Health Technology TRENDS

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Patient Safety Organization designation

Does recession affect how healthcare facilities evaluate new technology?

According to a November 2008 American Hospital Association survey, more than half of hospitals are reconsidering or postponing investments in facilities and equipment. *Health Technology Trends* asked several top executives at health systems how the country's current economic problems have affected the way they evaluate new medical technologies being considered for implementation at their facilities, and how they are addressing the challenges of meeting their technology needs with dwindling resources.

"Clearly, an association exists between the performance of the broader economy and what a hospital's expenditures will be if fewer people are seeking treatment," says Karl Ulrich, M.D., M.M.M., president and chief executive officer, Marshfield Clinic (Marshfield, WI, USA). "When healthcare executives are forced to reduce expenses, they can do two things: cut staff or cut capital expenditures," Ulrich told *Health Technology Trends*. "Sometimes, it is psychologically easier to cut back on capital expenditures, as opposed to cutting employment," he says. "However, freezing capital expenditures is only a short-term solution. You need to invest in new, innovative technologies, in addition to replacement equipment. This is the long-term strategy to keep up with technological advancements in medicine. Most important, it ensures the best health of your patients," Ulrich says. "We always have to find the right balance, but doing so can definitely be more challenging in a difficult economy," he notes.

Undoubtedly, a struggling economy creates new challenges for hospital executives managing healthcare technology. However, in some respects, "it also provides an opportunity to both accelerate certain [technology implementation] projects and decelerate others," says Michael Restuccia, vice president and chief information officer, University of Pennsylvania (Penn) Health System (Philadelphia, PA, USA). Technology projects that may be accelerated tend to be "those for which we are already really committed, such as rolling out a complete electronic medical record (EMR)," which is currently more than 50% deployed at Penn, he says. "Completing our EMR implementation could give us a competitive advantage in a difficult market, as the ultimate value and associated benefits of an EMR are realized when all clinicians are utilizing the solution," Restuccia told *Health Technology Trends*. Furthermore, accelerating the EMR rollout "could avoid the situation of having a portion of our physicians using the EMR and the rest still using paper," he explains. "The EMR could improve patient safety, for example by identifying current medications or known allergies, and this additional safety benefit could possibly increase patient referrals," Restuccia says.

To balance the acceleration of projects like EMR implementation during a recession, technology projects that could be justifiably slowed tend to be those that were planned but not yet under way when the economy began to cool, says Restuccia. "For these kinds of projects, the feeling is generally that 'if we weren't already doing this before [the recession], now would probably not be a good time to start such a project,'" he notes. Halting some technology projects also allows hospitals to redirect the resources to completing

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more critical projects like the EMR implementation, says Restuccia.

Evaluating new technology

In today's technology-rich healthcare environment, "it is critical for every hospital to have some interdisciplinary process in place for evaluating new technologies under consideration for adoption," says Ray Seigfried, senior vice president for administration, Christiana Care Health System (Newark, DE, USA). "At Christiana Care, we have in place a long-standing technology evaluation committee that analyzes a prospective technology's quantitative and qualitative value for our institution from a clinical, financial, and strategic perspective," Seigfried told *Health Technology Trends*. "The extent of the current economic problems clearly demonstrates the importance of our technology evaluation process that is already in place," he says. Through this technology evaluation process, "we examine whether a prospective technology offers additional benefits in terms of patient safety, staff productivity, or clinical quality at an affordable price, and whether implementing that new technology would make sense for us," says Seigfried. "Our process helps us identify those companies that offer technologies with real value and screen out those that don't," he notes.

Robert P. Maliff, director, ECRI Institute's Applied Solutions Group, says that this kind of transparency goes a long way to reduce what he calls "capital envy," which can develop between departments as well as physicians.

Other healthcare executives generally agree that although the recession has not fundamentally altered the way they assess new medical technologies, it has increased emphasis on certain steps in the process.

"The weak economy does not fundamentally change our process for evaluating medical technology; however, [the recession] certainly raises the bar on the level of analysis and consideration needed when we are looking to acquire new technologies," says Joseph Hardisky, vice president of clinical engineering and Geisinger services at ISS Solutions, a Geisinger Health System company (Langhorne, PA, USA).

At the University of Pittsburgh Medical Center (UPMC, Pittsburgh, PA, USA), the slowing economy has not changed the institution's technology evaluation process, "but the recession has prompted an intensified and more stringent look at a prospective technology's return on investment (ROI) within our current evaluation process," says Jim Venturella, chief information officer of UPMC's Hospital and Community Services Division, a point that was echoed by all healthcare executives who spoke with *Trends*.

Belt-tightening?

