Medical Tourism

A Strategy for Containing Health Care Cost Increases and Immigration Pull

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INTRODUCTION

An intense case of finger pointing is underway within the US health care system. Doctors are blaming their high charges on liability insurance premiums. Hospitals are treating doctors as customers, viewing the patients as only a necessary evil. Insurance companies are generating obstacles to deter legitimate claims, presumably to avoid the bogus ones. All the while, politicians are profiting from the inefficiencies of the industry, hindering all attempts to control costs. The unique hybrid structure of the US health care system is purported to be one of the best in the world—is this really the case?

The market has identified the problem and politicians have quickly followed suit. The November 2008 presidential elections are gearing up for debate over two of the most controversial issues facing the American public today: health care reform and immigration. Health care expenditures in the US are significantly higher than that of peer countries. 16 percent of US Gross Domestic Product (GDP) was spent on health care in 2005 compared to the 8.5 spent on average by other countries part of the Organization for Economic Cooperation and Development (OECD). Health care expenditures as a percentage of GDP are predicted to rise to approximately 25 percent by the year 2050 if the system stays in its current state. Immigration rates are nearly as discouraging as health care expenditures. As of 2006, 3,310,000 legal Mexican residents were living in the US. This number accounts for 27.3 percent of total legal immigrants to the US. The estimated number of illegal Mexican immigrants in the US as of 2006 is 6,570,000, an increase of 40 percent since 2000 (Camarota, 2007). What if we could devise a single solution to address both issues? By developing a market driven and government endorsed strategy to outsource health care, US citizens can simultaneously reduce their health insurance expenditures and lower overall costs to the health care system. A percentage of the amount saved by traveling abroad for medical treatment can be reinvested into the very facilities US citizens are traveling to. By promoting overseas investment in hospitals and medical education, we can spur sustainable economic development in impoverished nations, leading to a reduction of immigrants to the US.

Before we analyze the potential solutions to these two disconcerting problems, we must explore complex issue of health care. Who gains the most from the inherent inefficiencies of the health care system? What are the major causes? Most importantly, how do we drive down the phenomenally high costs of the health care system to provide US citizens more accessible and affordable options? After we address the issue of health care we can explore how outsourcing health care and providing medical investment overseas will slow migration rates and how we might encourage Americans to seek out treatment overseas.
BENIFICIARIES OF THE CURRENT HEALTH CARE SYSTEM

There are several groups who might prefer the US health care system to maintain its status quo. These groups, while not directly profiting from the systems inefficiencies, are certainly not hurt by them. Doctors, hospitals and insurance providers pass on heavy cost burdens to the patients they treat and the employers they insure. These groups argue that they are forced to charge more to help offset their higher costs.

Liability insurance and administrative costs are often cited as heavy burdens to doctors, hospitals and insurance companies, causing them to raise the price of their services. Higher premiums are charged to employers and those that are uninsured are faced with unfeasible bills given the off chance they seek medical treatment. Heavy administrative costs are a result of the multi-payer system that is unique to the US. Administrative costs include differentials in insurance regulation across states and complexities associated with the administration of Medicare, Medicaid and private insurance products. Marketing and sales, neither of which occurs in public health care systems provided in peer countries, also fall under administrative costs. The US spends 6 times the average cost of those in other OECD countries, or approximately $412 per capita. High liability insurance coverage is another heavy cost US doctors must compensate for. The average doctor in the US pays $27,500 each year in liability insurance. This number, multiplied by the approximate 700,000 employed within the US results in an approximate expenditure of $20 billion (Orszag, 2008). This insulation against medical malpractice is virtually unheard of among other OECD countries. While both the administrative and liability costs seem large in absolute terms, they only account for a small percentage of the providers operational costs, and therefore provide little explanation for increasing premiums and overall costs. They are not the driving factors that continue to push US healthcare costs further and further from what would constitute as normal expenditures. We might then ask the question if the main explanation for doctors and hospitals increasing their costs rings hollow? Where does the extra money being paid by the health care consumer go?

