Medical tourism in the eyes of insurance companies

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Abstract

The purpose of this paper is to provide an overview of issues that insurance companies face in the consideration of offering health plan for medical services abroad. In the health care sector, one of the most notable developments in recent years has been the rise of medical tourism. Medical tourism is the phenomenon that people are seeking health care outside their own country. Many researches on this phenomenon have primarily focused on the perspective of the individual patients and their motivation to go abroad, and on legal perspectives. This paper focuses on the perspective of the private insurance companies in their decisions to join the globalization of health care. Although many instances demonstrate potential for cost-saving when insurance companies offer their customers the options of having surgery abroad, a closer examination of other aspects of medical tourism shows that careful consideration is required in their decisions to offer such health plans. Apart from the rationale of cost-saving, other motivations such as increased demand, sufficient quality, supportive government policy and beneficial liability rules can be found. At the same time there are concerns about some disadvantages that may discourage insurance companies to join the bandwagon; these may include insecurity about the actual demand, risk costs like insecurity about quality and travel, and the question of ethics. The conclusion of the paper shows that medical tourism industry is too complex to assume that any insurance company can easily follow the development and even participate in it.

1. Introduction

Medical tourism, as the most popular medical trend nowadays in globalization of medical treatment, is the phenomenon of patients receiving medical care outside their country. The estimated number of annual medical tourists will reach 4 million by 2012; the worldwide medical tourism industry will generate $100 billion by 2012 (Piazolo and Zanca, 2010; Herrick, 2007). Some leading countries in medical tourism industry such as Malaysia, Thailand, Singapore and India already developed an organized and professional medical tourism system that generated huge impacts on their economy. In the U.S, about 500,000 Americans received procedures abroad in 2005; 750,000 Americans in 2007; and it is estimated that more than 15 million Americans will join medical tourism by 2017 (Piazolo and Zanca, 2010).

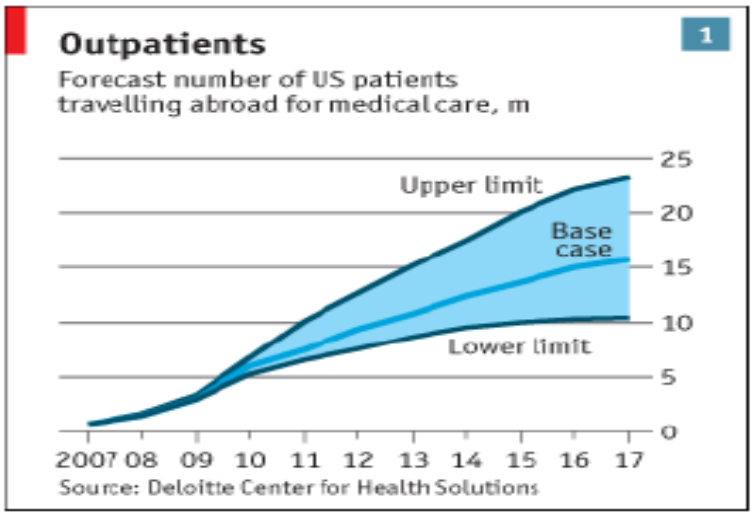
As the fast developing medical tourism industry seems to have a promising future, U.S insurance companies have started to consider joining medical tourism just as some other parties such as travel agencies and governments do. For example, BlueCross BlueShield of South Carolina started providing a health plan for medical tourism (Thailand and Mexico) in 2007; Health Net of California offers a health plan for the treatment received in Mexico; United Group Programs (UCG) has a health plan with Bumrungrad Hospital in Bangkok, Thailand (AMA-OMSS, 2007; Howze, 2007). However, apart from the rationale of cost-saving, many other aspects play a role in insurance companies' consideration to participate in medical tourism. These aspects, including other motivations as well as important concerns, are discussed in this paper.

