Report B: **Medical Travel Outside the U.S.**

OMSS Action: **Adopted recommendations of Governing Council Report B with a change in title, and filed the remainder of the report.**

HOD Action: **Referred Resolution 732.**

Introduction

At its 2006 Interim Meeting, the American Medical Association (AMA-OMSS) Assembly referred OMSS Resolution 6, "Medical Tourism and Quality Care," along with the Heartland Caucus amendment. Referred Resolution 6 and the amendment asked that our AMA:

1. Study the trend of "outsourcing" health care overseas in order to better understand the magnitude of the practice and its impact on U.S.-based physicians having to "pick up" the pieces after a procedure is done overseas without follow-up care by the overseas provider.

2. Work to encourage any health insurer using physicians in foreign countries to guarantee that reasonable U.S.-based follow-up care will be available prior to sending the patients to a foreign country.

3. Advocate that any health insurer sending patients to foreign countries require credentialing and assessment of the physicians in foreign countries and facilities comparable to that required for providers and facilities in the U.S.

4. Work to assure that all patients have the option of U.S.-based health care if they so choose.

5. Work to assure that patients sent overseas by their health insurer for medical procedures are provided with the same appeal and legal rights as to their benefits as they would be provided were their provider U.S.-based.

This report discusses the reasons why Americans are traveling the world for health care, provides an industry overview, and offers conclusions and policy recommendations.

1. OVERVIEW

In 2005, an estimated 500,000 Americans journeyed overseas for medical care, often as part of a vacation-like travel package[i]. Medical tourism is now a world-wide, multibillion dollar phenomenon that is expected to surge in the coming years along with the ranks of cost-conscious uninsured Americans and financially strained U.S. employers.

In the past, those that traveled internationally for healthcare were typically interested in treatments that were either unavailable in their home country or were not covered by health insurance (including many cosmetic and dental surgeries). However, due to increased out of pocket healthcare expenses in America, along with long waiting lists in single-payer countries like the U.K. and New Zealand, many westerners are now traveling to developing countries like India, Thailand, and the Philippines for procedures like heart surgery, knee replacements, and hip resurfacing.

Travel agencies and insurance companies catering to the medical tourist have sprung up around the nation and the world, often touting the fact that the hospitals they send their clients to are accredited by the Joint Commission International and that the physicians the patient will see, who are sometimes introduced to them via teleconference, have been trained in the U.S. or have U.S. Board Certifications.

It is possible that the effects of medical tourism could soon be felt by the grassroots physician. When combined with recent domestic initiatives for transparency in healthcare price and quality (including President Bush's 2006 Executive Order on the matter), the fact that major payers and employers may soon follow in the footsteps of individuals and self-insured firms now leading the charge overseas could exert significant downward pressure on U.S. fees in the coming decades, driving down physician reimbursements and making it more difficult for doctors and hospitals to cross-subsidize patient care[ii].

To illustrate, the international price gap for a mitral valve replacement operation can be over $150,000; the procedure in India might cost $9,000, whereas in the U.S. the price is closer to $160,000[iii] (see Appendix A). The financial benefits to an uninsured individual are clear, and given the large and growing costs U.S. employers pay for their workers' health care, it is easy to see why American firms might be interested in tiered insurance plans that could serve to narrow the international price gap by including providers in foreign countries.

Mercer, a major human resources consulting firm, is currently developing such programs for several Fortune 500 companies[iv] to allow them to outsource elective surgeries, and the West Virginia State Legislature is considering a plan to cover State employees for treatment outside the U.S., including first class flights for the patient and a companion, recovery in a four-star hotel, and other incentives including bonuses and sick leave[v].

Due to the potential impact of medical tourism on patient safety and on the profession of medicine, the trend is clearly an issue that the AMA should be monitoring closely. This report provides context for evaluating the medical tourism business by exploring the reasons behind a U.S. patient's decision to seek medical care in a foreign country, summarizing the current state of the industry, and discussing the global convergence of medicine. Because participation by major insurers would appear to be the tipping point, it is recommended that the AMA-OMSS Assembly focus on this aspect of the medical tourism industry when formulating a resolution to present to the AMA House of Delegates at the 2007 Annual Meeting. Policy opportunities in this area might include developing model legislation to regulate U.S.-based travel agencies and insurance companies seeking to send American patients overseas for medical care.

2. DISCUSSION

2.1. Why Americans Travel the World for Health Care

America's healthcare system has failed many of our citizens, in particular the 46 million uninsured. While some are willing to wait until their symptoms are acute enough to warrant an emergency room visit (when their condition will be most difficult to address and their care will be the most expensive and least effective), those that seek to take preventative action can either search for health coverage (which is often cost-prohibitive in the light of serious pre-existing conditions) or face self-pay charges arbitrarily set by hospital CFOs.

At a June, 2006 hearing held by the U.S. Senate Special Committee on Aging, *"The Globalization of Healthcare: Can Medical Tourism Help Reduce Health Care Costs?"*,

Senator Gordon Smith (OR) observed that while Americans should not have to travel overseas for affordable health care, the decision to do so has become an understandably attractive option for the nation's uninsured. The following section describes how market forces including 1) price sensitivity, 2) competition on quality, 3) customer service, and 4) convenience may accelerate growth in the medical tourism movement in the coming years.

