

## **Small-City Clinics: Competing with India and Thailand in the Global Medical Market**

**By Marvin Cetron, Ph.D.  
President, Forecasting International  
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For most of us, getting sick is a good way to ruin a vacation. However, for growing numbers of people needing to see the doctor is the whole point of going abroad. When they require surgery or dental work, they combine it with a trip to the Taj Mahal, a photo safari on the African veldt, or a stay at a luxury hotel—or at a hospital that feels like one—all at bargain-basement prices. This is medical tourism, and it is a growing trend. In the long run, like low-priced competition in any field, it could have a noticeable impact on the market for American medicine.

This growing trend also may offer an opportunity for hospitals in relatively low-priced regions of the United States. By giving relatively economical care, they may be able to siphon off at least part of the demand that, in the future, will be served by foreign providers. After all, if American patients can believe that Third-World destinations such as Hyderabad and Cape Town are reasonable alternatives to high-priced medical care at home, why not a small city in the United States?

There is a reason, of course. In Norfolk, Nebraska, the cost of medical care is 80 to 90 percent of the national average. This offers little incentive to leave home for care, particularly for seniors, for whom Medicare will pick up a large portion of the bill. However, this may be less significant than it first appears. Some 85 percent of procedures performed in the United States already take place in community hospitals; even patients without insurance tend to get their medical care close to home and are forced to pay the cost. In this context, a significant portion of patients who might be expected to become medical tourists appear to be a reasonable market for a low-cost provider within the country.

Additionally, some 70 to 90 percent of surgical operations already are handled on an outpatient basis. It makes very little sense for these patients to consider flying to a distant land for care. However, a relatively short journey to a facility within the United States could be extremely attractive if it offered worthwhile savings.

The question is how to bring the cost of care low enough to compete with overseas clinics without sacrificing quality of care. The proposed study will attempt to find practical ways for a small-community hospital to meet this challenge with a program specifically designed for the purpose.

### **The Future Market for Medical Care**

Some important trends guarantee that the market for inexpensive medical care will continue to expand in the

years ahead. They will be familiar to most people. Yet as background for our discussion it seems worth noting a few of the most significant.

The first obviously is the aging of the American population. By 2015, the health of the vast Baby Boom generation will have begun its slow and final decline. There are something over 70 million Boomers in the United States, who will reach age 65 between 2011 and 2026. (Some 80 million Americans, including the youngest Boomers, will turn 50 in the next decade.) Their medical needs soon will begin to grow rapidly and will not peak until after 2020.

At the same time, the price of health care is rising rapidly. Over the last decade, medical inflation has run in double digits, even when general consumer prices were nearly constant. Estimates for medical inflation over the next ten years range between 12 and 20 percent annually. According to most estimates, the cost of prescription drugs alone will rise by 20 to 30 percent per year for the foreseeable future. The cost of new medical technologies is growing almost as quickly. And personnel costs are rising rapidly as demand for skilled technicians and, especially, nurses outstrips the supply.

For all these reasons, the nation's medical bill will rise dramatically over the next 20 years or so. Advances in medical care, such as more effective treatments for Alzheimer's disease, will keep the cost of medical care for seniors below worst-case estimates. Yet in 2004, the Office of the Actuary at the federal Centers for Medicare and Medicaid Services forecast that U.S. healthcare spending would reach \$3.4 trillion by 2013, nearly doubling over the period. At that point, medical care will absorb nearly one-fifth of the American gross domestic product.

These trends, the aging of the population and the rising cost of health care, will mesh badly with another clear trend in American society: Many health-care consumers will be uninsured. Already, an estimated 46 million Americans are without health insurance and perhaps 120 million lack dental coverage. The number of uninsured or underinsured is likely to grow quickly as companies cut back or eliminate their medical and pension programs. Thus as our national need for medical care rises sharply, our individual ability to pay for it will decline. Baby Boomers who find themselves with little or no insurance but Medicare in old age will welcome any chance to cut their medical costs. So will many younger workers for whom medical benefits are as remote as the Second World War and dial telephones.