CAUSES OF HIGH HEALTH CARE COSTS

Now that we have established who might benefit from the system in its current state, we can look into why US health care costs are so high compared to their OECD counterparts. Rising health care costs have historically been driven by rising incomes, an aging population and increases in third party payers. These factors all contribute to the demand in medical services; yet, taken together, cannot explain even half of the growth in long term health care spending. Surprisingly, the driving culprit behind increases in health care expenditure is technology.

Every year the US spends billions of dollars in research and development of state of the art diagnostic tests and surgical procedures. While technological innovation has the potential to lower costs and raise efficiency for most goods and services, increasing technology in the healthcare sector has seen opposite effects. Increases in technology have historically raised overall costs and continue to be the most significant factor in increasing healthcare expenditure.
Changes in health care costs that can be attributed to technology accounted for between 38 and 62 percent as of 2000. This number far surpasses the contributions in cost changes from any other source. Advances in technology include everything from new drugs, services and new clinical applications that use existing technology. Medical breakthroughs present patients with new treatment and service options that were not previously available. Let us take for example the development of diagnostic imaging. Prior to its advent, patients suffering from unknown ailments were given the option of exploratory surgery. These procedures posed many risks and heavy costs. While diagnostic imaging lowers the cost per procedure, it encourages a greater number of patients to seek out treatment. When presented with the new and less expensive option of diagnostic imaging, patients became more inclined to agree to procedures. Doctors are equally inclined to offer diagnostic tests to their patients (Congressional Budget Office, 2008).

Diagnostic and outpatient centers are growing at an unprecedented rate throughout the US. The "fee-for-service" nature of the US health care system actually encourages independent physicians to see a greater number of patients and refer them to more treatment and diagnostic options. The more patients seen and treatments/screenings provided, the higher profit margins for the physicians. These independent practitioners must incur heavy upfront capital costs when opening up a new medical center. They must also acquire the newest and most expensive equipment to ensure their patients have the very best treatment possible and of course to ensure their own competitiveness in the market (Angrisano et al., 2007). The US has 40 percent more MRI machines and 54 percent more CT scanners per one million people than their OECD counterparts. Self-referring physicians order two to eight more scans than the average physician. 30 to 40 percent of diagnostic tests being done are unnecessary or inappropriate. The excess capacity of durable medical equipment of this nature accounts for about $40 billion additional expenditure in the US health care system.

This brings us to a significant question that is often overshadowed by the glow of innovation; do these cutting edge treatments offer patients better results than their less expensive predecessors? Not necessary. New technology is often put into mainstream practice prior to comparative effectiveness tests being done. There is little evidence to prove these more costly treatments provide a higher quality of service or more accurate results than those used previously. The adoption of these new treatments and diagnostic tests in mass is the most significant and potentially avoidable factor pushing health care costs to astronomical levels.

**POTENTIAL SOLUTIONS**

Now that we know who benefits and why costs are so high, what can we do about it? How do we lower costs and make diagnostic and surgical procedures more available to US citizens without compromising the quality of service and results? Allow customers the opportunity to travel abroad to state of the art medical facilities and receive comparable or superior treatment. Medical procedures that are performed overseas are 30 to 80 percent less expensive than analogous procedures that are performed in the US. The majority of these facilities and
physicians are board certified and exceed US standards. The Joint Commission on Accreditation of Healthcare Organizations provides accreditation for hospitals worldwide, ensuring that proper standards and codes are being followed. Physicians are often trained and certified in the US and have simply returned to their home country to provide their services in a more amicable environment.