As the effects of the economic slowdown have taken hold, some executives have seen a reduction in the number of requests for new equipment. "Part of the reason is that our departmental administrators have already been advised of our financial constraints, so requests for new as well as replacement technology typically reflect an acknowledgement of the current economic conditions," says Ulrich.

However, the situation can vary according to the institution. Despite the general understanding that healthcare budgets are under greater pressure now, "we really haven't seen any decrease in the number of requests for new medical technology, especially when it comes to some of the more sophisticated emerging technologies," Hardisky told *Health Technology Trends*. "One recent trend that we have observed is an increased interest from healthcare providers in alternative options for acquiring new medical technology, such as equipment leasing, pay-per-use, etc.," besides outright equipment purchasing that was not as widely used in the past, Hardisky says.

However, ECRI Institute's Maliff cautions that this may be counterintuitive for a large-scale solution. "Operating funds are just as tight as capital funds."

At Christiana Care, "departments know that if they present our technology evaluation committee with a solid request and can demonstrate its value, they can be assured that we will act on their request," says Seigfried.

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"When healthcare executives are forced to reduce expenses, they can do two things: cut staff or cut capital expenditures."

Choice and quality concerns

The cooling of the national economy has slowed the pace of new medical technologies coming to market, especially as many smaller companies have had difficulty obtaining investors to finance their new ideas. What does this mean for hospitals?

"Any consumer—including hospitals—always wants to have as many choices as possible," says Ulrich. However, if fewer companies are developing new medical products, "I believe we are likely to see fewer real innovations in medical technology until the overall economic picture improves," he says. In this environment, "some healthcare executives may ask themselves, 'Do we invest in this equipment now, or do we use the recession as a justification to postpone capital acquisitions for now and wait until a new technology that offers truly significant improvement over the current standard becomes available down the road?'" says Ulrich. Often, the pace of change regarding a particular medical technology can help healthcare executives decide how and when to proceed, he notes.

Geisinger's Hardisky has noticed an alarmingly negative effect that may be tied to the economic environment. "We certainly have seen an increase in the number of manufacturing problems and product quality issues for several technologies over the last couple of years," says Hardisky. "Although we are not exactly sure why such problems have increased, the trend seems to be associated with the amount of competition and production levels in a particular market," he notes. Although "dealing with recalls is a huge challenge," Hardisky notes that Geisinger's technology evaluation process has not changed because of them. "The higher risk level has prompted us to increase our due diligence and reminded us to keep patient safety paramount in our technology evaluations," says Hardisky. See side bar in this issue for an ECRI Institute perspective on an increase in safety alerts.

To illustrate his point, Hardisky explains that Geisinger is currently evaluating whether to implement a new class of three-dimensional C-arm fluoroscopy systems at its facilities. "Currently, only one vendor has an FDA [U.S. Food and Drug Administration]-approved system on the market, and we are considering whether we should wait to see if new vendors enter the market before we make a decision, in light of the overall increase in quality problems that we have witnessed," he says.

New considerations

The recession has prompted many healthcare facilities to pay closer attention than ever before to potential vendors' financial health when deciding whether to adopt a technology.

"The long-term viability of any company is always in the back of your mind—that's a constant whether we're in a booming economy or a recession," Ulrich states.

At UPMC, "looking at a company's financial health has always been a part of our technology evaluation process, but lately it has become more closely linked with how big a purchase is involved and what level of risk the technology represents," says Venturella.

At Christiana Care, "the financial stability of potential vendors has always been a concern, and it may be even more important in the current economic climate," says Seigfried. "For a newer or smaller company, we will do a financial review as part of our technology evaluation process," he says.

Hardisky concurs that review of a company's financial stability and long-term viability to support its products has become increasingly important with the slowing economy. "When we review a potential vendor, especially smaller vendors and those with minimal competition, we really pore over the details, like looking at the installed base, and performance reliability of the systems in use," Hardisky says.

Penn is also placing more importance on a potential vendor's reputation and position in the market—for both large and small firms—"which also speaks to a company's financial viability," says Restuccia. Over the last few years, many large corporate conglomerates have entered the healthcare field because they have viewed healthcare as a rather lucrative business opportunity,

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Technology assessment in a challenged economy: An ECRI Institute perspective

Summary

ECRI Institute provides perspective on technology assessment and capital budget prioritization in a lean economy.

"I think the value of the technology evaluation or technology assessment committee really comes into play in times like these," says Richard Diefes, director of operations, ECRI Institute's Health Devices Group. "Some facilities have done a good job of establishing a well thought out technology evaluation process, so it's just a matter of continuing what they are already doing, with maybe a bit more emphasis on the financial impact of acquiring the technology." However, the economic crunch could pose an even bigger challenge for facilities without formalized committees and processes in place.