2. Rationale to join medical tourism

Increased demand for medical tourism

Increased demand for medical tourism is the most important driving force to push insurance companies to join medical tourism. In a 2008 research from Deloitte Center for Health Solutions about U.S. consumer interest in medical tourism, it was found that 39% of the consumers would consider having an elective procedure in a foreign country; 27% of the consumers would travel outside the U.S. for treatment; and 3% of the consumers had traveled outside the U.S. for treatment already (Deloitte, 2008). According to the data from Deloitte Center for Health Solutions in 2009 and 2010, there were 750,000 Americans traveling abroad for medical care in 2007, 540,000 Americans (almost 50% of medical tourists worldwide) in 2008, 878,000 Americans (estimated) in 2010 and 1,283,000 Americans (estimated) in 2011 (Deloitte, 2009; Deloitte, 2010). Deloitte predicted that the number of U.S. medical tourists would be about five times higher after ten years (Figure 1).

Figure 1: Forecast number of US patients travelling abroad for medical care



Source: Medical Tourism: Alternatives to the United States Healthcare System (2010).

Most Americans seeking medical treatment abroad are those who need cosmetic surgeries (generally not covered by insurance), those who do not have health insurance, and those who have limited health insurance coverage (Marlowe and Sullivan, 2007). As a matter of fact, the number of

uninsured Americans has risen from 45.7 million in 2007 to 46.3 million in 2008, to 50.6 million in 2009, however, the U.S. health expenditure has risen to 17.6% of GDP in 2010 and to an estimated of 19.3% by 2019 (Altin, *et al*., 2011; Deloitte, 2011; DeNavas-Walt, et al., 2010). As the number of uninsured individuals and the cost for national health expenditure is increasing, the number of patients that search for offshore medical care will keep increasing as well due to the most significant concern for most Americans - cost. Medical tourists from the U.S. normally can generate 50% to 80% savings on cost by having a surgery in another country (York, 2008). Besides cost, there are other reasons for consumers to choose medical tourism. These include long waiting lists in the home country, unavailable or restricted procedures in home country, tourism and vacations, privacy and confidentiality (in some cases, medical tourists do not want to leave any medical record in home country), information technology (easy access to information: over 75% of medical tourists used the internet to search for information about medical tourism destination countries, hospitals, medical services), increasing number of medical tourism companies (e.g. Planet Hospital, Med Retreat, and Medical Tours International), and more international health insurance offered by insurance companies based at home (Altin, *et al*., 2011; Beauvais *et al*., 2010; Horowitz and Rosenweig, 2007).

Decreased demand for domestic health care

Apart from the increased demand for searching offshore medical care, the decreased demand for domestic health care in the U.S. also enhances the progress of U.S. insurance companies joining the medical tourism. Because of rising medical cost in the U.S., an insurance company will increase medical insurance premiums for domestic medical care, so consumers will need to pay more

and eventually more consumers will feel tempted to give up their insurance coverage. "Recently, fewer employers are offering their employees health coverage, as it is increasingly expensive for the company to provide. The percentage of Americans who are uninsured rose largely because the percentage of people with employer-sponsored coverage continued to decline as it has in the past several years" (Kramer, 2010). Moreover, some companies (especially self-insured) in the U.S. already started to offer their employees cross-border health plan (incentives) to encourage employees to join medical tourism, and most importantly, to reduce the health plan expenditure. As a self-insuring American company, White Hill Paper Products, Inc. from North Carolina provides its employees a medical incentive plan that includes a $10,000 bonus, extra sick-leave time, and coverage of airfare cost if its employees choose to have their non-emergency surgeries done in a hospital in New Delhi, India, which was approved by the company's "PPO" - preferred provider organization; Hannaford Brothers also started to offer its 9000 employees health incentives for medical tourism (Cohen, 2010).

The rising cost situation will not be changed in the short run because "hospitals are predominantly fixed-cost institutions", the demand for domestic health care will continue to decrease (Forgione and Smith, 2006). However, the U.S. medical cost will be driven down by global competition in the long run, which may change the demand for domestic health care.

Cost

The difference in medical cost between the U.S. and foreign countries is the most powerful driving force for consumers to choose medical tourism. It is also a very important driving force for insurance companies to join medical tourism, because saving expenditures is one of the key elements

to generate profit for an insurance company. Table 1 shows some cost differences between four countries.