- *Price sensitivity.* The expense of standard medical treatment is forcing uninsured patients to seek healthcare outside the scope of traditional medicine through the use of complementary and alternative healthcare, by making visits to retail health clinics, and increasingly by looking to physicians in foreign countries when they find that they have run out of local options. But it is not only uninsured individuals that are looking overseas. As the weight of providing healthcare cuts into profits and impairs the ability of both small and large employers to compete in the global market, some American companies are looking for international solutions to help them stay afloat until they can get out of the healthcare business[vi]. To that end, self-insured firms have begun to explore the possibility of providing voluntary medical travel options to workers. Prices offered to medical tourists are often 60-85% lower than insurer-negotiated charges in the US, a margin that easily offsets travel, first class hotel for the patient and a companion, and often an opportunity for the patient to share in the financial savings enjoyed by the employer[vii].

  In short, price sensitive consumers may consider America less competitive as medicine goes global. Along with our higher labor and malpractice insurance costs, drug, device, and equipment manufacturers currently have differing price schedules across countries. How quickly international competition will flatten these differentials remains to be seen, but it is doubtful that parity in those factors alone will close the international price gap. Given that the Institute of Medicine has estimated that 30-40% of all American healthcare spending is waste, we will continue to fall short in international benchmarks of value until major public and private payers create a profoundly more efficient system that is sensitive not only to price, but also to quality[viii].

- *Competition on quality.* Does cheaper necessarily mean lower quality? Is traveling overseas for a common procedure truly a danger or are objections from organizations like the Society of Plastic Surgeons merely protectionist scare tactics? The Joint Commission International (JCI) has accredited over 100 foreign facilities, but given the significant differences between the Joint Commission's domestic and international standards (see Appendix B) does that mean that the quality of care in those hospitals is truly comparable to what one would expect in the U.S.? Should those that want to ensure quality patient care focus on transparency in outcomes data on or on compliance with JCI Standards?

  Answering these questions will become easier each year as more and more outcomes data is made public both domestically and internationally. In 2006, President Bush signed an Executive Order directing Federal agencies to promote price and quality transparency in healthcare through the collaborative development of quality measures, the aggregation of claims data, the procurement of interoperable information technology, and the adoption of pay-for-performance models of reimbursement by January 1, 2007. Accordingly, the Center for Medicare and Medicaid Services (CMS) has begun posting the prices it pays physicians for certain services online, along with the number of services provided in each Medicare locality (a figure that might correlate with more experience and therefore higher quality). Although private payers are not required to make their pricing schedules public, CMS contends that Medicare patients might "get a better deal on care if they are

willing and able to travel elsewhere in the state to receive it"[ix], translating into lower costs for the patient and for CMS. CMS also asserts that the uninsured will be able to make good use of the information when negotiating with doctors and hospitals about fees.

Additional quality measures are also being posted to the web. For example, it is expected that by June, 2007, the 30-day mortality rates of heart failure and heart attack patients will be posted to www.hospitalcompare.hhs.gov, by hospital, using methods developed at Harvard and Yale and approved by the National Quality Forum. "We are supporting collaborative efforts that are providing unprecedented information to help people get the best quality care for the best price," said CMS Acting Administrator Leslie Norwalk.

The data is beginning to show tremendous variation within and across states, but how do performance measures compare across countries? Patients may soon be able to answer that question as hospital standardized mortality ratios (HSMRs) become more public (the HSMRs for 29 hospitals in Minnesota were published on a Web site in 2005) and international competition across specialty hospitals brings quality differences to light.

For example, with respect to inguinal hernias, "it is less expensive to fly someone round-trip from Boston to the Shouldice Hospital for three days and pay the entire bill than to have the procedure done locally. Furthermore patients recuperate and return to work much faster because of the nature of Shouldice procedures"[x]. Shouldice (www.shouldice.com) is a specialty hospital in Ontario that has the lowest inguinal hernia recurrence rates in the world. Maple Leaf HIFU (www.hifu.ca), a Canadian prostate cancer specialty hospital, has also attracted a number of Americans since it first started treating patients using the non-invasive Ablatherm HIFU device in April, 2005. The for-profit facility treats a total of 25 patients a month for the $21,500 treatment that is not yet available in the United States. On the other side of the globe, several Indian hospitals, including Escorts Heart Institute and Research Centre (www.ehirc.com), are working hard to be recognized as global centers of excellence in heart surgery.

The fact that large payers are looking to outsource elective surgeries would not be possible without the recent perceived increases in quality at international hospitals. As has happened in the automobile industry, it is conceivable that in the future, Americans will chose international providers of medical care not only for cost reasons, but also on the basis of side-by-side quality comparisons. According to Ann Mond Johnson, President of Subimo, LLC:

"We're going to see more risk- and severity- adjusted data provided by overseas providers as they position themselves to compete against American providers. An Orbitz or Expedia for healthcare…is a real possibility…and we'll see the importance of the brand continue to grow…this is a natural development of Americans becoming savvier healthcare shoppers…when Americans realized more LASIK was being done in Toronto at a lower price, they began heading north for that procedure. What is different now is that as our financial exposure grows, we're more inclined to shop for and create our own value equations for a broader spectrum of health services[xi]."