Nonetheless, in this economy, Diefes stresses that return on investment (ROI) is a key concern. To determine ROI, he offers some sample questions to consider:

- Are there codes in place and reimbursement rates established for the technology?
- Are the reimbursement rates higher for the new technology than for the existing technology?
- If the new technology is part of an array of technologies needed for a procedure, is there a pass-through payment available for the new technology?
- Will the new technology provide an additional source of revenue by attracting new patients or increased reimbursement for care of existing patients?
- What is the cost to acquire and maintain the technology, including training, staffing, and facility requirements?
- What is the timeframe in which revenues generated will make up for these costs?

"It's one thing to say that acquiring a new technology for the sake of improved patient safety or better clinical outcomes is something to consider, but in many cases a technology may be too new to definitively know if these can be achieved."

In addition, Diefes says to look at the evidence. "It's one thing to say that acquiring a new technology for the sake of improved patient safety or better clinical outcomes is something to consider, but in many cases a technology may be too new to definitively know if these can be achieved." Ultimately, he adds, "it still comes back down to the finances." Finally, Diefes suggests considering the stability of the vendor supplying the technology. Smaller companies may not be able to weather a weak economy, which could jeopardize future support of the technology.

ECRI Institute offers capital budget prioritization guidance

An effective capital budget maximizes patient care outcomes and technology investments. "Prioritizing the capital budget is always difficult, and now even more so, since available funds are nonexistent, or shrinking at best," says Robert P. Maliff, director of ECRI Institute's Applied Solutions Group (ASG). In response, "ASG is introducing new services aimed at assisting hospitals in prioritizing capital."

Using a tiered approach, hospitals can choose to submit a capital equipment list for pricing comparison. Building on these comparisons, ECRI Institute's ASG can conduct comparative reviews of major capital budget requests, and review those against industry trends for healthcare facilities providing similar levels of patient care.

"This is a new offering that builds on what we've done in the past," says Maliff, but with "a new flavor" for this economic climate. "This program will really help the hospital identify and prioritize its top capital requests," he stresses. "It's not going to go through all 5,000 line items; just your top critical, technologically complex systems."

Reviews may include the following:

- Assistance in determining the appropriate level of technology for certain types of equipment, such as a 64-slice computed tomography scanner for a small community hospital. It helps establish "that you're buying a General Motors car, versus a Ferrari," offers Maliff. In other words, "that you get what you need to meet clinical needs."
- Review of technology adoption considerations if there's unclear data on an item's efficacy.

ECRI Institute perspective on lean times

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- Review of potential business impact considerations if, for example, an item provides increased patient volume.
- Assessment of implementation considerations, such as a surgical robot that requires extensive staff and surgeon training time.

ECRI Institute will also review capital budget requests intended to replace existing items. This would include:

- comparison of replacement requests against ECRI Institute's data on service life and suitability of the existing items; and
- identification of the potential impact of non-replacement, such as service disruption, patient safety, or hazard risks from existing items.

ECRI Institute's prioritization guidance for major capital budget requests is based on the current healthcare marketplace and projected trends in patient care technology. This guidance includes arming administrators with a series of specific questions and issues for further investigation with the capital budget requestors (i.e., department managers, clinicians). These questions assist in prioritizing the complete capital request list.

For more information on these services, feel free to e-mail us at consultants@ecri.org, or call us at 610-825-6000, ext. 5284.

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he notes. From a hospital's perspective, "we would like to know whether that vendor will be around for the long-term to support its technology or be sold off to another company if its healthcare products become less lucrative over time," says Restuccia. For healthcare information technology products, "we would be able to continue to work with these products, but doing so adds much more work on our end—and we already have plenty of work to do without these added problems," he says.

For smaller vendors, says Restuccia, "we worry whether they will have enough sales to allow them to maintain and update their products and to provide us with a sufficient level of service."

Medical device and supply alerts escalate

Joseph Hardisky, vice president of clinical engineering and Geisinger services at ISS Solutions, a Geisinger Health System (Langhorne, PA, USA), has noticed what he considers an alarming trend—an increase in the number of manufacturing problems and product quality issues within the last couple of years. Hardisky questioned what connection, if any, this has to the current economic environment.

Health Technology Trends *asked ECRI Institute's Eric Sacks, product manager for Alerts Tracker, a patient safety system that automates and enhances the alert and recall management process, to weigh in on the idea. "It's an interesting theory," Sacks told* Trends. *"We have documented escalating numbers of safety alerts over the past several years," Sacks noted. "We published 250 device and supply alerts in 1991. Last year, we published more than 2,000."*

Although Sacks isn't sure he could tie the trend to today's economic climate, he listed several additional factors that could account for the rise, such as:

- *the increase in the number and complexity of devices and supplies used in healthcare (i.e., more products to potentially have problems), and*
- *increased post-market surveillance by the U.S. Food and Drug Administration and other international regulatory agencies.*

Sacks speculated that these issues could also work to lower the threshold in determining when to run a recall. He cites the prominent coverage of medical product safety problems in recent years, such as implantable cardioverter-defibrillators, pacemaker leads, and Vioxx (Merck & Co., Inc., Whitehouse Station, NJ, USA) coupled with increased regulatory scrutiny and action. "Manufacturers are pulling the trigger [sooner] when it comes to running a voluntary action (recall, field correction, and/or safety bulletin). There's a much lower threshold than there was 10 years ago."