Table 1: Cost comparisons between countries (selected surgeries)

Procedure	**U.S. Retail Price***	**US Insurers' Cost***	**India****	**Thailand****	**Singapore****
Angioplasty	$98,618	$44,268	$11,000	$13,000	$13,000
Heart bypass	$210,842	$94,277	$10,000	$12,000	$20,000
Heart-valve replacement (single)	$274,395	$122,969	$9,500	$10,500	$13,000
Hip replacement	$75,399	$31,485	$9,000	$12,000	$12,000
Knee replacement	$69,991	$30,358	$8,500	$10,000	$13,000
Gastric bypass	$82,646	$47,735	$11,000	$15,000	$15,000
Spinal fusion	$108,127	$43,576	$5,500	$7,000	$9,000
Mastectomy	$40,832	$16,833	$7,500	$9,000	$12,400

* Retail price and insurers' costs represent the mid-point between low and high ranges.

** U.S. rates include at least one day of hospitalization; international rates include airfare, hospital and hotel.

Source: Medical Tourism: Global Competition in Health Care (2007).

Moreover, the traveling expenditure in some countries is comparatively low, which will not generate an extra financial burden that is too big for U.S medical tourists or their insurance

companies. For example, in India, the cost for a normal hotel is $50 per day (Gopal, 2008).

The three primary reasons for the medical cost difference among different countries are lower labor costs, no malpractice costs and lower pharmaceutical costs. Lower medical cost is also due to less or no third parties involvement, fewer regulations, efficient streamlined services, and currency rates (Herrick, 2007; Forgione and Smith, 2006).

Quality and liability

Reliable medical treatment encourages insurance companies to join medical tourism. Lower cost is not equal to lower quality treatment. A study about health care quality in developing countries by the World Bank found that the quality of healthcare in developing countries is above the minimum required standards in industrial countries (Forgione and Smith, 2006). India performs nearly 15,000 heart operations every year with only 0.8% death rate in surgery, which is "less than half of the most major hospitals in the United States" (Kramer, 2010). "In many foreign clinics, the doctors are supported by many more registered nurses per patient than in any other western facility and some clinics provide single patient rooms…with a nurse dedicated to that patient 24 hours a day" (Horowitz and Rosenweig, 2007).

To attract more international customers, international health institutions seek international organizations to prove their accreditation. Since the Joint Commission International (JCI) – the international accreditation - organization was established in 1999, there have already over 120 hospitals and health care facilities in Europe, Asia, India, the Middle East, South America, and the Caribbean been accredited by 2007. In Asia (the most popular medical tourism destination), Singapore (11 hospitals) and India (6 hospitals) had the most JCI accredited hospitals by 2007.

Besides JCI two other leading international medical care accreditation organizations, the Trent Accreditation Scheme (TAS) and the Australia Council on Healthcare Standards (ACHS), also play an important role in quality standardizing medical tourism (Forgione and Smith, 2006). Because of international medical care accreditation organizations, it is more secure for insurance companies to do business with accreditated hospitals with guarantee services.

Board-certified physicians are also one of the guarantees of quality and liability of a hospital. There is an increasing number of international students (now approximately 25% of medical students in the U.S.) studying medical schools and getting certified in the U.S., who then go back to their home countries to bring their education into practice. Bumrundgrad hospital in Bankok, Thailand, with a high percentage of physicians and nurses having international experience and generating board certification from the UK, Australia, Germany, or Japan, has more than 200 surgeons who are broad-certified in the United States, "and one of Singapore's major hospitals is a branch of the prestigious John Hopkins University in Baltimore" (Cohen, 2010; Kramer, 2010). The rapid development of international hospital (health care center) affiliation and international medical education affiliation also contributes to the quality of physicians in foreign hospitals. Harvard Medical International has collaboration hospitals in more than thirty countries; the Cleveland Clinic operates hospitals in Austria and Canada (Cohen, 2010). "Duke University…will receive over $350 million from the Singapore government to create graduate medical school in conjunction with National University of Singapore. Cornell University's Weill Cornell Medical College runs a medical school in Qatar…" (Turner, 2007). Therefore, the overall professional standard of physicians in many countries is not below the global medical standard.