- *Customer service.* Physicians are often so pressed for time in the U.S. that a patient may spend only a few moments with them prior to having a procedure. Frustration with a perceived lack of courtesy may also contribute to the medical tourism trend, particularly since many patients do not have a close relationship with their health-plan assigned physician nowadays, and because the demands on American nurses are often stretched beyond appropriate working conditions. The CEO of IndUSHealth has stated that his affiliated doctors and nurses are very aware of the impact that customer service will have on their hospital's "brand" and are very much geared toward ensuring that their patients are treated well and are satisfied. Finally, some assert that falling cultural barriers resulting from the fact that 25% of physicians practicing in the U.S. are international medical school graduates may mean that Americans will feel less apprehension about working with foreign doctors in the future than they may have felt in the past[xii].

- *Convenience.* For patients from the United Kingdom, New Zealand, or other countries with long waiting lines for some healthcare services, traveling overseas can allow them to get treatment sooner. For Americans, the one-stop-shopping offered by a number of medical tourism companies, including making all arrangements for the patient's flight and accommodations and assigning U.S.- and destination-based "program managers", may be a draw, along with the leisure and anonymity medical tourism companies promise during the patient's recuperation.

- *Legal landscape.* Uninsured patients will probably have little legal recourse, and the insured are only slightly less likely to encounter serious difficulties in seeking legal remedies for bad healthcare outcomes incurred overseas. Medical tourism is a new and evolving area of the law; many issues vary across states, and legal theories such as "vicarious medical malpractice liability", for example, have yet to take root in court. That said, it is probable that in most areas of this developing industry the medical tourism company (MTC) will act as a third party administrator for the patient's insurance company.

  The MTC will likely use a disclaimer in its contract with the insurance company, disclaiming liability for any wrongdoing in connection with the referral process or for care rendered by the overseas patient care providers. Whether that disclaimer is upheld will likely be a state specific determination. The US patient can always sue the MTC in the state in which the patient resides or in which the insurance contract is written. However, whether a cause of action is recognized for negligence in the process of referring the patient to the overseas provider, will again be a state specific determination.

  Like the MTC, the insurance company is likely to have a disclaimer for tort liability related to the care rendered overseas. Of course, the patient could sue the insurance company in the state in which the insurance contract was entered into, and the insurance company may be liable either in contract or for negligence in the referral process, depending on the state.

  On the issue of enforcement, collecting a judgment against the insurance company would likely be less problematic than collecting against the MTC, since the insurance company is likely to have assets in the US. If the MTC does not have assets in the USA, collection on a judgment would require legal action in the foreign country.

2.2. Market Overview: Countries, Travel Agencies, and Insurance Firms

The U.S. is a net importer of patients, but in the last five years a significant and growing number of Americans have traveled to other countries for high quality, lower cost health care. Their trips are facilitated by foreign governments, entrepreneurial travel agencies, and insurance firms.

Selected Countries:

- Mexico is a popular destination for Americans, and physicians, dentists, and private hospital companies are building new facilities along the border to attract patients within driving distance. Cross-border health insurance plans have enrolled more than 150,000 Californians.

- India attracts about 150,000 patients each year; its facilities are known for heart surgery and hip resurfacing. English-speaking physicians and nurses put American patients, many of whom are accustomed to Indian doctors (there are 37,000 practicing in the US) at ease. The Indian government recently introduced a new category of visa: the M-Visa, or Medical Visa, to be issued to medical tourists. The government has also initiated an initiative on uniform pricing for several specialty services[xiii], and defines the treatment of foreign patients as an export, making such treatment "eligible for all fiscal incentives extended to export earnings[xiv]".

- Malaysia's private hospital groups started targeting medical tourists in the late 1990s with the help of the Malaysian government. Prices are up to 80% less than prices in the U.S.

- Thailand is home to perhaps the world's most famous medical tourism destination: Bumrungrad International Hospital, which treated 55,000 Americans last year.

- The Philippines competes with Thailand for western patients; its government began actively promoting medical tourism in 2006. Many of the country's doctors, surgeons and dentists were educated in Europe and the United States. The Department of Health estimates that 250,000 people visited the Philippines in 2006 for eye treatment, cosmetic surgery, and dental treatment; it expects that the industry will draw between $300-$400 million in 2007[xv].

- South Africa attracts more than 100,000 medical tourists from around the world each year; its high-quality academic medical centers and English-speaking physicians and nurses make it a preferred destination for many British patients.

- Brazil and Argentina have attracted cosmetic surgery patients from around the world for decades, and new medical facilities, along with favorable exchange rates, are positioning them to compete for medical tourists in other areas as well. Brazil has the most Joint Commission accredited hospitals of any country outside the U.S.