Alerts Tracker is a Web-based service that automates and enhances the alert and recall management process for medical devices, pharmaceuticals, blood and food products. For more information on this service, please contact clientservices@ecri.org, or call us at 610-825-6000, ext. 5891.

U.S. health insurers show interest in affordable care abroad

Summary

A small number of U.S. health insurers are working with intermediaries that connect patients in employer-based plans with accredited overseas hospitals to provide orthopedic or cardiac procedures that they couldn't afford in the United States.

The U.S. medical tourist of 10 years ago may have planned a discreet vacation for some inexpensive plastic surgery, perhaps rhinoplasty, and returned home two weeks later with a new nose and a tan. Today's medical tourists look a little different, and that total hip replacement, or coronary artery bypass graft (CABG) procedure for which they're now traveling, just may be covered by a U.S.-based health insurer.

The price appeal

Traditionally, Americans have had little concept of the costs of healthcare. Cost transparency is absent from the existing private, employer-based payer system and U.S. Medicare/Medicaid programs. But skyrocketing costs, whether due to aggressive pricing competitions or an overly litigious system, have resulted in small employers cutting health plans or providing only limited coverage. This leaves patients reaching into their own pockets, and those who fall short of, or entirely outside, the payer support network can easily incur overwhelming debt in the tens to hundreds of thousands of dollars for necessary medical procedures. Elective surgeries may simply be out of reach.

However, these procedures cost roughly one-fourth as much in some reputable overseas hospitals. Companion Global Healthcare (Columbia, SC, USA), a subsidiary of BlueCross BlueShield of South Carolina launched in March 2007, has posted on its Web site some staggering cost comparison figures for procedures in the United States, compared to hospitals overseas (www.companionglobalhealthcare.com). All of these facilities have developed business models that cater to medical tourists.

For example, a patient at Bumrungrad International (Bangkok, Thailand), a 554-bed, state-of-the-art facility, can undergo a CABG procedure for $23,000 to $25,000, compared to the average cost of CABG in the Southeastern United States, at $144,317. Or, a patient could choose to travel to Bangalore or New Delhi, India, and have the procedure done at a facility in the Apollo Hospital network for $8,500 to $10,500. David Boucher, M.P.H., FACHE, president and chief operating officer, Companion Global Healthcare, says they've got 13 facilities in the network thus far, all accredited by the Joint Commission International (JCI), with 4 more facilities to be added soon.

"We were the first major U.S. insurance company to embrace the trend of international medical travel in healthcare," says Boucher. The company's business model involves working with employer groups to offer overseas care to their employees as a benefit. These employers may offer health coverage, but with high deductibles. "In the first phase of this shift, we've got six procedures that we suggest employers amend their benefits to incent their employees to access abroad." The procedures include total knee replacements, total hip replacements, spinal fusion, heart valve replacements, heart bypass, vaginal hysterectomies, and some other procedures under consideration. "These tend to be procedures that most, although not all, patients can travel long distances for," says Boucher (upwards of 24-hour travel times). "They tend to be high-dollar procedures with very low complication rates, and the whole rehab process tends to be relatively short." Boucher says things like organ transplants and cancer treatments aren't recommended. "When members return back home, they need to have a seamless continuum-of-care plan back here in the U.S. I think we've got a ways to go to achieve that."

Mixed reports

It's difficult to quantify just how many uninsured or underinsured Americans travel overseas for care. The American Medical Association (AMA) said that in 2006, an estimated 150,000 Americans received healthcare overseas, and nearly half of the procedures were for medically necessary surgeries (see sidebar on AMA's medical tourism guidelines). The Deloitte Center for Health Solutions reported that

in 2007, 750,000 Americans traveled abroad for care, and is projecting that 6 million consumers will travel for care by 2010.

Not everyone trusts the numbers; however, and not everyone sees this tidal wave-like trend. Charles Cutler, M.D., M.S., national quality management medical director, Aetna, Inc. (Hartford, CT, USA) recalled his industry's earlier push for health reimbursement accounts and cost transparency discussions. "I challenge anyone to say that people make rational purchasing decisions about anything, to say nothing about healthcare," he told an audience in San Francisco, CA, USA, on September 10, 2008, where the Medical Tourism Association (MTA) held a one-day symposium. MTA has a podcast of the event on its Web site at http://medicaltourismassociation.com.

