Friday August 15th 2008

Briefing

Globalisation and health care

Operating profit

Aug 14th 2008 | NEW YORK
From *The Economist* print edition

Why put up with expensive, run-of-the-mill health care at home when you can be treated just as well abroad?

Jonas Bergstrand

ROBIN COOK knows how to spot the latest scare in medicine. Mr Cook, a Harvard-trained doctor, is author of over a dozen medical thrillers, including "Coma" and "Outbreak", which have anticipated pandemics, anthrax attacks and the black market in organs. "Foreign Body", published this month, is about the next big thing: medical tourism.

Central to the plot is the story of Maria Hernandez, a working-class American woman who travels to Delhi to get a hip replacement she could not afford back home. Alas, she and other medical tourists die in mysterious circumstances. Contrast Ms Hernandez's fate with that of another American health tourist, Robin Steele. Mr Steele, a real patient, recently went to India's Wockhardt hospital chain for a heart operation. Not only is he in fine shape, but he also enjoyed a holiday afterwards and saved several thousand dollars to boot.

Mrs Hernandez's tragedy may sell books, but Mr Steele's good health is more typical. The future of health care, long one of the most local of all businesses, promises to be increasingly global. Over the next few years the world is likely to see a lot more investment, medical staff and patients crossing borders—bringing economic benefits and greater access to care as they do so. Even a modest surge in global medical tourism could prove a powerful catalyst for government bureaucracies and sclerotic American health-maintenance organisations to think afresh about what they do. It may even introduce competition to private health care in America and elsewhere.

Globalisation is not new to medicine. The outsourcing of record-keeping and the remote transcription of doctors' notes and X-ray analysis are becoming common.

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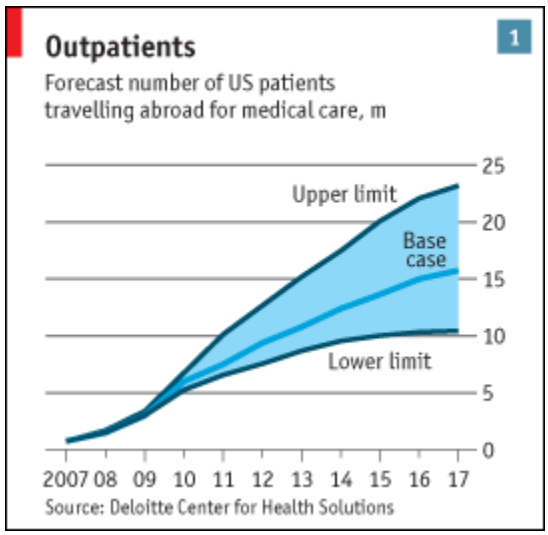
Jagdish Bhagwati, an economist at Columbia University, thinks that the offshoring of, for instance, customer service and claims-processing could save America alone $70 billion-75 billion a year. In recent years leading American hospitals such as the Mayo Clinic and Johns Hopkins have set up offshoots in the Middle East and Asia.



Some wealthy patients have always travelled for fancy medical care. Denis Cortese, head of the Mayo Clinic, in rural Minnesota, observes that "we have been global for a hundred years." A few years ago Britons fed up with waiting for elective surgery started heading overseas to get joints replaced or cosmetic surgery—sometimes at government expense. Recently, shorter queues in the National Health Service and restrictions on reimbursements have undermined this trend.

However, globe-trotting patients only ever occupied a niche. What is getting people excited today is the promise of a boom in mass medical tourism, as a much bigger group of middle-class Americans prepares to take the plunge. A report published last month by Deloitte, a consultancy, predicts that the number of Americans travelling abroad for treatment will soar from 750,000 last year to 6m by 2010 and reach 10m by 2012 (see chart). Its authors reckon that this exodus will be worth $21 billion a year to developing countries in four years' time. Europe's state-funded systems still give patients every reason to stay at home, but even there, private patients may start to travel more as it becomes cheaper and easier to get treated abroad.