- Costa Rica is a popular destination for plastic surgery and dentistry, and was the first country to offer "recovery retreats" for the post-surgical period.

Selected Travel Agencies:

- GlobalChoice Healthcare (Albuquerque, NM) states: "Our company was established with the goal of opening access to worldwide healthcare facilities to corporate America. We contract with domestic and international healthcare facilities capable of delivering the highest quality healthcare on a fixed-price, all-inclusive basis. These savings are in turn passed through to insurers who can represent them to their clients. We provide all of the logistics and travel arrangements to enable individuals to take advantage of this expanded network. This service includes the qualification of the client for medical travel, HIPAA compliant electronic transfer of medical records, scheduling of procedures, procurement of travel documents when needed, arrangement of travel and accommodations, client assistance at the international destinations, and client transport at the site of care. The GlobalChoice Healthcare Benefit is a complete, packaged solution for companies wanting to take advantage of global medical care[xvi]".

- IndUSHealth (Raleigh, NC) states: "At IndUShealth, we offer an affordable, high-quality global health care option. By partnering with India's leading hospitals – Apollo, Escorts and Wockhardt – we provide easy access to some of the best care in the world, at a fraction of U.S. costs[xvii]".

- MedRetreat (Vernon Hills, IL) is launching a division to market services to employers beginning in 2007[xviii], its mission statement is as follows: "Our mission at MedRetreat is simple. We want to help you receive your medical procedure at the best and most reputable healthcare facilities the world has to offer, and, design an exotic and amazing recuperation experience; all at a fraction of the cost in the US[xix]".

- PlanetHospital (Calabasas, CA) states: "At PlanetHospital, we are more than just a medical tourism company. We are in the business of making healthcare affordable. We achieve this by finding the best and safest hospitals and surgeons around the world. We also achieve this with innovative solutions to healthcare such as our BEST OF BOTHWORLDS HEALTHCARE ™ plan which allows you to have an American doctor fly with you to another destination for your surgery[xx]."

Selected Insurers:

Health plans certainly have a financial incentive to export patients. The tipping point in the medical tourism trend will likely occur when major insurance plans begin incentivizing patients that are willing to go overseas for care.

- In March, 2007, BlueCross BlueShield of South Carolina began to cover surgeries at Thailand's Bumrungrad to members whose policies do not cover the surgery they need[xxi].

- BlueShield of California offers plans to individuals who permit members to receive their health care in Mexico or Southern California[xxii], and Health Net offers health plans to individuals and employers in California which allow members to receive health care in Mexico[xxiii].

- United Group Programs (UGP) of Boca Raton, FL caters to self-insured employers and has begun promoting overseas surgeries to 40 corporations[xxiv]. UGP claims that its plan saves employers up to fifty percent and cuts employee contributions to zero[xxv].

2.3. The Global Convergence of Medicine

Frustration with US health care costs, specialization and improving quality overseas, and the ease of international travel (tourism is expected to triple by 2020[xxvi]), are encouraging more people to have surgery far away from home.

When combined with the outsourcing of teleradiology, the implementation of pharmaceutical trials in foreign countries, the import of international medical graduates and nurses, the export of U.S. trained doctors, and the sharing of best practices across borders (Harvard, Cornell, Johns Hopkins, and Mayo are all involved overseas), medical tourism serves to illustrate the global convergence of medicine.

A look at what is happening in the pharmaceuticals industry may be instructive for American physicians. Many Americans travel to Canada to purchase cheaper prescription drugs (sometimes as part of an AARP-organized bus trip) and are now allowed to bring back a 90 day supply without it being seized[xxvii]. According to the Maine Medical Society, a number of physicians in the State have obtained dual licenses allowing them to prescribe medicines from Canada, and Illinois Governor Rod Blagojevich garnered much media attention when establishing a program to import drugs through the I-SaveRx program, which has facilitated over 18,000 purchases from 28 foreign pharmacies in Canada, the UK, Australia, and New Zealand since its October, 2004 launch.[xxviii] The irony is that most drugs sold in Canada are actually made in the U.S.; the price differential exists because the Canadian government negotiates discounts. "There is a gross inequity between the prices charged by name-brand drug companies in the U.S. and the prices charged in Canada", said U.S. Representative Jo Ann Emerson.[xxix] As these international price gaps have come to light, downward pressure is being applied to the price of drugs sold in the U.S. The same dynamic could soon occur with respect to reimbursement for medical care.

Continuity of Care. Although there have long been policies to provide emergency medical care to those who travel, medicine needs to anticipate those that will travel solely for medical care, both domestically and internationally. There is concern over infectious disease migration, emergence, and control, as the patient may be exposed to bacteria and other microbes that they would not be accustomed to at home. In addition, different antibiotic resistance profiles exist internationally, meaning that a pathogen contracted overseas may need to be treated by some other antibiotic than what would be used in the U.S. for that same organism. The global emergence of infectious diseases like HIV and SARS have taught several valuable lessons with respect to the difficulties and costs of international efforts to manage disease migration after travelers contract novel agents abroad.