"Over the past decade, many hospitals overseas have really tightened up their quality standards and are very much in line with what the U.S. healthcare centers offer."

"Healthcare is an emotional decision, and to convince somebody that results are better at some hospital … even in another state … is challenging, to say nothing of encouraging people to get on an airplane and go some place far away for healthcare," said Cutler. He also cautioned that some employee unions have fought against the idea of outsourcing their care, especially in industries where their jobs have been outsourced overseas.

Cutler said that more than anything, "this could cause U.S. hospitals to become more competitive on price and more transparent." But of Deloitte's 2010 projection, he adds, "whether there are, or will be, 6 million people getting care abroad for those purposes, I have to say I'm somewhat skeptical."

Still, Aetna is among a growing group of insurers entertaining the idea of offering treatment overseas as a health benefit to its members. Big name insurers have slowly been making headlines in *The New York Times, The Wall Street Journal, or The Los Angeles Times*, including OptiMed Health Plans/United Group Programs, Inc. (Boca Raton, FL, USA), and most recently, Wellpoint (Thousand Oaks, CA, USA), now working with an employer in Wisconsin to offer elective surgeries in India.

"Certainly, it's clear from the insurance companies we speak with that they are looking at the most cost effective places for care to be provided for their cohort of insured patients," observed Andrew A. Jeon, M.D., M.B.A., president and chief executive officer, Partners Harvard Medical International (Boston, MA, USA). "If that means someone traveling to Turkey or to Mumbai for CABG at a fraction of the cost of the United States, I don't think it's too far off in the future that we're going to see that being provided as an option." Harvard Medical International has affiliations with a number of hospitals overseas, including Wockhardt Hospitals Ltd. (Mumbai, India) and Acibadem Healthcare Group (Istanbul, Turkey). "The challenge I think right now for the insurers is: how do they ensure the same quality of service is being provided … as one would receive here in the U.S.? That's the real challenge," said Jeon.

Quality, continuum of care

"Over the past decade, many hospitals overseas have really tightened up their quality standards and are very much in line with what the U.S. healthcare centers offer," says Patrick Marsek, managing director of MedRetreat (Vernon Hills, IL, USA), a company that connects uninsured patients to overseas facilities. "Some of that is due to JCI," says Marsek, in addition to Harvard Medical International affiliations and affiliations with academic hospitals such as Johns Hopkins (Baltimore, MD, USA) and Cleveland Clinic (Cleveland, OH, USA) (see related feature in this issue).

Boucher is quick to defend the hospitals in his network, which have all received JCI accreditation. He says many of these facilities are more forthcoming with metrics data than U.S. hospitals. "We get detailed outcomes information; clinical information, morbidity, mortality rates, and post-surgical site infection rates, on a pre-procedure basis." In addition, "we do a personal onsite survey," and while he says they don't try to duplicate JCI inspections, "we really try to assess the member experience to make sure there are features like English signage, ample interpreters available, ample physicians and nurses that speak [English], ample phone access, access to Anglophone television stations, and in-room computers."

Globalization of healthcare
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Traveling abroad for care: An option for the uninsured?

Summary

In this scenario there's no health insurance company, just out-of-pocket paying patients who need or want a procedure, but can't afford to pay the going rate at U.S. healthcare facilities. They're willing to travel overseas where the same procedure can be done at a fraction of the cost.

"Today, the business has evolved into coordinating orthopedic procedures such as hip and knee replacements, spinal fusions, spinal disc replacements, even multilevel disc replacements."

Some U.S. healthcare insurers are offering low-cost overseas options for the so-called underinsured with high deductible plans. But this doesn't help the remaining 47 million Americans without health insurance, the latest figure from 2006 U.S. Census data. Patrick Marsek, managing director of MedRetreat (Vernon Hills, IL, USA), has an option for some of these people.

"The healthcare crisis was continuing to worsen, and we saw a need for people to safely travel overseas to receive affordable healthcare, without reducing the quality of care," said Marsek. People were already starting to travel on their own for cosmetic procedures, in addition to some less complicated elective procedures, when his company started in 2003. "Surgery itself is a pretty traumatic experience, so we established a process to take all the guesswork out of safely traveling abroad for care."

In this model, there's no insurance company, just out-of-pocket paying patients who may need that heart valve replacement, but don't have the $177,665 to cover it. Marsek says that with hospitals in his network, there's a negotiated 20% discount, so patients don't pay any more to use his service. "Today, the business has evolved into coordinating orthopedic procedures such as hip and knee replacements, spinal fusions, spinal disc replacements, even multilevel disc replacements," said Marsek, who has observed that doctors overseas are more willing to do two- or three-level disc replacements. "We also see a demand for gynecological procedures, coronary surgery, and cosmetic procedures."