### **The Competition**

They will have good cause to seek out care far from home. The cost of surgery in India, Thailand, or South Africa can be one-tenth of rates in the United States, and sometimes even less. A heart-valve replacement that would cost \$200,000 or more in the United States goes for \$10,000 in India, including round-trip air fare and a brief vacation. A

metal-free dental bridge worth \$5,500 in the States costs \$500. In Thailand, a knee replacement with six days of physical therapy costs about \$5,000, one-fifth the American price. Lasik eye surgery worth \$3,700 here is available there for only \$730. And a full facelift that would cost \$20,000 in the U.S. runs about \$1,250 in South Africa.

Inferior medical care would not be worth having at any price, and some skeptics warn that Third-World surgery cannot be as good as that available in the United States. In fact, there have been cases of botched plastic surgery, particularly from Mexican clinics in the days before anyone figured out what a gold mine cheap, high-quality care could be for the developing countries.

Yet, the hospitals and clinics that cater to the tourist market often are among the best in the world. Many are staffed by physicians trained at major medical centers in America and Europe. Many are equipped with state-of-the-art equipment. Some offer advanced procedures not yet available in the United States at any price. More than 100 are certified by a branch of the same organization that certifies hospitals in the United States. Bangkok's Bumrundgrad hospital has over 200 surgeons who are board-certified in the US. One of Singapore's major hospitals is a branch of the prestigious Johns Hopkins University, in Baltimore, MD. In a field where experience is as important as technology, Escorts Heart Institute and Research Center, in Delhi and Faridabad, carries out nearly 15,000 heart operations every year. Its death rate among patients during surgery is only 0.8 percent, less than half that of most major American hospitals.

Skilled doctors and glistening new equipment are not the only benefits offered by medical centers specializing in foreign patients. In many, the doctors are supported by more registered nurses per patient than any Western facility could offer. Some facilities provide single-patient rooms that look more like a four-star hotel, with a nurse dedicated to each patient 24 hours a day. Some assign patients a personal assistant for the post-hospital recovery period. There is always the chance for a quick vacation, before or after surgery, to sweeten the deal. And many of the Asian national airlines offer frequent-flyer miles to ease the cost of returning for follow-up visits.

Under the circumstances, it is no surprise that the medical tourism market is growing rapidly. Ten years ago, it was hardly large enough to be noticed. Today, something over 250,000 patients per year visit Singapore alone. Perhaps half a million annually travel to India for medical care; in 2002, it was only 150,000. The number still is growing by an estimated 30 percent per year. In Asia alone, medical tourism is expected to generate \$4.4 billion in annual revenue by 2012.

No one knows exactly how many American patients now travel abroad for inexpensive medical care. However, one startling figure is indicative: Bangkok's Bumrundgrad Hospital alone treated 58,000 American patients in 2005, up 25 percent from the previous year.

Now "guesstimate" the number of Americans visiting other facilities in Thailand, plus their competition in Singapore, India, South Africa, and parts of Latin America and Eastern Europe, and project them a few years into the future. This is the market our hypothetical hospital will aim to tap.

One segment of this market may be particularly easy to approach. American companies are struggling to pay the cost of health care for their employees. Many are abandoning their health plans. The rest are desperately seeking to cut their costs. Dr. Arnold Milstein, chief physician at the consulting firm of Mercer Health and Benefits, reports that three *Fortune* 500 companies have hired his firm to assess the feasibility of outsourcing non-urgent major surgery to overseas clinics for their self-insured health benefit plans.

"These are hard-dollar savings," says Jonathan Edelheit, vice president of sales for United Group Programs, which offers a plan for self-insured employers that includes services at Bumrundgrad Hospital. "If we send someone there for a bypass, the employers save sixty to seventy thousand dollars. We consider this a magic bullet."

