

BY JOHN ROSENTHAL

When Melvin Jacobs, a 60-year-old Michigan home inspector, learned he had an aortic abdominal aneurysm, his local hospital told him it would cost \$450,000 to repair. Like more than 50 million other Americans, Jacobs had no health insurance and couldn't begin to cover the cost from his savings. "The hospital said they would pay for the surgery if it were an emergency," he said. "But in an emergency, the aneurysm would burst and I'd be dead."

Then, Jacobs discovered he could have precisely the same surgery at a thoroughly modern hospital in New Delhi, India, for about \$9,000. Even after adding the cost of airline tickets, hotel rooms and visas, the total was still a laughably small fraction of what the Michigan hospital would have charged him. And the quality of service he was offered in New Delhi was hardly second-rate. Jacobs's board-certified, English-speaking surgeon, Dr. Naresh Trehan, trained at New York University before returning to India to open his own hospital, where (among other responsibilities) he serves as the personal physician to India's president.

Jacobs is one of a growing number of Americans who are looking beyond their own borders for high-quality health care without the hefty price tag. Once limited to day-trip dental visits to Mexico and furtive escapes to Switzerland for facelifts and tummy tucks, the field known as medical tourism has ex-

panded into a \$5 billion industry. Dentistry and cosmetic surgery still constitute most of these trips because they have fairly reliable outcomes and don't preclude patients from taking long flights shortly before or after the procedures.

But each year, the list of medical treatments for which it might make sense to get on an airplane grows longer. So, too, does the number of countries where it's possible to receive world-class medical treatment. Today, Americans are traveling abroad for procedures ranging from hip replacements to *in vitro* fertilization. And many of them come home very satisfied.

Thailand and Singapore began courting patients from the United States in the late 1990s, when the Asian financial crisis suffocated local demand for elective surgery. Since then, they've been joined by India, Barbados, Brazil, Costa Rica, Mexico, Malaysia, the Philippines and Turkey. More are on the way: Hoping to cash in on this new category of exportable services, South Korea and Dubai have recently passed laws giving their hospitals tax breaks on revenues from foreigners.

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Pre-surgery: Colleen Hiltbrunner, 53, and her husband, Donn, on safari at Entabeni Lodges in the Waterberg wilderness area, South Africa.

The savings can be staggering, even after factoring in the cost of airfare and first-class hotel accommodations. The bill for heart-valve replacement surgery, for example, can approach \$200,000 at a top American hospital. At the high-tech Bumrungrad International Hospital in Bangkok, the same procedure performed by an English-speaking, board-certified surgeon may cost as little as \$18,000. A hysterectomy, priced at more than \$30,000 in the United States, can be done for less than \$5,000 at CIMA Hospital, a veritable *maquiladora* of medicine in Hermosillo, Mexico. Many of these facilities have dedicated staff members who deal solely with international patients –

not to mention five-star hotels attached to the hospital for the convenience of family members and recuperating clients.

What's more, elite foreign medical care is a giant step up from the production-line care found in many U.S. hospitals. Even before he traveled to Belgium in 2004 for a hip resurfacing, Alan Ray, a 57-year-old radio host in San Diego, marveled at the personalized service he received from his internationally renowned orthopedic surgeon, Koen De Smet. "I'd e-mail him a question," he said, "and I'd have an answer by 9:00 the next morning."

Medical tourism is hardly new; patients from all over the world have long come to the



Post-surgery: Six days after her facelift and other cosmetic surgery, Colleen Hiltbrunner's stitches and nose guard bandaging are removed by her doctor, Dr. Rick van der Poel.

United States in search of the finest doctors and hospitals. But the quality of health care in other countries is catching up and, by many measures, is now on par with those in the United States. Accreditation from the Joint Commission International (JCI) is recognized worldwide as the gold standard for hospitals. JCI screens facilities for the condition of their physical plants, their management of medications, the quality of their surgical care, their commitment to continuous improvement, and their responsiveness to feedback from patients.

In the United States, the organization accredits more than 17,000 facilities, from hos-

pitals to laboratories to long-term-care centers. JCI began accrediting hospitals outside the country in 1999. Today, the organization vouches for the quality of care at some 400 institutions in 45 countries from Austria to Yemen.

HOW MUCH THERE IS THERE?

Just how many Americans are boarding international flights before checking into hospitals is very difficult to pin down. A May 2008 study by McKinsey put the number at 60,000 to 85,000 annually, but the study did not count dental work, cosmetic surgery or any of an ever-increasing number of arthroscopic

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procedures done on an outpatient basis. A report from Deloitte's Center for Health Solutions in that same year estimated the yearly United States clientele for medical tourism at a much more robust 750,000, and predicted it would reach an astonishing six million within two years.