Marsek said that not every procedure is economically feasible for overseas travel. "We've developed what we call the $6,000 rule," he explains. "If you're considering a procedure that costs $6,000 in the U.S., you'd probably notice a break even scenario if you travel abroad." Marsek says that although the procedure itself may only cost $1,500, "by the time you add airfare, ground transportation, post-op expenses, and other ancillary costs, it could very well add up to about $6,000."

Marsek has four U.S. regional offices, and says he gets the most clients from Florida and California. And they occasionally accommodate Canadian clients, whose care is covered by a government plan, but due to long waiting lists, can be delayed for months. "It's a quality-of-life issue for these clients," says Marsek. "They are looking for expedient care."

Marsek says patient complications have been low. Two cosmetic surgery cases that resulted in infections compelled them to develop a timeline for care. "Most complications will occur within a set amount of time, depending on the procedure," he says. "We've set up a timeline of the minimum amount of time you must remain in the hospital and the minimum amount of time you must remain at the destination to allow the overseas surgeon to handle these complications, if they occur." Marsek says it also helps that most overseas hospitals charge between $150 and $200 a day for a private room. "It allows you to spend the proper amount of time in the hospital to receive aftercare and ensure you're well on your way to recovery before you leave the hospital."

Still, even if the cost is justified, Marsek says that medical travel is not for everybody. "There are psychological issues that need to be addressed up front," he explains, and patients often experience anxiety, fear, worry, and doubt. In addition, "patients will have people in their family who say: 'What? Are you crazy? You're going where?'" Overall, Marsek says, "if there are any major concerns that arise in our initial consultation, we recommend that they remain in the U.S. We ultimately want complete customer satisfaction, and if we don't think we can attain that based on their demeanor and expectations, we need to advise them accordingly."

Medical travel agencies: Sun! Sand! Spinal fusions?

Summary

As more patients travel abroad for care, a market for medical intermediaries is emerging.

David Boucher, M.P.H., FACHE, president and chief operating officer, Companion Global Healthcare (Columbia, SC, USA), doesn't like the term "medical tourist" because "it suggests that people are going out of the country for a knee replacement or a valve replacement and are actually thinking about a vacation." His company, a subsidiary of BlueCross BlueShield of South Carolina, is in the business of assisting patient travel overseas for medical procedures. But Companion Global's travel services themselves are outsourced to Mondial Assistance (Richmond, VA, USA).

Kerri Green, director of specialty products for Mondial Assistance, says her company was already assisting BlueCross's international travelers, assistance you might need "if you break a leg on your honeymoon, or you have an emergency medical situation," for example. "We make the arrangements to get you to a hospital in the network, and make sure you're medically monitored," says Green.

The medical travel project with Companion Global is different. Mondial handles all of the travel arrangements for the 13+ facilities in the Companion Global network. This involves booking flights to cities like Bangkok, Istanbul, or Singapore, which can involve 20 to 25 hours of flight time, in addition to arranging for ground transportation, lodging, and related services.

"Believe it or not, about 20% of the inquiries we get on the Internet are from people trying to start their own medical tourism business."

Green estimates that staff in her organization speak at least 20 languages. However, she adds, "most of the people who are involved in medical travel for the U.S. already speak English, and in fact most of the paperwork is in English, so there shouldn't be that language barrier, but we can step in as needed."

Overall, Green says many overseas hospitals have become savvy to the needs of traveling patients. "A lot of these hospital networks are very well versed in what people need once they hit the ground," and many hospitals provide greeters at the airport, she adds. "To use Bumrungrad International [Bangkok, Thailand] as an example, the services they provide are really incredible from a concierge point of view." Boucher says that all of Companion Global's hospitals provide this service at no additional cost.

Mondial's primary business is travel insurance, so they're not like many of the new medical travel startups the industry has seen in the past few years. Still, Green says medical intermediaries come and go. She observed a spike in such businesses last year while attending the Healthcare Globalization Summit, but not nearly as many businesses were represented at this year's show, in Washington, DC, USA.

In the past, she says the marketplace comprised "intermediaries online, trying to get consumers—under-insured or self-insured—to travel abroad, without the incentive coming from an employer group or a health plan."

Patrick Marsek, managing director of MedRetreat (Vernon Hills, IL, USA), has a company with a strong online presence that markets to uninsured clients (www.medretreat.com). However, he says most of his business comes from word-of-mouth referrals. "Believe it or not, about 20% of the inquiries we get on the Internet are from people trying to start their own medical tourism business. They pose as a patient, try to get as much information as possible, but nothing ever happens from the business end of it."

Those contracting with medical intermediaries should keep in mind that the business is largely unregulated. One group, the International Medical Travel Association, which describes itself as a not-for-profit association of stakeholders trying to legitimize the industry, published a position paper warning against the emergence of trade groups declaring themselves "quality accreditors" (see www.intlmta.org).