IndusHealth, a leading company in medical tourism, is working with Blue Ridge Paper, in Canton, NC, which employs about 2,100 people and is partially union-owned. The company has an on-site pharmacy, a medical clinic, and wellness programs that have saved 3 percent in employee medical costs. Yet they still spend \$20 million per year on care. "We see major savings with Indus," comments Darryl Douglas, vice president of human resources.

Not everyone is convinced that employers will embrace medical care abroad for their workers. Regulatory hurdles, not to mention questions of safety and liability, may scare off some companies. "Employers will be very cautious about this," says Mike Taylor, a principal at the benefits firm of Towers Perrin. "Smaller employers will try it. The big employers will wait to see how it's going."

Yet, if Dr. Milstein's experience is any guide, even the largest companies may be open to low-cost medical care. If it can be provided by a hospital in the United States, so much the better!

### **A Secondary Opportunity**

It turns out that medical tourism is not one-way. Growing numbers of foreign patients are coming to the United States for care that many still consider to be the best in the world. Most are affluent people from Europe, Asia, and the Caribbean, prepared to pay for immediate, high-quality care. Many come for procedures not available in their native lands. Philadelphia International Medicine, a consortium of nine area hospitals formed specifically to attract foreign patients, has proved highly successful. Together with the Mayo Clinic, Johns Hopkins, the

Cleveland Clinic, and Texas Medical Center, they served more than 30,000 patients from 100 countries in 2005.

This is a second market that a highly focused regional hospital in the United States might hope to serve—one that has the advantage of avoiding contact with Medicare and other intrusive third-party payers. This would be an effort for the long run, as competing with the Mayo Clinic and Johns Hopkins would require the cultivation of an international reputation that could take many years, and perhaps an alliance with other forward-looking institutions. However, the success of Philadelphia International Medicine suggests that the task could eventually be accomplished, with rewards that easily justify the effort. In the course of this study, it is well worth considering whether a program designed for this secondary opportunity would be compatible with the primary goal of attracting would-be medical tourists.

### **Cost Cutting**

In order to attract those patients who otherwise might leave the country for inexpensive care, our hypothetical hospital must solve the problem that faces all of American medicine: how to cut costs without reducing quality as well. Thus, whatever this study learns about competing with offshore hospitals and clinics may find wider application. We cannot tell without significant data collection and analysis what measures will prove most useful in this context. However, some obvious possibilities come to mind.

*Facilities:* It should be possible to minimize construction costs by adapting an existing building to this new use, rather than starting from scratch. In the case of Norfolk, Nebraska, a large warehouse recently taken out of service and in good condition could be divided (relatively) economically into patient quarters, operating theaters, offices, cafeteria, and other necessary accommodations. The primary cost then would be that of equipping the rooms with beds, medical equipment, and office and support hardware. This would be a significant expense, as the facility must be fully self-sufficient and capable of sustaining a patient through any emergency. Yet removing the amortization of new construction from the patient's bill should provide a modest, yet significant, saving on the total cost of care.

*Personnel:* Perhaps the greatest single opportunity for saving is in the cost of staffing; at a typical hospital, paying physicians accounts for fully half of operating expenses. Skilled doctors don't come cheap, at least if they have graduated from the medical schools at Harvard or Yale. However, foreign medical graduates make up a growing fraction of the American M.D. population. An estimated 41,000 physicians practicing in the United States come from India alone. It should be possible to recruit doctors overseas at relatively low cost in return for giving them experience with the American medical system. Those physicians would be considered post-doctoral students.

They would work under the supervision of skilled American physicians and would be compensated accordingly.

Of course, it is essential that foreign recruits be fluent in English before beginning work in the United States, as poor communication between doctor and patient inevitably leads to poor medical care. In this respect, physicians from India, where English is a native language, have a clear advantage over their peers in other lands.

American medical graduates also might be recruited at reduced cost by contracting to pay off their student loans if they remained with the hospital long enough to make it worth the hospital's investment. In addition, they could be provided with low-cost housing and other benefits in return for the loss of immediate income. Given the enormous bills facing most new medical graduates, this should be a significant recruiting incentive.