Advanced medical technology and treatment are also of significance in evaluating quality and

liability of an international hospital. The more up to date medical technology is, the better the medical quality in the hospital. In their promotion efforts, a lot of hospitals mainly focus on their advanced devices and surgery. For example, Apollo Gleneagles Hospital in Hyderabad promotes its PET/CT scans devices and Bangkok Hospital in Thailand promotes its Gamma Knife device (Turner, 2007). Furthermore, there are some more advanced treatments outside the U.S. such as gender reassignment surgery in Thailand, plastic surgery in South Korea, tooth-in-eye surgery in Singapore (Forgione and Smith, 2006). The overall standard of devices and treatment in many foreign hospitals is the same or even more advanced than that of U.S. hospitals.

Legal environment

Government policy concerning medical tourism influences/indicates the future developing trend of medical tourism in a region, which is very important for insurance companies in consideration of making health plans for offshore medical care. Supportive government policy encourages insurance companies to join medical tourism with a favorable legal environment. There are some state legislators such as the Colorado and West Virginia legislators, that have already started considering to make policies support and benefit medical tourism. In West Virginia, House Bill 4359 (HB2841 when reintroduced in 2007) was introduced by Delegate Ray Canterbury in 2006, aiming to subsidize employees a percentage of medical cost in another country, and to encourage them to join medical tourism by reimbursing a part of travel cost, providing seven supplementary sick days and incentives for cost saving medical plans. In Colorado, a similar bill – HB07-1143 was introduced by State Representative Spencer Swalm in 2007 (York, 2008; Horowitz and Rosenweig, 2007; Turner, 2007).

3. Concerns

Limited Demand

Despite the promising figured mentioned above, some insurance companies consider medical tourism as a business with limited demand. First of all, most consumers travel abroad to search three major types of medical surgeries: invasive (dental, plastic surgery, eye, cardiac; joint replacement, etc), diagnostic (blood screening, heart stress tests, lipid analysis, etc), and lifestyle (weight control, anti-aging treatments, etc) (Cohen, 2010). There are only a small number of consumers seeking daily health care in medical tourism. Second, "only highly motivated individuals will travel long distances for medical treatment". Quality of care and outcomes outside the U.S. are not the biggest motivation for most U.S. consumers, because U.S. health care standards are ranked high in global medical industry (Marlowe and Sullivan, 2007). Third, "most eligible individuals covered in group health plans will not be attracted to as radical a concept as offshore healthcare for life threatening or life altering treatment" (the risk included in medical tourism such as potential travel risk), and there is only a limited number of consumers who meet medical tourism healthcare criteria. Fourth, only a limited number of employees will choose to do medical tourism for the opportunity cost (time and money) created during their absenteeism, especially for the employees in the states without government subsidy for medical tourism (Marlowe and Sullivan, 2007). Fifth, most medical tourists go abroad for significant savings. According to a research about U.S. consumers' interests in intra medical tourism, 40% of consumers would travel outside of immediate area for care if their physician recommended it or for 50% savings, but only 8% of consumers sought healthcare outside of their immediate community (Deloitte, 2009). If most consumers only would consider domestic medical tourism for cost savings above 50%, the demand for international medical

tourism is not promising. Last but not least, the changes of health policy may also influence the demand for domestic health care. President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010, which was aimed to increase the access of health insurance and reduce the health care cost (Beauvais *et al*., 2010). If this legislation is effective and efficient, it may limit U.S. patients' demand for medical tourism but increase the demand for domestic health care.

Cost

Even though medical tourism generates a large amount of medical treatment savings, cost is still a big concern for insurance companies to join medical tourism. For several reasons, insurance companies have questions about whether medical tourism is indeed a money saving business for them for several reasons. First, insurance companies will generate cost savings by sending customers abroad only if the procedure cost in the U.S. is above $25,000 (Marlowe and Sullivan, 2007). Second, savings for insurance companies in medical tourism may be deducted by travel cost (if covered), extra labor cost, health plan incentives for customers, and risk cost (Marlowe and Sullivan, 2007). Travel cost may include hotel cost, transportation cost, visa cost, and travel insurance cost (if covered). Hotel and transportation costs are all very flexible due to currency exchange rates and the economic condition of the destination country. Extra labor cost derives from the complex procedure of doing healthcare business with foreign hospitals, because "all treatment must be elective and scheduled". Insurance companies may also need extra managers, supervisors, processing employees, customer service employees, and lawyers for starting an organized medical tourism department. Risk cost from medical tourism for insurance companies include travel risk

cost, quality of medical service risk cost and international legal issues risk cost.