On the level of an individual patient, some are also concerned about the fact that travel combined with surgery can increase the risk of blood clots. Insurance companies are not likely to cover complications from surgeries performed outside the U.S., meaning that American physicians and hospitals may be left to "pick up the pieces". AMA's Council on Medical Service provided a report at the 2006 Interim Meeting, Postoperative Care of Surgical Patients, which explored the issues confronted by doctors providing follow-up care to patients cared for in other localities. This report detailed the proper use of CPT codes in

such cases, notably Modifier 55, which is defined as follows: "When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number". This modifier would be appropriate for use by physicians caring for patients treated in a foreign country, however, it is important to note that in order to bill Medicare using modifier 55, a written agreement between physicians must exist.

Achieving Accountability in Global Health. As more and more segments of the healthcare industry begin to operate on a worldwide basis, international standards for quality, safety, records interoperability, and patient confidentiality will be required. In addition, the morality of absorbing the best medical resources in developing countries and drawing them away from the local population is questionable at best (India counts 500,000 tuberculosis deaths and 600,000 deaths from easily treatable diarrheal diseases every year[xxx]). Several other ethical issues have emerged in recent years:

- Women on Waves is a "floating" abortion clinic based on a ship registered in the Netherlands. "By sailing out to international waters before undertaking the procedure, the ship is acting under the legal jurisdiction of the country in which it is registered[xxxi]". The ship has met with mixed reaction in Ireland, Poland, and Portugal, where abortion is illegal. Plans for a floating euthanasia clinic registered in The Netherlands have yet to materialize.

- According to the CDC, ""Transplant Tourism" has been increasing as the number of available organs, especially kidneys, is decreasing relative to the increasing demand. A number of international transplantation rings have been discovered, in which people from developing countries are paid for donating organs. This practice is considered legal in only a few countries[xxxii]."

Conclusions

Medical Tourism as a Crisis Indicator

The fact that Americans are venturing overseas for healthcare is indicative of a domestic health system in peril. "You can run, but you can't hide from this mass of statistics that, taken as a whole, say we fall far short of having the best health care system," says James J. Mongan, MD, CEO of Boston's Partners Health Care Systems, Inc. and Chair of the Commonwealth Fund's Commission on a High Performance Health System[xxxiii].

It is unlikely that the U.S. will ever be able to export enough patients to solve its healthcare problems. What is needed is a sustainable domestic system that is geared toward maximizing value to patients across the disease cycle. Currently, competition in American health care is focused not on patient outcomes but rather on shifting costs, restricting access, and supporting bloated administrative expenses. This lack of transparency on results threatens the ability of our economy to compete globally as rising health costs, not necessarily correlated with quality[xxxiv], weigh down American employers, suppressing both wages and purchasing power. Health care is now 16% of the American economy.

It is important to note that other western countries are also facing unsustainable healthcare costs. Waiting times and hospital infection rates make headlines in Europe on a regular basis, and like the U.S., Japan and Europe are fast aging; there is therefore much concern about the decreasing proportion of workers that will be paying into these countries' healthcare systems

as utilization continues to climb. Combined with aggressive marketing tactics on the part of foreign countries, foreign hospitals, and U.S. based travel agencies, the stage is set for a significant new outsourcing stream.

Will competition from abroad exert a downward pressure on US prices? It has often been said that arguing against globalization is like arguing against the law of gravity. The medical field may not have been the first to globalize, but it is unlikely to be completely immune to trends in the international health economy.

Recommendations

Recommendation 1:

The Governing Council recommends that the following resolution be submitted to our AMA House of Delegates for consideration at its 2007 Annual Meeting:

