethnic minorities, most were Asian. Asian students accounted for 19 percent of new medical students in 2001.

How good is the training and certification of foreign physicians? More than two dozen hospitals in Massachusetts, including Massachusetts General Hospital, now send their CAT, MRI, and ultrasound scans to doctors in Southeast Asia for overnight reading. These radiologists routinely render crucial medical judgments, and are board certified as well as licensed in Massachusetts.

The internationally generated outcomes data are impressive. For example, the Apollo Hospital in Hyderabad India boasts the same surgical success rate as the Cleveland Clinic. Escorts Heart Institute and Research Center in New Delhi and Faridabad, India, performs nearly 15,000 heart operations every year, and the death rate among patients during surgery is only 0.8 percent - less than half that of most major hospitals in the United States.<sup>7</sup>

The American medical establishment asserts that our system produces the best health care outcomes in the world and therefore our cost structure is justifiable. It is time to prove that assertion or begin to abandon the field.

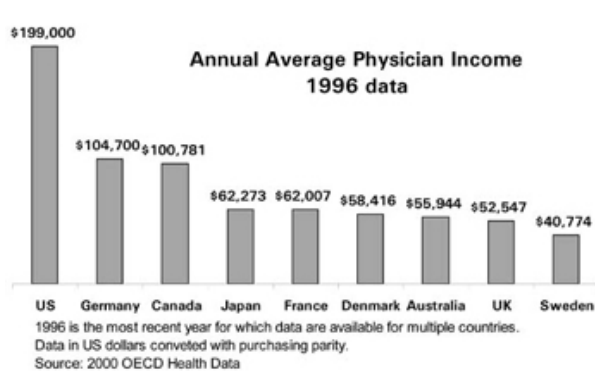
### **The U.S. Cost of Care**

The second issue that must be addressed is the exceptionally high cost per unit of care delivered in the United States. A recent study by the School of Public Health at Johns Hopkins University<sup>8</sup> found that the primary cause for America's disproportionately expensive health care system is the cost of labor. Studies published in May 2004 by the California Workforce Initiative found that labor costs in this state account for almost 70 percent of all health care expenditures.

Health care labor costs key off physician incomes, which are twice as high in the U.S. as in any other industrialized country. Furthermore, the ratio of the average income of U.S. physicians is approximately 5.5 times higher than average employee compensation for the United States as a whole. By comparison, Germany's was the next highest, at 3.4; Canada, 3.2; Australia, 2.2; and the United Kingdom, 1.4.

This disparity in income translates through the entire health care industry's labor cost structure. For example, nurses in the U.S. earn 50 percent more than their counterparts in Canada; similar income disparities are found for physical therapists, occupational therapists, as well as laboratory and X-ray technicians.

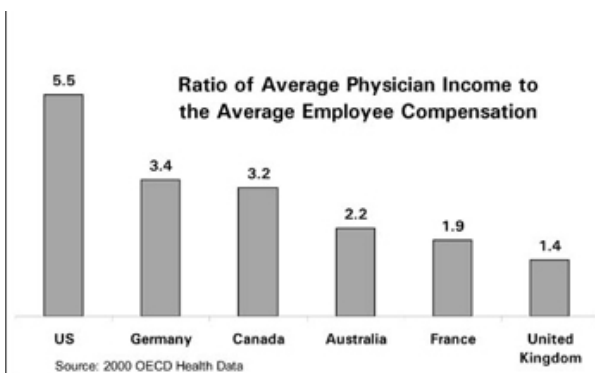
The two accompanying graphs demonstrate Organization for Economic Co-operation and Development (OECD) data from 1996, the most recent year for which data from multiple countries is available. These graphs illustrate the magnitude of the problem.



The first graph demonstrates the annual average incomes for physicians among other industrialized countries. The second, and much more important, demonstrates the average physician income compared with other employees. All of health care's labor cost infrastructure keys off this aberrant physician income. The American health care system will be unable to compete internationally until labor costs in the industry are restructured.

The axiom that "all health care is local" never applied to complex episodes of care. We have always had centers of excellence in Boston, Houston, Cleveland, and Rochester, MN. Patients have long traveled beyond their local market to receive care in these centers.

Now a new competitor has taken the field. This competitor is not only challenging us based upon outcomes, but also by delivering far lower pricing per unit of service. So far, America's physicians have not responded to the challenge.



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1. Bill to amend the Code of West Virginia, designated §5-16-28.
2. Health Affairs, 25, no. 2 (2006): 358-368 doi: 10.1377/hlthaff.25.2.358
3. Source: Devon Herrick (moderator), Milica Bookman and Rudy Rupak, "Global Health Care: Medical Travel and Medical Outsourcing," National Association for Business Economics, Health Economics Roundtable Teleconference, July 25, 2007.
4. For example, Gorgeous Getaways Pty. Ltd. of Australia arranges cosmetic surgery packages, at [www.gorgeousgetaways.com/home.htm](http://www.gorgeousgetaways.com/home.htm)
5. <http://medicaltourism.com> represents a medical professional-based service.
6. A health savings account, or HSA, allows an individual to set aside pre-tax dollars for future medical, retirement, or long-term care expenses. The individual is allowed to invest these funds in a broad range of choices, then use them for qualified expenses. The funds roll over from year to year. These investments are transportable as the owner moves through changing employment status.
7. Hutchinson (2005). "Medical Tourism Growing Worldwide." UDaily, University of Delaware (July 25, 2005).
8. "Health Spending In The United States And The Rest Of The Industrialized World," Anderson et al. Health Affairs. 2005; 24: 903-914.

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