Then came the global economic meltdown. "We expected that the recession would force a lot of patients onto planes seeking lower-cost, higher-quality care," said Josef Woodman, author of *Patients Beyond Borders*, regarded as the bible for potential surgical travelers. Instead, patients generally delayed the elective procedures that make up the bulk of medical tourism. Even at savings of up to 90 percent, hip surgery may seem like a luxury to Americans worried about putting food on the table.

In 2009, Deloitte revised its estimates down to 648,000 travelers annually, but forecast 35 percent increases in each of the three succeeding years. It predicts that more than

adolu Medical Center, a hospital in Istanbul affiliated with Johns Hopkins. The total cost there would be less than the typical 20 percent co-payment on a \$100,000 bill at a major United States facility.

The case is equally compelling for dentistry. For one thing, relatively few Americans are insured. But even an insured patient with a typical deductible and a \$2,000 cap on annual insured expenses is likely to save money abroad. A couple of dental implants retailing for \$5,000 in the United States will run to just \$900 (plus travel expenses) in Costa Rica.

Medical tourism is popular for other reasons among recent Asian-American immigrants, especially women suffering from hormonal or gynecological problems. Many of them would prefer to receive treatment where they were born, using the kind of holistic approach they find missing from Western medicine. Paul Keckley, the executive director of the Deloitte Center, says the savviest of these patients negotiate treatment options with

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1.6 million Americans will travel abroad for health care in 2012.

You'd expect the uninsured to be the biggest consumers of international medical tourism. But the vast majority consists of people with some kind of commercial health insurance who apparently look abroad in part because the cost of surgery overseas may be less than the after-insurance cost at home. Take, for example, a spinal fusion performed at An-

their employers' human resources departments, saving their companies a bundle while securing free trips home for themselves.

STRUGGLING FOR TRACTION

Medical tourism won't truly go mainstream, though, unless employers and their health insurers embrace it. Their endorsement is essential – if for no other reason than the assurance that patients won't be denied follow-up

coverage back home, especially if something goes wrong.

That kind of wholesale participation has been slow in coming. In 2007, Hannaford Supermarkets, a Maine-based grocery chain, decided to waive deductibles and cover travel expenses for patients who agreed to have knee or hip replacements performed at National University Hospital in Singapore. But the company found no takers among its employees, so it dropped the initiative.

“None of our clients are asking for it,” said Carlo Mulvenna, vice president of domestic group business for Pan-American Life Insurance. “It’s a topic of discussion, but we haven’t seen a demand for it.”

Interest may be perking up, however. Like most international patients, David Boucher, an executive at Blue Cross Blue Shield of South Carolina, was initially incredulous of prices 80 to 90 percent lower than those in U.S. hospitals. But when he went to Bumrungrad in 2007 to see for himself, he was “absolutely amazed” at what he saw: “GE MRI machines made in South Carolina, Hill-Rom



beds, Stryker implants, drugs from Pfizer and Merck, and board-certified physicians – all of whom spoke perfect English.”

Upon his return to the United States, he persuaded his bosses at Blue Cross Blue Shield to start Companion Global Healthcare Inc., a subsidiary that helps employers find affordable quality care abroad for their employees. Today, the company endorses 31 JCI-accredited hospitals in 14 countries. “We believe that if we put together a network of high-quality hospitals, we could save an em-

MEDICAL TOURISM: A CLOSER LOOK

PROCEDURE	TYPICAL COST IN A U.S. HOSPITAL	TYPICAL COST ABROAD
Heart Valve Replacement ¹	\$177,665	\$16,500 in Turkey
Heart Bypass ¹	144,317	14,500 in Turkey
Spinal Fusion ¹	103,761	14,750 in Germany
Hip Replacement ¹	100,047	12,896 in Turkey
Knee Replacement ¹	65,918	12,787 in Turkey
Gastric Bypass ²	32,927	5,000 in India
Shoulder Arthroscopy ¹	32,500	5,800 in Thailand
Vaginal Hysterectomy ¹	31,474	4,800 in Turkey
Lap Band ²	30,000	6,500 in Mexico
Facelift ²	15,000	3,440 in Malaysia
IVF Treatments ²	14,500	2,180 in Korea
Dental Implants (each) ²	2,800	900 in Costa Rica

SOURCE:

¹Companion Global Healthcare Inc.; ²Medical Tourism Association

ployer anywhere from \$30,000 to \$60,000 on a hip replacement and a lot more on a heart valve replacement,” said Boucher, who is now Companion’s president.