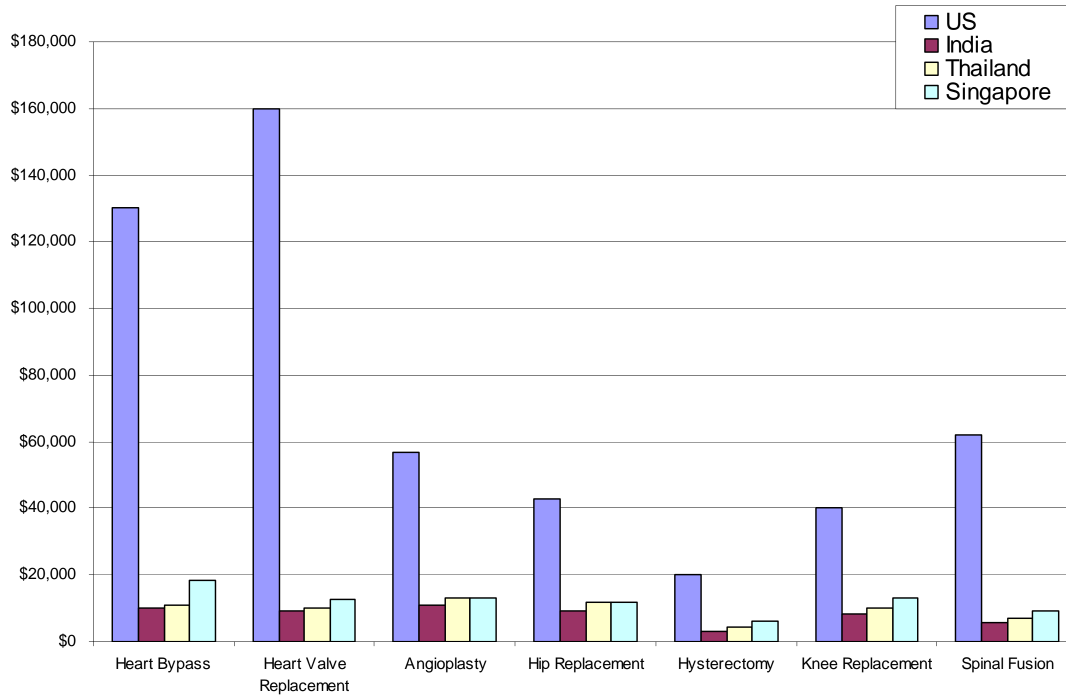
> RESOLVED, That our American Medical Association (AMA) work with National Association of Insurance Commissioners and other interested parties to examine international medical liability issues (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA work with The Joint Commission, The Physician Consortium for Performance Improvement, and the World Medical Association to develop policy in the area of international quality (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA consider development of a separate CPT code for the post-operative care of surgical patients treated overseas (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA develop model State legislation obliging companies that facilitate medical tourism to 1) require that the patient sign a form acknowledging that they have been informed of the differences in standards of care across countries, 2) provide for HIPAA-compliant transfer of the patient's medical record, 3) arrange follow-up care prior to sending the patient to a foreign country, 4) ensure that seeing a physician in a foreign country is always voluntary, and 5) make facility outcomes data, physician licensing and outcomes data, and the patient's rights to legal recourse, if any, transparent to the patient prior to care delivery (Directive to Take Action).

Recommendation 2:

The Governing Council recommends that this report be adopted in lieu of Resolution 6 (I-06)..

APPENDIX A

International Price Comparisons: Selected Surgeries



Procedure	US Cost	India	Thailand	Singapore
Heart Bypass	$130,000	$10,000	$11,000	$18,500
Heart Valve Replacement	$160,000	$9,000	$10,000	$12,500
Angioplasty	$57,000	$11,000	$13,000	$13,000
Hip Replacement	$43,000	$9,000	$12,000	$12,000
Hysterectomy	$20,000	$3,000	$4,500	$6,000
Knee Replacement	$40,000	$8,500	$10,000	$13,000
Spinal Fusion	$62,000	$5,500	$7,000	$9,000

Source: www.medicaltourism.com

APPENDIX B

JOINT COMMISSION STANDARDS

The Joint Commission has a 39 page chapter on Medical Staff Standards in its 2007 Hospital Accreditation Standards Manual. In contrast, below are the Medical Staff Standards from the Joint Commission International's Accreditation Standards for Hospitals Manual, p. 153:

Medical Staff Standards
SQE.7. The organization has an effective process for gathering, verifying , and evaluating the credentials (license, education, training, and experience) of those medical staff permitted to provide patient care without supervision.
SQE.7.1. The organization maintains a record of the current professional license, certificate or registration, when required by law, regulation, or by the organization, of every medical staff member.
SQE.7.2. The credentials of medical staff members are reevaluated at least every three years to determine their qualifications to continue to provide patient care services in the organization.
SQE.8. The organization has an effective process to authorize all medical staff members to admit and treat patients and provide other clinical services consistent with their qualifications.
SQE.9. The organization has an effective process for medical staff participation in the organizations quality improvement activities including evaluating individual performance, when indicated, and for periodically reevaluating the performance of all medical staff members.

AMA POLICY

H-475.991 Postoperative Care - Responsibility and Reimbursement
Our AMA: (1) continues to support repeal of the federal law which allows reimbursement to optometrists for the unsupervised/independent provision of postoperative care; and (2) reaffirms its position that physicians performing surgery have an ethical responsibility to continue the care of their individual patients through the post-surgical recovery and healing period. (Sub. Res. 8, A-89; Reaffirmed: Sunset Report, A-00)

D-505.998 International Trade Agreements
Our AMA will: (1) monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco; (2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable AMA policy; (3) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that involve the distribution and advertising of alcohol and tobacco, and other pertinent public health issues, and advocate applicable AMA policy; and (4) continue to strongly advocate for US ratification of the Framework Convention on Tobacco Control. (BOT Rep. 18, A-04)

G-630.070 International Strategy
Our AMA: (1) recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship; and (2) encourages the involvement of International Medical Graduates in state medical associations in settings appropriate to each state. (BOT Rep. 21 and Res. 618, A-97; Consolidated: CLRPD Rep. 3, I-01)

H-165.881 Expanding Choice in the Private Sector
Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97; Reaffirmed BOT Rep. 6, A-98; Reaffirmation A-02)

H-255.995 International Medical Graduates
The AMA believes that reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools. (Res. 23, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CME Rep. 5, A-04)

H-478.999 An International Code of Ethics for Internet Health Sites
Our AMA supports of a universal code of ethics for Internet health sites. (Res. 615, A-00)