US citizens can be provided exceptional treatment at a fraction of the price. To help illustrate the cost savings we can compare a commonly performed surgical procedure, such as heart valve replacement. In 2005, approximately 32,000 individuals underwent heart valve operations in the US. This procedure costs the average insured American $41,300. The same procedure cost the average uninsured American $136,700. Given the unlikely assumption that all people undergoing this surgery are fully insured, approximately $1.3 billion is paid for this single type of procedure. This same heart valve procedure, if performed abroad in India, would cost approximately $12,000 including transportation costs. This cost is the same whether the individual undergoing the surgery is insured or uninsured. If we were to multiply this price by the number of individuals in need of this procedure, we get a total cost of $384 million. This gives us a total cost savings of approximately $916 million, keeping in mind we assumed that all individuals undergoing the surgery are fully insured. The real cost savings taking into account the millions of uninsured Americans would be much higher. These savings represent just one of the thousands of procedures that can be performed overseas at substantial savings.

There are potential options for those who are hesitant to travel halfway across the world for treatment. Mexico offers surgical and diagnostic procedures for about 40 percent less than what hospitals in the US charge and is only a short flight or car ride away. The cost of hip replacement surgery varies from state to state, but the average insured American is likely to pay about $21,100 for a full replacement. The same hip replacement surgery costs $14,500, including transportation and accommodation, in Mexico. Many retirement homes in Arizona offer bus tours to residents seeking low cost dental care and prescription drugs. International Hospital Corporation, located in Dallas Texas operates medical facilities in Mexico, Brazil and Costa Rica. Over 40 medical facilities are being constructed under a new US-Mexican partnership known as Christus Muguerza. These facilities are all designed to meet US standards (Herrick, 2007). With all of these low cost, yet high quality options available so close to home, we would urge for more public discussion regarding the matter.

**ADDITIONAL BENEFITS TO OUTSOURCING HEALTH CARE**

A number of these state of the art medical facilities are located in developing countries that are suffering from high emigration rates. The facilities are an oasis of excellence in countries plagued with poor infrastructure and employment opportunities. Foreign investment into the manufacturing and industrial sectors of these countries does not provide citizens with the employment opportunities necessary to pull them from poverty. It simply reinforces the already present emphasis on unskilled manual labor. The impoverished countries remain focused on their export driven economies and remain exposed to the volatile and unforgiving nature of the business cycle.
By investing in overseas medical facilities, foreign entrepreneurs can be certain they will provide local citizens dependable employment opportunities within the service sector. The hospital employment multiplier, as calculated by Bureau of Labor Statistics is approximately 2.5. This means that for every one hospital job, another 1.5 jobs are created in the surrounding area. Hospitals represent an excellent alternative investment opportunity and are likely to spur steady employment growth and help to improve domestic economies and services. Local citizens will be inclined to remain in the area, thanks to the improved economy and available employment opportunities.

Excessive expenditure as a percentage of GDP is the only statistic, in which the US health care sector surpasses their OECD companions. US citizens do not experience higher service, better overall health or greater life expectancies. Doctors, hospitals and insurance providers blame high operational costs on their increasing premiums, yet the numbers do not add up (Angrisano et al., 2007). The many excessive costs incurred within the system are a result of new and sometimes unnecessary technologies that are mainstreamed prior to their comparative effectiveness being measured (Orszag, 2008). US citizens can experience comparable surgical and diagnostic procedures overseas at a fraction of the price, reducing not only their out-of-pocket costs but also the demand on the health care system. By investing in overseas medical facilities and promoting their utilization, investors and providers can slow migration patterns providing foreigners with greater opportunities for employment and improved domestic economies.

**HOW TO ENCOURAGE OUTSOURCING HEALTH CARE**

Will Americans opt for treatment and screening overseas? At what savings rate will wary travelers put aside their hesitance and board a plane? The $60 billion grossed from the medical tourism industry worldwide in 2006 demonstrates that a vast number of individuals have already shed their inhibitions and jumped at the chance to receive treatment abroad. Intermediaries for medical travel have found a niche in the market place, acting as specialized travel agents. These agencies link patients with quality health care providers throughout the globe and often have doctors and nurses on staff to assess patient/hospital compatibility. Even the most leery traveler might be enticed by the huge cost differentials, especially if that traveler happens to be uninsured. Cardiac surgery in the US costs approximately $30,000. In Apollo Hospital in New Delhi, India, the same procedure costs approximately $4,000. The same procedure costs nearly 8 times as much in the US as it does abroad! Looking for more aesthetic surgery? A rhinoplasty will cost the average US citizen about $4,500. If you were to have the surgery in India you would be out a mere $800. Still not convinced? Take the average list price of cardiac surgery in the US if you are one of the 14 million uninsured Americans, a whopping $121,000. The $4,000 you pay in India for the same surgery is applicable for both insured and uninsured patients (Herrick, 2007).