Still, with insurers getting behind some of these travel programs, Green speculates, "we're on the brink of something. I think everybody is just waiting to see what's going to happen next."

Why are top U.S. healthcare institutions investing in overseas healthcare delivery and education?

Summary

Top U.S. healthcare institutions are investing time, money, and resources in hospitals and other healthcare institutions located in Saudi Arabia, the United Arab Emirates, India, and elsewhere. Is the U.S. healthcare market maxed out?

It may be comforting for U.S. citizens traveling abroad to see that green Starbucks Coffee shop sign, or even those tell-tale golden arches. But travelers in places like Mumbai, India; Abu Dhabi, United Arab Emirates; or Singapore, may also see some insignias from highly respected U.S. academic healthcare institutions. Names like Harvard, Johns Hopkins, and Cleveland Clinic now grace the façades of hospitals and other healthcare institutions abroad. And more notable imprimaturs may follow, as this trend continues.

Global beginnings

Harvard University (Boston, MA, USA) may well have set the stage several years ago for the advent of overseas healthcare affiliations for major academic medical centers, which can involve assistance in training healthcare professionals, developing plans for performance improvements, and beyond. Although not a medical center, Harvard Medical School has long-standing teaching affiliations with 18 healthcare institutions in the United States, such as Brigham and Women's Hospital, and Massachusetts General Hospital (Boston, MA, USA). Andrew A. Jeon, M.D., M.B.A., president and chief executive officer, Partners Harvard Medical International (PHMI), said that Harvard Medical International was formed in the early 1990s in response to a number of requests for international collaboration. "Dan Tosteson, the dean of Harvard Medical School at the time, really anticipated the globalization of medicine and healthcare, long before a lot of other people," explained Jeon. "He felt that Harvard could be out there in extending its mission of the pursuit of excellence in medical education, healthcare delivery, and research, internationally."

"Very few places that I'm aware of are ready to hang their hospital brand internationally."

Johns Hopkins Medicine International (JHI, Baltimore, MD, USA) was also getting calls for assistance, from both governments and private entities. "It was 1999 when we started our first partnership with Singapore," recalls Harris Benny, chief executive officer of JHI. "We came in and started a small oncology unit," he says, which is now a 30-bed unit. The project also involves educational work and cancer research.

Today Johns Hopkins has three management agreements with hospitals in the United Arab Emirates, and another most recently established in Panama. In addition, they have affiliations with places like Anadolu Medical Center, Turkey; and Clemenceau Medical Center, Beirut. They also have numerous strategic partnerships with less emphasis on branding.

Vetting international partners

In the beginning, Jeon said the challenge was vetting those early institutions and "ensuring that those potential partners who came to us had missions consistent with those we espouse at the medical school and the affiliated hospital community here."

Jeon said they got better at this over time. For example, "if a group of businessmen [came to us] and didn't think they really needed physicians and nurses and other allied health professionals on the team that would interact with us, we knew it was unlikely that that program would have a very high chance of success."

"We spend a lot of time on this," says Benny of partner vetting. "It's not uncommon for us to spend up to a year discussing things and working with a potential partner before we sign an agreement." Much of the energy is spent on determining the needs of the client. "Then we talk about whether Johns Hopkins is the partner to best help them accomplish their goals," which aren't always aligned. "Part of our strategy is that we want to help improve the infrastructure by working with someone in the country, and that may be one of the differences that sets us apart from other institutions," says Benny. "We pay a lot of attention to the legal

AMA issues guidelines on medical tourism

The American Medical Association (AMA) released its first set of guidelines on medical tourism in June 2008. AMA said its guidance is meant to "outline steps for care abroad for consideration by patients, employers, insurers and third-parties responsible for coordinating travel outside of the United States."

However generic, and perhaps reactionary, the nine tips in these guidelines may seem, they are arguably more significant in that AMA acknowledges this trend in healthcare—a trend that has evolved from elective cosmetic surgeries or alternative medicine seekers, to uninsured or underinsured patients who travel outside the United States for cardiac care or orthopedic procedures they can't otherwise afford, to health plans looking abroad for lower costs of care for members.

"Medical tourism is a small but growing trend among American patients, and it's unclear at this time whether the risks outweigh the benefits," said AMA Board Member J. James Rohack, M.D., in a press release. "Since this is uncharted waters, it is our hope that the AMA's new guidance on medical tourism will benefit patients considering traveling abroad for healthcare."