H-10.974 Assurance of the Public's Health Aboard Cruise Ships
The AMA, through federal legislation or international treaty as appropriate, urge the development of standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports. (Res. 429, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-130.995 International Liability Regulations Pertaining to Emergency Care
Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations. (Sub. Res. 73, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-250.995 International Medical Records
It is the policy of the AMA to work with the U.S.-Mexico Border Health Commission, the U.S. Public Health Service, the Mexican Medical Society, regional medical societies, and appropriate specialty societies to foster the development and use of international perinatal and pediatric care records for children who may receive medical care in both the United States and Mexico. (Sub. Res. 510, I-92; Reaffirmed: CMS Rep. 10, A-03)

H-373.998 Patient Information and Choice
Our AMA supports the following principles:

(1) Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

(2) Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
(3) In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such

services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

(4) Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

(5) Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

(6) Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05)

H-165.856 Health Insurance Market Regulation
Our AMA supports the following principles for health insurance market regulation:

(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;

(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;

(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual’s genetic information should not be used to determine his or her premium;

(5) Insured individuals should be protected by guaranteed renewability;

(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;

(7) Guaranteed issue regulations should be rescinded;

(8) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and

(9) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05)

AMA PHYSICIANS GUIDE TO MEDICAL STAFF BYLAWS, p. 32-34,

Pages 32-34: Categories of Membership
As telemedicine capability increases, medical staff bylaws rules and regulations will need to integrate telemedicine practice with on-site practice. For some medical staffs, the consulting staff category of membership can be tailored to include physicians at remote sites who offer telemedicine services, address their responsibilities to the medical staff and otherwise provide guidelines for telemedicine privileges. Issues of meeting attendance, geographic location, committee service and other requirements must be considered as remote-based members and privileges holders are added to the medical staff. Other medical staffs may wish to create a telemedicine category of membership. No matter how telemedicine providers are categorized, medical staffs determine the services that will be provided. Under JCAHO Standard MS.4.130, "The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites." At a minimum, the medical staff bylaws should include providers of telemedicine services under the credentialing and privileging processes of the medical staff, to comply with JCAHO Standard MS.4.120. The Standard permits the originating site to grant privileges to the distant provider using credentialing information from the distant site, if it is JCAHO accredited.

Page 47: Telemedicine Privileges
Providing care through telemedicine consultation is becoming more prevalent in facilities. Under JCAHO Standard MS.4.130, the medical staff is to make recommendations as to which services are appropriately provided via telemedicine. JCAHO Standard MS.4.120 requires the credentialing of the distant provider by the medical staff of the health care entity caring for the patient, subject to that hospital's medical staff credentialing and privileging process. State law may require state licensure of the distant provider. See the discussion of the telemedicine category of membership of the medical staff in this Guide.

Page 104-105: Compiled Model Medical Staff Bylaws
Only physicians providing telemedicine who are currently licensed to practice in the state and meet the following basic qualifications shall be eligible for membership in the

consulting/telemedicine medical staff of the hospital/medical care organization: (a) documented (1) adequate experience, education, and training, (2) current professional competence, and (3) current adequate physical and mental health status to perform the clinical privileges requested, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care; (b) are determined (1) to adhere to the ethics of the profession, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff; (c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the governing body and medical executive committee; and (d) are members of the active or associate medical staff of another hospital/medical care organization.

The responsibilities of a consulting/telemedicine staff member shall include the following: (a) provide patients with professional care of generally recognized quality of care meeting the professional standards of the medical staff of this hospital/medical care organization; (b) provide telemedicine service or consultative services on a timely basis within their area of competence; (c) supervise nonphysician providers or technicians delivering services via telemedicine and have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine; (d) provide patient care protocols for all levels of telemedicine; (e) ensure the legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of a telemedicine modality; (f) abide by the medical staff bylaws, medical staff rules and regulations, and policies; (g) discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as requested; (h) prepare and complete in a timely fashion medical records entries for all the patients for whom the member provides care in the hospital/medical care organization; and (i) abide by the ethics of the profession.

The consulting/telemedicine staff member shall be entitled to: (a) exercise such clinical privileges as are granted by the governing body of the hospital/medical care organization only upon recommendation of the medical staff; and (b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs. AMA Board Report 3 (A-97), “Medical Staff Membership Category for Physician Providing Telemedicine.”

APPENDIX C

World Medical Association Declaration with Guidelines for Continuous Quality Improvement in Health Care

Adopted by the 49th World Medical Assembly, Hamburg, Germany, November 1997

Preamble

The purpose of health care is to prevent, to diagnose or to treat illness and to maintain and to promote the health of the population. The goal of quality review in health care is continuous improvement of the quality of services provided for patients and the population, and of the ways and means of producing these services.

The obligation continuously to improve one's professional ability and to evaluate the methods used is included in the ethical codes of physicians. According to them a physician has to maintain and increase his/her knowledge and skills. He/she shall recommend only examinations and treatments that are known to be effective and appropriate according to the state of medical art.