Of course there are additional incentives that can provide potential travelers with the piece of mind necessary for them undergo treatment abroad. Endorsements from their insurance carriers and employers, government sponsorship, facility accreditation would all encourage patients to seek treatment abroad. While the majority of US insurance providers to not include foreign treatments in their network, a small and growing
percentage do. Blue Shield of California allows patients to seek medical treatment in Mexico by reimbursing costs to Mexican medical centers. Premiums of treatment provided in Mexico are less than two thirds that of treatment provided in California because of the comparatively low cost. Government sponsorship of overseas treatment is being brought to the table. In 2006, West Virginia held hearings to address the prospect of including foreign providers in the health network for their state employees. More than 150 hospitals worldwide are accredited by the Joint Commission International and the International Standards Organization. Specific countries are starting to develop their own accreditation standards to help reassure prospective patients (Herrick, 2007).

**IMPACT OF OUTSOURCING HEALTH CARE ON MIGRATION**

It is undeniable that outsourcing health care to developing nations will lower costs for not only individual US citizens seeking treatment but also the country as a whole. But will it really slow the influx of migrants coming from countries in South and Latin America? If the future is a reflection of the past, than yes! Radical shifts in migration patterns have occurred in Spain, Portugal and Ireland, just to name a few. The economies of these countries were virtually incapacitated from mass migration outflows. Few skilled jobs were available, dissuading citizens from seeking out higher education. Those who became highly skilled were quick to move abroad in search of opportunity. It was not until foreign investments were made directly into their economies that opportunity prevailed. Migration patterns quickly reversed as these countries became more attractive to both foreigners and nationals.

International migration is driven by the perceived differences in standards of living across nations. Recent evidence has shown that migration between countries with differing average real wages will remain low if citizens in the lower income country believe their economy is improving. All else equal, individuals would prefer to remain in their home country, amongst family and friends. Poverty, unemployment, low wages, lack of education; all of these factors pushing a capable labor force abroad could be abated if the US were to invest in overseas medical facilities (Mansoor and Quillin, 2006: 75-9).

**CONCLUSION—A CASE FOR HEALTH CARE OUTSOURCING**

The weak economies of these three underdeveloped countries are heavily dependent on remittances from immigrants. This trend is unsustainable and mutually detrimental to both the host country and the receiving country. It is imperative that the US government work with underdeveloped countries such as to develop a comprehensive medical exchange framework. Outsourcing low cost, low skill manufacturing jobs to these countries would only reinforce poor education standards, low wage living and unskilled labor affinity. Instead, the US should outsource high skilled, high wage medical centers to these countries. Citizens can be educated and trained in specialized areas. With the establishment of medical centers comes a wealth of new opportunities, from surgical positions to office assistants, radiologists to janitors. The job multiplier effects of a
hospital are likely to be much greater than those of a manufacturing plant. By providing local citizens in these countries the opportunities to advance, professionally, educationally and economically, they will have great incentives to remain at home. Migration trends will gradually decline as economic conditions and opportunities for success improve.

If the US and partner governments do not wish to directly involve themselves in the establishment of medical infrastructure they could formulate policies to help encourage citizens to seek services abroad in low cost but reputable areas. They could reduce the impediments for those seeking visas for medical travel. They could also establish cooperative programs and networks between US and foreign hospitals. These initiatives would help promote medical travel and give patients greater incentives and confidence to seek treatment abroad. The lower costs of seeking treatment could be passed on to not only the consumer, but also the insurance company, the hospital, and the government. The globalization and integration of US health care is an excellent option for reducing health care costs, improving service and increasing the health of US citizens.
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