Pills and pils

Asian hospital chains stand to be the biggest winners, as their rising stars, such as Singapore's Parkway Health, look for foreign patients. Thailand's modern Bumrungrad hospital in Bangkok already sees tens of thousands of Americans a year. It has just opened a new extension, designed to handle 6,000 foreign patients, which it claims makes it the world's biggest private clinic. The surge of American patients flocking to India's Wockhardt hospitals has convinced Vishal Bali, the chain's boss, that medical travel is now "truly reaching an inflection point."

Not everyone is as gushing. Paul Mango, the chief author of a report by McKinsey, a management consultancy, disputes wild-eyed claims that millions of patients are already travelling abroad. Yet even he predicts that the future for medical travel is bright, and that in the long run it may even "largely dispel the idea that health care is a purely local service."

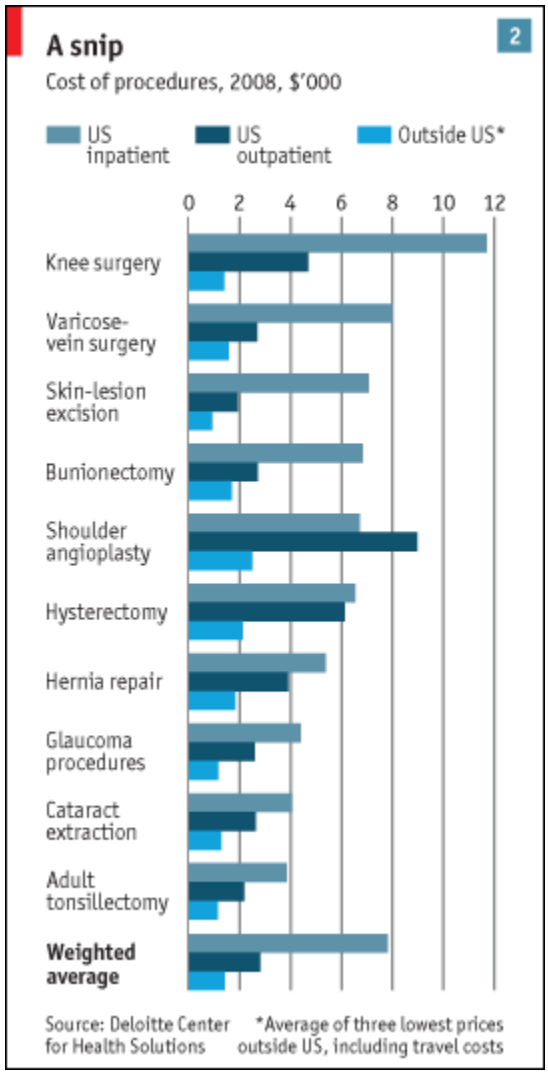
Regina Herzlinger, of Harvard Business School, broadly agrees: "The medical travel market is a bit over-hyped today, but economics dictates why it will become huge over time: if a supplier has very high prices and erratic quality, it creates an opening for nimbler rivals." That supplier is America's health-care system, a $2.4 trillion colossus in desperate need of reform.

This prospect of an American-led boom in global medical travel raises two questions. Why is it happening now? And what will be the effect on the health-care systems of poor and rich countries?

Impatients

Until recently, few Americans went abroad for medical treatment. Over the past decade, however, that has begun to change. Americans seeking medical care are increasingly making trips far from home, often at their own expense—not just short hops to Caracas for a nip and tuck or dashes across the *frontera* for cheap Mexican

pills. As Mr Steele's testimonial suggests, they are now travelling across the world for knee and heart surgery, hysterectomies and shoulder angioplasties.



One motive is to save money. America's health inflation has consistently outpaced economic growth, making it the most expensive health market in the world. The average price at good facilities abroad for a range of common medical procedures is, by Deloitte's reckoning, barely 15% of the price a patient would have to pay in the United States (see table).

But costs have long been much higher in America than in poor countries, so this alone does not explain the new exodus. Two other factors are now at work. One is that the quality at the best hospitals in Asia and Latin America is now at least as good as it is at many hospitals in rich countries. The second, more worrying, factor is that America's already imperfect insurance safety net is fraying.

Over 45m Americans are uninsured, and many millions more are severely underinsured. Such people may find it cheaper to fly abroad and pay for an operation out of their own pockets than to find the money for deductibles or "co-payments" charged for the same procedure at home. Arnold Milstein of Mercer, a consultancy, calls them America's "medical refugees".