Nurses and technicians in high-demand specialties would receive similar incentives to join the hospital and remain there for at least several years. Our test-case community is home to an active nursing school, and this new hospital would make extensive use of its students and graduates.

Routine functions, such as reading X-rays, would be outsourced to foreign physicians, as is already common practice.

Wherever possible, lesser nursing functions would be handled by volunteers, many of them recruited from the local senior population. These would be more than candy-strippers. Volunteers would receive extensive training, so that they could take on much more active, responsible roles than handing out magazines and chatting with lonely patients. For Baby-Boom retirees with an urge to serve, this kind of volunteerism could be an ideal late-life career.

Over all, we would not hope to save more than 20 percent or so on the cost of personnel, compared with a more traditional facility. Yet even this represents a significant economy.

*Equipment, pharmaceuticals, and medical devices:* Reducing these costs is a greater challenge. It may be possible to obtain some standard equipment used or reconditioned, rather than buying new. Save in the case of state-of-the-art hardware, this seems a reasonable economy to pursue.

Drugs are another matter. Given the current political situation, there seems little hope of breaking the pharmaceutical companies' hold on pricing. However, even a hospital begun today could not begin operation for several years. By then, a change in national leadership could make it possible either to source basic pharmaceuticals in other, less expensive countries or to negotiate lower prices with American suppliers. How likely this seems will have to be investigated. However, despite federal policies banning the practice, institutions in at least two states already are allowed to obtain drugs from Canada. For this institution, Nebraska's state government

might be convinced to permit what Washington does not. If so, it would offer a significant saving in this area.

Medical devices, such as pacemakers and artificial joints for implantation, fall into a different category. So far as we have been able to discover, there are no legal obstacles to sourcing these items from abroad, where devices identical to those in use here are available for as little as one-third their cost in the United States. Finding a suitable source will require some research, but it seems likely that this does offer one significant category of savings that can easily be realized.

Because procedures in our hypothetical hospital are being designed from scratch, they can achieve savings in one other important way. According to the Institute of Medicine, hospital patients in the United States are subjected to an average of one drug-related error every day! More than 1.5 million patients in the United States are injured by a medication error each year, and the cost of a single mistake can reach nearly \$9,000. According to a study at Veterans Administration hospitals, simply bar-coding drugs and entering prescriptions in the computer, so that personnel can read them rather than having to decipher medical handwriting, has eliminated up to 95 percent of these errors.

*Specialization:* It seems likely that certain procedures, certain forms of care, will lend themselves to cost reduction more than others. The services offered by the hospital should be built around them. In particular, patients should be treated on an outpatient basis wherever possible. Laparoscopic procedures should be preferred, so that patients can be moved quickly out of the hospital and into some less costly facility. In many cases, it may be possible to put them up at the most luxurious local hotels at a lower cost than devoting a hotel room to them. (This would have the added benefit of spreading income from outside the region through the community.) Volunteers or, where absolutely necessary, nurses should remain with them to handle minor needs or more demanding problems. Where volunteers are used, nurses and physicians would be on call 24/7.

This area represents one more field for study. Deciding which procedures should be performed at the hospital will require careful balancing of the size of the market, the equipment and training required, the irreducible cost of the procedure, and many other such factors before detailed planning can begin.

*Paperwork:* According to one estimate we have read, the simple cost of maintaining patient records and other paperwork accounts for no less than 80 percent of each patient's medical expenses. While this may be somewhat exaggerated, nonetheless it is clear that this budget item adds up to an astonishing sum. Clearly any savings that can be made in this area will result in considerable economies, both for the patient and for the hospital's own bottom line.

In this instance, it may make more sense to bring foreign patients to the United States than to give American patients an alternative to going abroad. Foreign patients will require no Medicare forms, no Medicaid, no forms from private third-party payers, and few of the normal concerns for the American sue-for-a-hangnail legal system. They could receive a massive economic benefit simply by avoiding these all-American expenses. Whether any similar savings could be achieved for American patients remains to be seen.