Purpose of the guidelines

Physicians and health care institutions have a moral obligation to strive for continuous improvement of services. The purpose of these guidelines is to strengthen this pursuit by means of quality review practices and to create ethical grounds for such review practices, like clinical peer review.

Application of the guidelines

Ethical guidelines for continuous quality improvement concern all physicians, institutions providing health care services for patients, and producers of review services.

Obligation for quality review

All physicians, other health care professionals (including health administrators) and institutions have to aspire to improvement of their work. Active participation by everyone in clinical audit and in quality review initiatives should be encouraged. Quality review evaluations can be used for independent external audit, and with the aim of accreditation.

Standards for good quality work

Those involved in work with patients need to specify the standards necessary for good quality work and for the evaluation of the quality of the work. The resources and skill mix of staff within health care establishments should be adequate to attain the required standards of good quality work

Patient data, whether recorded on paper or on computer, has to be written and preserved with care, taking into consideration the obligations for confidentiality. Procedures, decisions and other matters connected with patients need to be recorded in a form which will allow information for measuring specific standards to be available when needed.

Health care professionals should have adequate opportunities to maintain and develop their knowledge and skills. Recommendations and clinical guidelines should be easily available for those requiring them. Health care institutions need to create quality systems for their own use and to ensure that instructions concerning such systems are followed.

Recognition of quality review
All physicians should continuously evaluate the quality of their work and their level of ability by self-review methods.

The quality of health care can be assessed by both internal and external methods. The agencies for both processes have to be widely approved, and the methods used must be generally accepted and based on research or sufficient knowledge.

Internal clinical peer review, observation of examination and of treatment methods, comparison with others, observation of the organisation's ability to act and monitoring of the feedback from patients have to be continuous activities undertaken by every service provider.

External quality review initiatives, such as external peer review and audit, should be carried out with a frequency corresponding to the evolution of the field and always when there is special reason for it.

Confidentiality of patients' records
Patient records can be used in quality review. Patients should be made aware of the use of their records in quality review. Their medical records should be kept confidential and anonymised and should not be accessible to inappropriate persons. All reports, photographs, videos and comparative data have to be presented in such a form that the patients involved in a review cannot be identified.

Confidentiality of peer review
A precondition for successful peer review is the freedom of institutions and physicians to agree to be reviewed and their commitment to review. It is recommended that informed voluntary consent be obtained from those to be reviewed.

The results of a review belong to those subscribing to it. The results can be used for comparisons and general purposes only with the approval of the subscriber and those involved in the review, unless national legislation provides otherwise.

A provider of services can inform his/her customers about the results of quality review and use them in marketing his/her services, provided this is allowed by the law.

The review of the work of an individual physician is the responsibility of the physician himself/herself and his/her superior physician. Information regarding an individual physician should not be published without the consent of the physician concerned.

An external review shall not reveal to others the results of the review, or other information obtained during the review, without the written permission of the subscriber of the review.

Ethics committees
Generally approved ethical principles of health care and national codes of medical ethics have to be followed in quality review.

If doubts are raised about ethical issues in a review project they should be referred to an ethics committee. However, in general the routine submission of review projects for approval by ethics committees is not necessary.

Competence of the reviewer

The reviewer has to be experienced in the field that the review concerns and competent in quality development techniques and in clinical audit methods. When medical care is reviewed, the reviewer must be a physician. The reviewer has to be accepted by those to be reviewed, whenever possible.

Impartiality of the review

The chosen reviewer must be as impartial and as independent as possible. He/she has to be well acquainted with the activities of those to be reviewed. The reviewer has to be objective in his/her report. His/her conclusions should be based on a critical evaluation of observations and facts. The reviewer must not allow commercial or competitive matters to influence the content of his/her statement.

Review and supervision by authorities

Quality review of health care and continuous quality improvement of services is a part of the activity of every physician and institution. The supervision of professional activities made by health care authorities is a distinct activity and should be kept separate from health care review. The results of a review of physicians can be used for the purposes of supervising authorities only by a separate mutual agreement between the health care authorities and the physicians concerned, unless national legislation provides otherwise.

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[vi] Andrew L. Stern, President of the Service Employees International Union has said that "the employer-based system of health coverage is over ... (it) is collapsing, crushed by out of control costs," *The New York Times,* January 19, 2007.
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[xi] *Consumers Go Abroad in Pursuit of Cost-Effective Healthcare,* Managed Healthcare Executive 16, no. 7, July 2006, p. 10.
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[xxii] *Some Companies To Market Medical Tourism Services to U.S. Employers,* Medical News Today, August 1, 2006.
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[xxiv] *Medical Meccas,* Newsweek, October 30, 2006.
[xxv] *Businesses May Move Health Care Overseas,* Seattle Post-Intelligencer, November 2, 2006.
[xxvi] World Tourism Organization.
[xxvii] *U.S. To Ease Canadian Drug Import Rule,* AMNews, October 16, 2006.
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[xxx] *Lines Drawn in India Over Medical Tourism; As Business Booms, Some Doctors See Domestic Patients Getting Shortchanged,* International Herald Tribune, December 5, 2005.
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