Big business may soon join this wave. Epstein, Becker & Green, an American law firm, says that in the past year big employers have become interested in promoting medical travel among the employees they insure. Many are struggling to cope with soaring health costs and some, they report, are willing to take radical steps to save money.

Hannaford, a grocery chain based in New England, now offers its 27,000 employees the option of getting a number of medical procedures done in Singapore rather than America—at a saving to the employee of $2,500-3,000 in co-payments and deductibles. Blue Ridge Paper Products, a firm in North Carolina that makes milk cartons, also offered employees the option of medical travel, but a backlash from a union has put a stop to the plan. Despite that setback, the general rise in corporate interest is such that in June the American Medical Association, the chief lobbying group for the country's doctors, issued (surprisingly supportive) guidelines for foreign medical travel.

That has emboldened insurance firms, which had thus far been cautious. A few are beginning to offer voluntary "global medical travel" options on their corporate plans. According to the industry watchers at Epstein Becker, other insurers fear that they may be at a disadvantage if they do not offer such schemes.

Overcoming initial scepticism, Aetna, a giant American insurer, has this year launched a pilot scheme in partnership with Singaporean hospitals. Charles Cutler of Aetna notes that the savings for his firm are not as great as they may be for some others, since it gets volume discounts from American hospitals thanks to its size.

Therefore travel abroad for Aetna's clients makes sense only for procedures costing $20,000 or more, which might include heart surgery. But he remains bullish, observing that quality at the best foreign facilities can be much better than at the average American hospital, thanks to greater transparency and better information technology. He thinks this is inspired by the Asian hospitals' need to market to a sceptical foreign audience.

David Boucher of Blue Cross and Blue Shield of South Carolina, another big health insurer, at first doubted the quality of care abroad. So he visited Thailand's Bumrungrad hospital a couple of years ago to see for himself. He recalls sipping coffee at the Starbucks in the hospital's lobby and thinking that "this is not a straw-village clinic with rusty scalpels!" He has persuaded his firm to let him run a division, called Companion Global Healthcare, to pursue this "blue ocean" opportunity.

Mr Boucher says his division's customers, mostly manufacturers and other firms with margins that are squeezed by global competition, are keen to experiment with an idea that he reckons could easily replace 5-8% of a company's health spending with cheaper options; in time, he reckons that share may rise to a fifth. Medical travel may be unfamiliar to individual patients, but he points out that thinking globally is nothing new to his corporate clients: "They may be based in Columbia, South Carolina, but they have competitors and customers in Colombia, South America, as well as in South Africa and in Asia."

Curtis Schroeder, boss of Bumrungrad, thinks the search for value will push people in his direction: "After all, we're selling Cadillacs at Chevy prices," he says. He has good reason to beam: some 33,000 Americans came to his outfit last year alone.

Behind the mask

How will that affect the health systems in rich and developing countries? Listen to critics of medical travel, and you might think that all of this is a tragedy. It has come about, they argue, because of the terrible state of America's health care, and its consequences for developing nations will be dire. The flow of foreigners will encourage capital and trained staff to flee state-run health-care systems in poor countries in favour of better-paying jobs catering to foreigners and local fat cats.

It is surely right that medical tourism is partly the result of the failings in America's health system. Moreover, recent research by the World Bank does indeed suggest that "internal brain drain" is a worry in some countries, especially those with few doctors and nurses.

However, in many huge net exporters of doctors and nurses, such as India and the Philippines, an internal brain drain is hardly much of a worry, because there are plenty of medics to go around. And shortages, in countries where they exist, can be alleviated by reforms changing the way nursing education is funded, for instance, that would help to improve their ailing state-run health systems.

A good prognosis

What is more, there are good reasons for thinking that medical tourism will help poor countries. For one thing, private hospitals did not cause the state sector's neglect of the poorest. Long before medical tourism or private hospitals took off, the state-run hospitals of India and most other developing countries were a shambles. This was chiefly the result of bureaucratic incompetence and corruption, not poverty—as the decent health-care systems in other developing countries like Costa Rica, Malaysia and even Cuba make clear.