In addition to screening hospitals, Companion helps employees make their travel plans (arranging flights, booking hotels and ground transportation) and assists in transferring medical records. As of January 2011, Companion had relationships with more than 200 companies in 22 states. About half of Companion’s client-firms are self-insured, meaning that no insurance company stands between employee and employer to bear the risk. For a small, self-insured employer, a single \$100,000 surgery may exhaust the funds set aside for the whole program. So the medical tourism option can be an economic lifesaver.

Boucher says a typical client-firm will waive deductibles, co-payments and out-of-pocket expenses for any employee who travels abroad for surgery. Blue Lake Casino, a self-insured resort in Eureka, Calif., offers to throw in two round-trip plane tickets and to kick back (to the patient) 10 percent of what the company saves on medical bills.

Most employers haven’t gone to the



lengths of Blue Lake to encourage procedures abroad for fear of being seen as too aggressive. “They don’t want medical travel to seem like a mandate,” Boucher said.

But Jack Norton, Blue Lake’s director of human resources, is focused on the bottom line. “We’re pulling out all the stops to get folks to take advantage of it,” he said. “I think we have the right mix of incentives to make them seriously consider it.” Norton says he would have no problem if an employee chose to go overseas for months of chemotherapy, as long as it saved the company money.

In spite of the incentives, Blue Lake hasn’t had anyone opt for medical treatment abroad since it adopted the policy in 2009. But Norton explains that’s simply because no employee has yet needed the kind of procedure for which medical tourism makes financial sense.

It’s not hard to see where medical tourism might be headed. As recently as 1970, there

were fewer than 100 HMOs in the United States. Today, more than 60 million Americans use HMOs, drawn by the lower premiums and smaller co-payments and deductibles. As insurers and employers look for ways to hold down health care costs, which are rising far more rapidly than the overall inflation rate, the appeal of medical tourism will only increase.

“At some point in my lifetime, almost everybody with a commercial insurance plan will have some level of medical tourism benefit included,” Boucher said. “The value proposition is too significant to ignore.”

CHEAP LUNCH

One reason that outstanding medical care can be had overseas at a fraction of United States prices is simple: lower salaries for doctors. “Physicians in India earn around 40 to 60 percent of what their U.S. counterparts earn,” said Mehul Mehta, a vice president at

Partners Harvard Medical International, a Boston-based organization that collaborates with hospitals abroad like the Wockhard chain of India to improve standards of care. But because the cost of living in Goa is so much lower than in Glendale, their rupees go a lot further. Indeed, from a purchasing power standpoint, Mehta says, there's little difference in compensation between the top surgeons in India and their counterparts in the United States.

In most of the world, doctors typically earn three to six times their nation's median income, according to Deloitte's Keckley. That's generally true in the United States as well – though there's far more room at the top for specialists, who often pull in 15 to 20 times the median income. For many specialist physicians overseas, however, money isn't everything; the chance to do well by doing good back home is just as important. Sertac Cicek served fellowships at the Texas Heart Institute, the Mayo Clinic and USC Children's Hospital before returning to his native Turkey, where he is now chief of cardiac services at Anadolu Medical Center. "If the decision were based solely on finances, I should have looked for a way to stay in the U.S.," he said. "But I wanted to serve my people, and they need my expertise."

The decision on where to practice isn't always up to the doctor, either. Visa restrictions put in place after 9/11 make it much more difficult for foreign students to stay in America after completing their education. As President Obama noted in his 2011 State of the Union address: "As soon as they obtain advanced degrees, we send them back home to compete against us. It makes no sense."

Many top-notch physicians also prefer the kind of direct relationship with patients that is rarely found in the United States, where bureaucracy and insurance companies increase

the cost of care – but not necessarily the quality. "Thirty percent of the \$2 trillion spent on health care in the U.S. is administrative," said Mack Banner, Bumrungrad's chief executive. "That's \$600 billion spent on utilization review and second-guessing the doctors."

In most developing countries, by contrast, patients pay doctors and hospitals directly for services. Linking the personal relationship with the professional one has the additional

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benefit of keeping prices low because patients have incentives to shop around for the best combination of quality and value. And since 60 percent of its patients are Thai, Bumrungrad must keep prices within their reach. Its most direct competitor is not Massachusetts General or Cedars-Sinai, but Bangkok International, just a few miles away.

A less litigious environment also keeps down medical costs in other countries, and not solely because malpractice insurance is much less expensive in just about everywhere else in the world. When doctors don't have to practice defensive medicine to protect themselves from lawsuits, they don't order redundant tests.

Salaries for nurses and other professionals are also a fraction of what they are in the

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United States. Nurses at Bumrungrad earn about \$16,000 annually, compared with nearly \$60,000 in the United States. The costs of drugs, materials and even high-tech diagnostic services are also lower elsewhere. In India, for example, prices for PET scan machinery and other imaging devices can be as



little as 30 percent of what a U.S. hospital would pay. “Once instrumentation firms make their money off developed nations, they tend to supply less-developed nations at significantly lower prices,” Woodman said.

