Finding Affordable Health Care: U.S. Vs. Overseas

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I. Philosophy and Background of Medical Tourism

Lawyers have a saying: if you have something to say, say it, and if you have nothing to say, yell, which seems to apply to medical tourism, in my opinion. Why is it that USA Today has on its cover a bunch of patients on airplanes going somewhere for health care? Are people really traveling or is there just a bunch of hype? I will speak on what is published on medical tourism which probably has some real measurement behind it, but because I believe that we know virtually nothing about the quality of care abroad, we know a little bit about the cost of care abroad, we are not in a position to make informed decision-making about the optimization of care and quality and cost, comparing the U.S. versus foreign sources. I will share some of my own personal experiences in the hope that we maybe learn some lessons and develop ways to make improvements at home rather than shipping everyone out of country.

Deloitte & Touche, the consulting firm, is one party interested in what Americans are doing in terms of their health care. Their 2009 survey showed that 8% of the respondents sought health care outside their community, 43% would travel if they could save 50%, and young people are more receptive to travel than old people. This is actually measuring attitudes and is useless from the patient perspective.

What exactly is medical tourism? In principle, it is not a new concept. We are not really talking about something that is medical, but rather surgical travel: liver transplant, aortic valve replacement, knee replacement, those sorts of things. At its core, it is not tourism at all; the word tourism refers to travel agents seeing this as an opportunity to make money. The Medical Tourism Association has an interesting distinction, having been written up in a very interesting investigative journalism report by Reuters Health, in terms of how medical tourism is run, where the money is going It is a serious money-making operation that talks a lot, brings in a lot of sponsorship dollars, but at day's end, I do not see where the health care part comes in. There is a lot of hype but I do not believe a lot of substance.

Forgetting about the hype, the media, the professional associations: let's discuss patients and doctors. Who travels? The notion of patient travel is ancient; ancient Greeks would travel to spas to get better. The contemporary counterpart to that is people go to the Mayo Clinic. From where? Everywhere. Patients have always traveled. Doctors also travel: this, too, is an ancient concept. The house-call is a pedestrian version of doctor travel, but there is also a much more aggressive form of doctor travel, for instance, a doctor going into the rain forest to fix cleft palates, a charity version of the same idea of

physicians serving. Doctors will travel great distances. Australia has a Flying Royal Doctor Service: people are giving birth out in the bush, people are breaking hips and having appendicitis, and they cannot always get the patients to the hospital, so medical services are sent out into the field. Some places actually have traveling hospitals; the Dominican Republic is one such example of this. They actually put an operating room onto a big truck and travel it around the country for specialty services.

The notion of mobility is both ancient and modern and not new in any way. It is being repackaged today, as I said, for profit motives because of two essential sociological forces: number one, globalization in general, and number two, the economic pressures are such that people are increasingly motivated to consider this sort of travel.

II. Practicalities

Here is a case which embodies the delivery of major surgery to a patient. A few years ago, a blue collar worker in Portland lost his job, income, and credit, and was diagnosed with prostate cancer, which was the disease that killed his father. He was fairly well-educated regarding prostate cancer having been through the disease and its progression, and the death of his father. He was highly motivated to return to work; this was not a lazy guy. He knew he wanted surgery plus a fast recovery, for which he made a very informed decision. Hospitals in Portland would do a robotic prostatectomy, which is what he wanted, but without income, insurance, or credit, they wanted $50,000 upfront, which he did not have.

Somehow this guy found me in Miami: on the phone, he sounded like the guys I grew up with in New Jersey; he could have been one of my friends and neighbors. In Miami, there was no way I could get him a prostatectomy for his budget. I either could subsidize or try to find a way to get it under the budget that he was perfectly happy to meet. As it happens, I had just been in Trinidad to give some talks, and had met an Indian anesthesiologist who insisted I visit his hospital. After speaking with the patient in Portland, I called the Indian doctor and say, let's make a deal: I want to rent your operating room for three hours. We were trying to meet the patient's needs, which were his specific treatment choice, his choice to keep a certain qualitative level, cost containment, and risk management.

Mobile Surgery International or MSI coordinated the details. The equipment in Trinidad is identical to the equipment we have in Miami; we did require bringing in specialized, complementary equipment, for example, a grooved urethral sound. MSI also coordinated the logistics of hotel stay and transportation to Trinidad and back to the U.S. He had surgery on a Friday, was out of the hospital on Saturday morning, two Tylenols, no transfusion, no perioperative issues; he was home in Oregon and fishing five days later. In sum, he saved $26,000 for an overnight hospital stay for the same service.

1. Lessons of the Mobile Model

At this point, this was a one-man, one-deal, one-time sort of event. But on the way home, obviously, we started to ask some questions. The problem here is not quality; the problem is distribution. We have quality here, but we have barriers including money, geography, and culture. The first lesson is that quality is mobile: quality of surgery does

not depend on the hospital but rather on who is actually doing your surgery; that is the fundamental premise of the house-call. The nature of health care is such that many of the important components are actually not fixed to the ground, and this becomes important as you try to optimize the match between supply and demand.

Second, America is extremely wasteful. We have increasingly taken the central authority, the doctor or surgeon or anesthesiologist in this case, and shifted it to third parties, insurance companies.