*Travel:* For medical tourists, the cost of traveling to their chosen facility can be even greater than the price of care itself. In this, a hospital in the middle of the United States should have a clear advantage. Minimizing the patient's travel expenses should be a priority for the facility's staff, which would help arrange "Angel" flights for the poor and coordinate the donation of frequent-flyer miles for use by patients. In addition, our test-case community in Nebraska has an advantage, because it is near an AmTrak line. Many patients may be able to make the trip by train, rather than by air, spending a little more time en route in order to save a significant part of their travel budget.

### **Obstacles to be Overcome**

Any significant change in our established practices inevitably requires finding ways around barriers to its implementation. This is doubly true in the field of medicine, which in the United States is circumscribed by both patient expectations and the law. In this case, it appears that the reward—if the project can be pursued successfully—would more than justify the effort.

One obvious problem is the American attitude toward medicine. We view cost as a problem only until we need care. Then all we think about is the quality of that care; no expense is too great if it seems to offer us or our loved ones the chance for a single extra day of life. And yet there are exceptions to this. The growing market for medical tourism makes it clear that, when possible, a significant number of patients are willing to hear the argument that quality care need not be extraordinarily expensive. Even a few companies have begun to send their employees abroad for necessary procedures that do not require immediate attention. Those firms alone represent a significant market that would be very open to considering an American hospital capable of reducing their health-care costs. Such an institution would have an advantage simply because it was an American facility, rather than foreign.

Federal regulations may present many more obstacles to just about any change in established medical procedures. The obvious question here is whether foreign physicians could be recruited to practice in the United States under current rules. The obvious work-around for this would be to establish the clinic as a teaching hospital affiliated with one of Nebraska's medical schools and consider the recruits as residents preparing for admission as

foreign medical graduates. There may be others. This clearly is one case where extensive research is needed. However, a preliminary study of the problem suggests that it can be overcome within present regulations. Brief notes of our research into this problem are offered as Appendix A.

Transportation is another issue. It would help if Norfolk had a major airport and a location near interstate highways. In fact, improved highway access, particularly to the north and south, would ease almost any proposal to improve the community's economic future, and we have noted elsewhere the need to lobby for construction of a new highway in that direction. However, Americans who travel beyond the country's major cities are well accustomed to changing at a major hub from one of the large carriers and completing their trip via a feeder airline.

Road-building, of course, is a government function, and many of the other problems facing a start-up clinic of this kind would be eased by political support. Fortunately, it seems that this support will not be difficult to find. We have had the opportunity to discuss this plan with representatives from both the Nebraska state legislature and the state Congressional delegation in Washington, and both seemed eager to smooth Norfolk's path in any way possible.

### **If You Can't Beat Them...**

Inevitably, there will be patients whom the hospital cannot economically serve. For these "customers," the facility can build alliances with overseas hospitals and clinics specializing in the care of Western medical tourists. The Norfolk hospital would screen foreign medical facilities, ensuring that any hospitals or clinics admitted to the program meet American standards. Then it would make the initial diagnosis for each patient, perform any necessary tests, arrange for the patient's care at a suitable facility overseas, and carry out post-op care for so long as it was needed. This last would spare patients the need to spend half a day or more in the air, each way, whenever checkups or secondary procedures were required.

There already are several companies that specialize in arranging trips to overseas clinics for American "medical tourists." Some have contracted with major companies here to ship their employees overseas for non-urgent care, providing important savings on corporate medical expenses. These firms often contract with American facilities to perform exactly the sort of preliminary work contemplated above.

One of the most prominent companies in this field is IndusHealth. (A set of PowerPoint slides describing their services will accompany this paper.) This firm has contracted with facilities on the coasts to provide patient screening and preparation but this far has no affiliate in the central states or Midwest. It is eager to establish such a relationship, so that it can better tap the potential demand from patients in the middle third of the country. A

preliminary discussion with a company representative at a recent meeting of the American Association for the Advancement of Science found him very open to the idea that Norfolk would be a logical place for to locate this function. If establishing a low-cost clinic for would be medical tourists or building direct relationships with overseas clinics both seem too ambitious at this point, it may still be possible to tap this growing trend by allying with IndusHealth. This might not be so rewarding as a more direct role in medical tourism, but it would provide a valuable "toe in the water" introduction to the market.