Besides, the rising standards at private facilities promise to have important knock-on effects that may benefit even the poor. The World Bank has observed that the rise of high-quality private clinics in Trinidad and other parts of the Caribbean, for example, has encouraged highly educated doctors to return home.

Mr Bali has seen this reverse brain drain at work in his own company. In the past few years, more than two dozen top doctors returned to India from Britain and the United States, he says, because his firm offers them world-class facilities and rewarding

work. He rejects the notion that only a handful among the elite benefit from his chain's excellence, pointing out that Wockhardt's expansion into second and third-tier cities in India means many ordinary people now have ready access for the first time to such specialisms as cardiac care and orthopaedics.

Standards, as a result, are rising. Several decades ago very few hospitals in poor countries could claim to offer the highest quality of heath care. Today, there are dozens of hospitals around the world that meet the stringent requirements for accreditation by the respected Joint Commission International, a non-profit outfit that assesses the quality and safety of health-care programmes. Indeed, gaining the commission's seal of approval has become a price of entry into the serious market for global medical travel.

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Tom Johnsrud of Parkway Health, a big Singaporean hospital chain with operations in Brunei and China, explains that foreigners make up 35-40% of his firm's patients: "American patients will not make or break any international hospital, but being able to attract them will enhance its reputation." So although hospitals may raise standards to attract foreigners, local patients will benefit too.

Some international hospitals may even leapfrog over their American counterparts. The best of the bunch are being created from the ground up, without the burden of old buildings and equipment, politicised unions and other baggage that weighs down American hospitals. When Bumrungrad looked for information technology to run its operations a decade ago, it found that vendors were so wrapped up in the arcane and fragmented ways in which rich-country firms do business that they could not manage to design a complete computer system from scratch.

Undaunted, the firm set about the job itself, using best practice from other industries. This was possible, says Mr Schroeder, because his firm's edge is not only based on cheap labour, though labour costs make up 18% of his total, compared with perhaps 55% at American counterparts. He says, "the bigger difference is the way health care is delivered."

The firm's IT proved so much better than that from American or European specialist firms that Microsoft last year took over Bumrungrad's Global Care Solutions division. Peter Neupert, who heads the American software giant's efforts in this area, was so impressed that he has decided to put the headquarters of his international health efforts in Bangkok. This leapfrogging is an example, he says, of how "innovation will come from many places as the health-care market goes global and flat very fast."

Costectomy

As far as America is concerned, there will be limits to the impact of health tourism. Many medical procedures cannot be done abroad safely, concerns about legal liability and malpractice will always linger, and the medical lobby may yet try to blunt this trend. Bumrungrad's Mr Schroeder argues that his hospital is "not the solution for America's health-care problem."

He is right that health care abroad is not a substitute for difficult reforms at home. But medical travel could serve as a catalyst for those reforms. Rajesh Rao of IndUSHealth, a middleman that helps insurers and employers co-ordinate medical care in India, reckons medical travel "is not really about exporting patients, it is importing competition."

A bit of rivalry from top foreign facilities may introduce transparency and price competition into an inefficient system riddled with oligopolies and perverse incentives. For example, American and European hospitals may cut prices once they realise how much potential business they stand to lose. By Deloitte's reckoning, medical travel will represent $162 billion in lost spending on health care in America by 2012. There are signs that American health-care administrators are starting to feel the heat. European hospitals may not be immune from such pressure, either. On one estimate, some 50,000 British medical tourists headed overseas in 2006, spending millions of pounds for care in such places as Turkey, India and Hungary.

Aetna's Charles Cutler confirms that hospital authorities are now "very aware of the competitive threat," from abroad. The case of Hannaford, the New England grocer, has already prompted local hospitals to reconsider their pricing policies. Christus Health, a health-care provider in the American southwest, has hedged its bets by buying Muguerza, a hospital chain based in northern Mexico, and is now touting its own medical tourism schemes there. And its boss, Thomas Royer, says that his firm is about to expand further, into Peru.

Medical tourism promises to be what Aetna's Dr Cutler calls "a disruptive market force that improves cost and quality here in America." Whether or not it turns out to be all its boosters wish for, it will be a force to be reckoned with.

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