Quality, accreditation and liability

Quality of medical care abroad is one of the big concerns for insurance companies to join medical tourism, because poor quality of medical care creates not only more cost (follow-up care or fatal medical accidents), but also some negative impacts on the credit of an insurance company. Although some data (e.g. "Apollo hospital chain has maintained a 99% success rate in more than 50,000 cardiac surgeries performed") provides certain guarantees for the quality of cross-border medical service, "mortality rates are a crude measure of quality" which may not reflect the problem that is generated in the follow-up care (Cohen, 2010). Moreover, low cost medical care may turn out to be inferior medical care. The Center for Disease Control (CDC) published a report in 1998 about nine patients getting mycobacterial infections from their liposuction and liposculpture procedures in Caracas, Venezuela; a report in 2004 about twelve women from the U.S. developing nontuberculous mycobacterial infections after receiving their cosmetic surgery in the Dominican Republic. Joshua Goldberg, a 23-year-old American, died during his medical procedure in Bumrungrad International Hospital in Thailand (Turner, 2007). Those sad offshore medical accidents came from unprofessional doctors and nurses, poor and old devices, unreliable medical sources, unethical or unreliable medical brokerage (asymmetric information between suppliers and consumers). Unreliable medical sources such as blood banks in some developing countries, for example, may lead to security and purity problems (e.g. blood with HIV) (Forgione and Smith, 2006).

Travel risk

Travel risk generated by medical tourism may have serious impacts on the results of procedures consumers get, which will influence consumers' satisfaction about the health plan offered by an insurance company (because an insurance company may have cross-border contracting with specific foreign hospitals). For instance, long international flights may have a bad influence on some patients' body condition; exposure to new germs and bacteria may increase the possibility of infection to certain diseases (York, 2008).

The condition of a country is also a part of travel risk. If the country has a low education level, the employees (nurses, cleaning workers, cooks) in the hospital may not have generated high awareness of sanitation, and patients are more likely to get an infection in the hospital. For example, the rate of the incidents of infectious diseases such as HIV is a lot higher than the U.S. (Forgione and Smith, 2006). If it is hard for patients to get used to the environment condition (e.g. weather, temperatures) of a country, the outcomes of their medical procedures may change a lot. Moreover, the cultural condition of a country also matters. For example, if the majority of the people in the destination country do not speak English or only speak poor English, patients will more easily experience feelings of loneliness, isolation, anxiety and vulnerability because of lack of communication, which are not helpful for their recovery from medical procedures.

Legal environment

Insurance companies may get involved in some legal issues when doing medical tourism business. It is difficult for insurance companies to solve the legal issues in another country with little legislation for medical tourism. "Language barriers, culture differences, questions concerning

jurisdiction and travel costs can make the search for legal redress very difficult" (Turner, 2007). The two biggest concerns for insurance companies with legal environment of the destination country are lack of legal remedies for malpractice and lack of legal protection of privacy.

Lack of legal remedies for malpractice cause the rate of risk for insurance companies offering medical plans to raise, especially those planes covering care in developing countries. Insurance companies rather do not want to bear extra cost for medical malpractice. Without malpractice laws, doctors or hospitals have no legal responsibility for injuring patients in medical procedures, which can seriously impact the outcome and cost of medical tourism for both patients and insurance companies. On the other hand, in some cases patients and insurance companies will bear more cost because of malpractice laws. In those cases, hospitals need to pay large amounts of money to offer malpractice insurance for their doctors. "A majority of the cost hospitals pay for this insurance is then transferred to the patients" (Kramer, 2010).

Lack of legal protection of privacy in a health system has potential risks for both patients and insurance companies. Legal protection like HIPAA in the U.S. is not considered very strict in some other countries (especially Asian countries) (Forgione and Smith, 2006). In that case, patients' information will possibly be used and sold for commercial purposes. Then insurance companies may escape from the penalty of legal protection like HIPAA, but may suffer from the damages on the goodwill of their company in the long run.