### **In Sum**

This has been only a limited look at the benefits and problems involved in setting up a special-purpose hospital for potential medical tourists. There are many questions to be resolved before we can even be sure that such a facility would be economically viable. Exactly what procedures should be available at such a targeted hospital? How can the cost of equipment and drugs be reduced? What obstacles would there be to recruiting physicians overseas and bringing them to the United States to practice? What can be done to reduce the burden of paperwork that hangs over all healthcare providers in the U.S.? Where would the necessary capital be obtained, from private investors, public funding, or some combination of sources?

The goal of the proposed study is to answer these questions, and many others like them. Our immediate goal is to evaluate the concept of creating a specialized hospital or clinic that can compete in the global healthcare marketplace without ceding any patients to low-cost providers abroad. Yet the information generated by this work could have much wider application to the issue of reduction the rise of American medical costs.

## Appendix A: Notes about the Use of Foreign Physicians

So far as we can tell, setting up the kind of program we contemplate, if it is to make use of foreign physicians, would require getting either the University of Nebraska College of Medicine or the Creighton University School of Medicine to run that part of the program. In effect, the hospital/clinic would have to be a "branch office" of one of the university hospitals. It should be possible to arrange this, and the advantage of access to medical-school staff could be significant. (The University of Nebraska might be easier to arrange, if Norfolk can muster the right kind of political support in Lincoln.)

To make maximum use of "foreign medical graduates," as they are termed, the hospital would have to set up a residency program in virtually every specialty it wanted to offer and have enough American physicians to oversee them. Thus far, we have no idea how many licensed physicians are required per student, if there is a standard. We believe all of the following applies to physicians already in practice overseas, but nothing I have seen thus far directly addresses that issue.

Note that there also is a so-called "Fifth Pathway" program for Americans who completed pre-med here (with grades good enough to get them into an American medical school) and then went to a foreign medical school, usually in Mexico, most often to save money. Aside from needing to prove that they can speak English, the requirements seem to be similar to those described below.

It would be interesting to know what other pathways are involved in the five. Thus far, all we can identify are getting one's degree from an accredited American medical school, the process described below, and the "fifth" pathway. That leaves two, which could be significant for our current purposes.

The process of accepting foreign medical graduates into practice here is managed by the Educational Commission for Foreign Medical Graduates (<http://www.ecfmg.org/>). The United States Medical Licensing Examination (<http://www.usmle.org/>) also comes in here somewhere, but the relationship between them and the ECFMG is not clear to us; more research will be needed to get everything straight.

According to the American Medical Association, which has the most concise Web page describing the process (see <http://www.ama-assn.org/ama/pub/category/1552.html>), foreign medical graduates need to meet three requirements in order to enter a program that leads to practice in the US:

ECFMG applicants must:

1. Meet a medical science examination requirement and clinical skills requirement
2. Meet a medical education credential requirement
3. Meet English Language proficiency requirement

Item one is satisfied by taking a test given periodically at any of five centers in the country.

Item two requires that they have graduated from a medical program (including at least four credit-years of training) listed in the International Medical Education Directory (<http://imed.ecfmg.org/>), which is managed by yet another group, the Foundation for Advancement of International Medical Education and Research (<http://www.faimer.org/>). It also is possible for graduates of unaccredited medical programs to get tested if a licensing board, such as the state licensing board for Nebraska, requests that the specific individual be tested.

Item three requires a standardized test of English-language proficiency. It seems like any of several are acceptable; the AMA site mentions the TOEFL (Test of English as a Foreign Language) exam given by the Educational Testing Service.

After meeting those requirements, foreign medical graduates must spend their time in an accredited residency program, just as graduates of American medical schools do.

It is this last requirement that appears to give the proposed clinic an opportunity to recruit carefully selected staff members from abroad.