Third, the mobile model reduces capital expenses. I went on eBay and bought a mint-condition piece of equipment, reducing expenses from $1.5 million to $100,000 to $3,000; we saved the initial expense, plus the machine is mobile and can be shared with others. Instead of having redundant systems of $1.5 million each that are underutilized, we dropped the cost to virtually nothing. This is just one example, but it is something for us to think about how we share; sharing is not just for crayons anymore.

Fourth, the mobile model permits transparency. One huge problem which uninsured patients in trying to understand what it is that they are buying, is that nobody will tell them. There is confusion in who is using a DaVinci machine, for example, despite respective websites which claim to use it; there is confusion in who is actually delivering which service. Also, buying a prostatectomy is fragmented: you cannot buy the package. Does the cost include the pathologist? You will have to call the hospital. Does the cost include the anesthesiologist? You must talk with them directly. How much is the surgeon's fee? It is between $30,000-50,000. Yes, but how much is it? It depends on what he decides. That is what it is like: the transparency does not exist.

Fifth, the mobile model allows us to fill gaps in coverage. This is obvious. The hospital in Trinidad did not have the capacity to do this operation, not because they did not have anesthesia machines but because they did not have trained surgeons. The mobility, very much like the house-call and the cleft palate stories, can help you fill in gaps both on the hospital as well as on the insurance company side.

2. Potential Barriers to the Mobile Model

How simple is this process? Are there barriers to a mobile model? First, there are administrative barriers to making this happen, which fall into two categories. We have got an insurance issue; we have got a malpractice issue. The American mindset is such that an employer will not send patients anywhere if they do not know who to sue at the end. This is a huge problem with the big companies: insurance companies like Blue Cross and United do not want the liability; they want to be able to pass that buck. In Trinidad, we got my malpractice insurance company to cover us.

The other barrier, in addition to who to sue, is licensing: you cannot just waltz into any old place and do surgery. Domestically, does it make sense to anybody why we need 50 state licensing organizations in the U.S.? States can cooperate: I have got a Florida driver's license which allows me to drive to Georgia; why can't I do surgery in Georgia? Would it be useful if we eliminated these domestic barriers? On an intuitive level, if we can have one DEA license, a VA system that allows surgeons from California to operate in Maine, why do we need all these state agencies? It seems redundant and wasteful to me. In regards to operating overseas, this is the fun part, the adventure part of this story,

to get licensed in Trinidad, one has to pay a fee, which is true everywhere; you have to send in your medical school diploma; and you must get lectured about the surgeon's role in society. Like in Antigua, the hardest part in getting licensed is sending in your check, then waiting for the post office to deliver the check to the health ministry.

Thus, there are barriers: logistical, clinical, and administrative. To me, the most bothersome is the domestic situation in the United States, which really is just, in my opinion, useless.

3. Where Are We Today?

This slide depicts models of surgical travel. This is our conventional model: patients come to the surgeons, patients go to the Mayo Clinic, MD Anderson, wherever. The example I showed has both parties traveling, both surgeon and patient, or the surgeon going to the patient as in the cleft palate situation. The big question is do we really need to be sending patients and surgeons abroad to Trinidad or Mexico or wherever, if we want to get to optimize the quality and the cost?

Since Trinidad, 18 months ago, the model, if presented in ways that we have learned to present it to hospital administrators, can actually help to bring the costs way down including in the United States. We have shown this now in Kansas and Florida. In essence, the surgeons and operating rooms are the same, the quality is the same, yet the location, feel, and cost are not the same. Surgeons can be shifted around such that excess capacity ORs, which are sitting vacant and in theory should be rentable at very low prices, can be used to accommodate, to better match the supply and demand. We have now expanded to include a rehab unit for total knee replacements.

Who are the clients? Who cares about this model? There is interest with uninsured patients, no question. My prostate cancer patient was the prototype: he was the most expensive; we have learned to cut costs even more since him. In the last four months, we have gotten our first contract from foreign insurance companies that routinely send patients into the United States to have surgery, for all the same reasons; they also need to manage their budgets. The big question on my mind is will any of this work for the mainstream insurance companies, like Blue Cross, for example? Could this model help government, Medicare, for example? Could we get our fees to a point that they are less than what Medicare is paying? I do not have an answer to that. This could last just a short time; I do not know.

We are beginning to get some interest from American insurance companies; we have looked at EOBs (explanations of benefits) from some of these, and our fees for a prostatectomy are 30% less than what these big insurance companies are paying. Literally, I will do a surgery and leave a check on the way out the door with administration, which they love; even though they are getting paid less than they would have been with somebody else, they seem to like the efficiency and they will work with us.

Why won't the insurance companies just jump on this? Same reason we have 50 medical licensing boards: we have got bureaucracy, and as soon as you start talking to a real American company, they are talking about who am I going to sue, I have got to check with my lawyers, I have compliance issues.

4. Umbrella Overview

In my personal opinion, taking a huge step back, I think we have a cultural problem. I think we have tremendous quality in terms of health care, but because we have shifted the expert to the periphery of the health care decision-making, where the insurance company accountants are packaging the health care services, and because I have got committees telling me when to take out the catheter and when to take the patient out of the OR, we have built in a lot of waste. This is not specific to medicine. If we leave this to third parties and the government to fix this, we are only going to get so far; if we do not start finding solutions at the grassroots and playing with models like this, I do not think we will get very far and I think the cost of health care here is going to remain really, really high, and with time, medical tourism will grow. What I would like to see is us delivering good care here without the discounting, paying for what we need, and eliminating the waste.