Continuity of medical care

The continuity of medical care problem might occur after patients come back from the destination country. If the procedure patients get outside the U.S. is not linked very closely to the

U.S. medical care system, it will be hard for them to receive follow-up medical care in the U.S. "Some American physicians may be reluctant to take clinical responsibility for such patients, if the surgery was performed in another country" (Marlowe and Sullivan, 2007). The risk of discontinuity of medical care may generate extra cost for insurance companies to send patients abroad again, and create potential loss for them to lose the customers who cannot get follow-up care.

Ethics

There are some ethical concerns for insurance companies in consideration of participating in the medical tourism industry, both from the medical tourism brokerage side and insurance company side. Even with legal contracting or legal protection, insurance companies may still get involved into the medical tourism business with unethical brokerages. Unethical brokerages may exaggerate the outcomes of a health plan in their promotions (hospital ranking/reputation, education background of doctors, devices, cost, location, etc) to mislead consumers (both individuals and insurance companies). The biggest victim of those flawed promotions is the consumer, because he or she may receive the medical care that is below certain required standards of safety and effectiveness, may not be provided follow-up care when needed, may force to be bound with some vacation plan, which will all generate unsatisfactory outcomes for consumers (Rothenberg, 2010). Dissatisfied consumers are potential loss for insurance companies in the long run. Moreover, an insurance company will also suffer loss from 'required' follow-up procedures or 'required' pre-testing for medical care requested by unethical hospitals which create those services for profit purposes.

The ethical concern from the insurance company side in medical tourism is that insurance companies offer unethical medical tourism plans which may include procedures (organ

transplantation, abortion, euthanasia) that are criticized or illegal in the U.S. The organ transplantation market has been fast developing due to the progress of global medical tourism. Insurance companies themselves will take part in an unethical movement if their customers get organs in some way that is criticized. As the development of organ transplantation progresses, the organ (especially kidney) black market is growing and expanding rapidly, and more donors choose to sell their organs because of poverty. Insurance companies have to think about whether it is ethical to offer a health plan for a patient to receive an organ from an unrelated donor. According to several researches of organ donors in different countries, 71% of 305 Indian kidney donors are below the poverty line and 75% of them had a huge decline in their health status after nephrectomy; 88% of 239 Pakistani kidney donors received no economic improvements and 98% of them reported health deterioration after nephrectomy; 66% of 300 Iran kidney donors had negative financial effects from vending and 94% of them were unwilling to be known as organ donors; 91% of 50 Egyptian vendors felt social isolation and 81% of them were unwilling to be known as organ donors (Demme, 2010). The only possibility for organ donors to feel happy about organ donation is when they donate their organs to their family or friends. The other donors will have hardly any benefits after donation, while they may have long-term damages in their life both physically and emotionally. Because of increased demand for organ transplantation, some organ centers even accept organs from donors that are of older age and having unhealthy bodies, which will cause even more serious fatal damage for those donors after vending (Demme, 2010). "Organ trafficking and transplant tourism violate the principles of equity, justice, and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited" (Demme, 2010). Insurance companies may also

be critized from offering organ transplant tourism plans.

Besides organ transplantation, abortion and euthanasia also generate some ethical concerns for insurance companies. In the U.S., abortion is legal in all states but with "trigger" laws in six states, and with "statements of policy" that oppose abortion in three states; euthanasia is illegal in all states, physical aid death (PAD) is legal only in the states of Washington, Oregon, and Montana (Justia research, 2011; Vestal, 2007). Insurance companies may receive criticism because of providing health plans for medical tourists to get their abortion or euthanasia procedures done in foreign countries.

4. Conclusion

Looking at the global trend of medical tourism, it seems logical that some insurance companies have started to offer health plans for treatment abroad. Apart from the rationale of cost-saving there are other motivations encouraging them to do so, such as increased demand, sufficient quality, supportive government policies and beneficial liability rules. However, at the same time there are concerns about disadvantages that may discourage them in certain cases, such as insecurity about the actual demand, risk costs like insecurity about quality and travel, and the question of ethics.

To conclude, insurance companies need to be conservative and critical when deciding to join medical tourism industry. A pre-analysis (e.g. PEST or SWOT analysis) may be necessary for every insurance company to evaluate itself and also this industry. Besides taking the major rationales and concerns into consideration, insurance companies also need to pay attention to specific factors such as the ethics, and the development of the new health reform, which may control the

natural growth of the U.S. patients' demand for medical tourism, when they join the medical tourism industry.

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