REALITY CHECK

In a truly flat world, United States doctors and hospitals might worry about losing lucrative business to customers outsourcing surgeries. And some analysts believe that medical tourism will ultimately serve as a check on United States health care costs, with rock-star surgeons suffering the biggest comeuppance.

But health care isn’t quite like cars or call-center services.

For one thing, there will always be emergency room visits, ongoing care regimens, and thousands of procedures that it will never be practical to buy on another continent, no matter how cheap the cost. For another, scaling up a global industry capable of posing a competitive threat to the \$2 trillion American health care system will take a very long time.

And then there’s the Medicare factor. The first baby boomers turn 65 this year. By 2050, the number of Americans 65 and over will double, to more than 80 million. The greater concern is thus not an exodus of patients to parts foreign, but a shortage of doctors at home to treat an aging population. The number of intrepid underinsured Americans who go to Bangkok or Istanbul for medical care will almost surely be offset many times over by the number of retirees wielding Medicare cards in Phoenix and Boca Raton. Medical tourism may well continue to thrive, but its growth will probably be fueled more by patients seeking to avoid long waits for elective surgeries in an overburdened American health care system than by those looking to save money.

Meanwhile, as the standard of living rises in developing nations, so too will the cost of medical services. Mehta says compensation of doctors, nurses and other health care professionals is increasing in all countries that are centers for medical tourism. So even if U.S. health care inflation isn’t contained, the upward pressure on costs abroad could make medical tourism less of a bargain. What’s more, if America continues to run a huge international current account deficit, borrowing abroad to pay for imports, the exchange value of the dollar is likely to fall. And this would further undermine the cost advantage of foreign medical providers.

The 2010 health care reform law could alter this equation – though not by much. It’s true that the numbers of uninsured will decline. Indeed, the provision allowing people 26 and under to remain insured under their parents’ policies has already given 4.7 million of them less reason to seek treatment abroad. And if the law’s requirement that all individuals purchase insurance survives judicial scrutiny, the ranks of the insured will swell sharply in 2014.

But there are other factors to consider here. The largest segment of the uninsured population consists of adults who are 18 to 34 years old. If the insurance mandate does take effect, these healthy but not wealthy people are likely to purchase high-deductible or limited-benefit insurance – exactly the kind of coverage that makes medical tourism appealing. They’re also more likely to be attracted by the adventure of medical tourism and undaunted by the 20-hour flight to Thailand or India.

On the flip side, however, the kinds of procedures that make up the bulk of medical tourism rarely afflict people under 40. “Young people are precisely the age group that doesn’t need what medical travel is really good at,” Woodman said. “They tend not to need cardiac care or orthopedic surgery.”

The one exception might be *in vitro* fertilization. Woodman says that international clinics specializing in IVF treatments are already seeing extraordinary growth. According to the Medical Tourism Association, the trade group for the industry, IVF treatments that cost more than \$14,000 in the United States can be had for far less in Costa Rica (\$2,800), Jordan (\$2,700), Korea (\$2,180) and even Israel (\$2,800).

REALITY CHECK, PART II

While most medical procedures don’t require much follow-up care, patients will always

have concerns about what to do back home if things do go wrong. The American Medical Association has remained agnostic on medical tourism, but strongly recommends that patients coordinate follow-up care with their local physicians before traveling abroad.

The paramount concern, however, will always be quality of care – real and perceived. Sharon Kleefield, a Harvard Medical School lecturer who spent 12 years improving training at hospitals around the world, worries that even JCI accreditation might not be enough to persuade Americans to put their lives in the hands of doctors and hospitals whose names they can’t pronounce. And she notes that JCI reviews aren’t the last word in quality. For example, they don’t drill down into details that U.S. hospitals routinely track, such as infection rates for specific surgeries.

“JCI is the floor, not the ceiling,” Kleefield said. “If you have ten hospitals that have been JCI accredited, how do you know which one might be better than the other?” She says international hospitals will have to do an even better job of proving that they are centers of excellence, not just places to save big bucks.

In that respect, hospitals like Bumrungrad in Thailand and Wockhardt in India are already on par with their American counterparts, and dozens of other facilities are well on their way to parity. Indeed, in other respects, the care may already be better than what’s available in the United States. It’s not uncommon to hear returning patients rave about VIP service, attentive nurses and frequent personal communications with their surgeons – aspects of care that have fallen victim to cost-cutting in the United States in recent decades that can make a real difference in medical outcomes.

Is medical tourism ready for prime time? Absolutely. Will it affect the price or quality of U.S. health care? Not anytime soon. **M**