The following tips were issued by AMA:

- *Obtaining medical care outside of the United States must be voluntary.*
- *Financial incentives to travel outside the United States for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.*
- *Patients should be referred for medical care only to those institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International, the International Society for Quality in Health Care).*
- *Prior to traveling, local follow-up care should be coordinated, and financing should be arranged to ensure continuity of care upon the patient's return.*
- *Coverage for travel outside the United States for medical care must include*

and regulatory environment, and our internal deliverables and internal resources."

Benny stresses that Johns Hopkins is not interested in developing an international care business model. "Johns Hopkins is not in the business of partnering with organizations whose main goal is attracting patients from outside of their country," he states. It has become a lucrative model for many facilities, most notably Bumrungrad International, a 554-bed, resort-like facility in Bangkok, Thailand that treated 450,000 international patients in 2008, 40% of the hospital's total patient population (they are not a Johns Hopkins affiliate). Still, Benny says facilities in places like Anadolu (Turkey) do have a high number of international patients. "We started with them very early on, even working on the design of the hospital, and working on the staffing. We had people come from Anadolu to Hopkins for a three-month period to absorb the culture."

In Harvard's case, in addition to ensuring that missions are aligned, Jeon says the partnering entity has to have the financial resources to adequately support its goals. "If someone comes to us from Nepal, we need to ask: 'What are the resources you have to do this? What are you allocating on the capital budget?' If they tell us $5 million for the capital budget, that's an immediate red flag that we're dealing with folks who are naïve at best, and the project would not have a very good chance of success."

Jeon said that early on, "we were very sensitive … that neither the Harvard name, nor the Partners Harvard Medical International name, can be used for the purposes of fundraising."

Evolution of the business

Ultimately, "as our clients became larger and more sophisticated, like the Wockhardts and the Dubai Healthcare Cities of the world, more of our work became what could be described as strategic healthcare consulting," Jeon explained.

Essentially, two service lines developed in Harvard's overseas ventures: one that focuses on medical education, and one with an eye to healthcare delivery systems. The growth of the latter ultimately resulted in an agreement to transition the oversight of Harvard Medical International to Partners HealthCare, a Boston-based healthcare delivery system, in April 2008.

Harvard's affiliation with Wockhardt Hospitals (Mumbai, India) is one example of the services it provides to overseas healthcare delivery systems. In 2003, Harvard assisted the newly opened facility in Mumbai to develop a performance improvement plan. The heart institute received Joint Commission International accreditation in 2005.

"Each agreement is unique," Jeon says. But overall, "our partnerships are multi-year in duration, whether it's a 2- to 3-year contract, or an 18-year contract with some of our partners." He adds that PHMI is distinguished from other academic centers in its capacity to train staff. "We have the capabilities to train the human resources, the people who will populate the very institutions that we help our partners build, whether that is a medical school or a teaching facility." In the case of Wockhardt, Jeon said they provided training opportunities to physicians and nurses. "Nurses from India would come to Boston, and Boston nurses would go to India," and Jeon says this model is replicated in many of their programs.

Chris J. Railey, director of communications and marketing, PHMI, stressed that PHMI's relationships abroad are "arrangements to provide services" and that "neither Harvard nor PHMI … are responsible for providing patient care."

Benny says their 5- and 10-year agreements entail a framework to groom leaders. "You'll see this in our relationships with the United Arab Emirates, in Trinidad, in Anadolu, Turkey … it is important within this 5- to 10-year framework that we help develop leaders in that country to take on management roles at the hospital, both administrative and clinical, to ensure successful transition of management of a facility to a local government, a local party, within a certain timeframe."

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Globalization of healthcare
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Boucher says that most of these hospitals are private hospitals, and the number of native patients varies. Facilities like Anadolu Medical Center, a modern, 209-bed Johns Hopkins affiliate near Istanbul, Turkey, are seeing a spike in the number of international patients. "Turkish patients probably make up 80% of their patients," said Boucher, who adds that Anadolu treats Canadians, Americans, Germans and others. "Bumrungrad International treated well over 450,000 international patients in 2008," notes Boucher. The remaining 60% of their patients are native to Thailand.

As savvy as these international hospitals are in treating traveling patients, it's only a part of the continuum of care, according to Kimberly Smith, director of development research, Assurant Health (Milwaukee, WI, USA). Smith told MTA meeting attendees that from an insurer's perspective, the continuum of care should begin "the initial moment one of our members says, 'I need to have my hip replaced and it's going to cost X amount here, and I can have it done in a number of other places around the world for a number of prices.'" Smith stressed that the continuum of care involves "the decision making, the actual commitment, the treatment, and the local coordination of care when they return to the states," which could take several months. "We need to focus on the continuum of care, not pieces or little episodes of care." However, Smith said, "at the end of the day, it's the consumer who will make the quality assessment." ▶

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Global expansion

It's evident that international partnerships are on the rise, given the recent news that University of Pittsburgh Medical Center (Pittsburgh, PA, USA) has penned a deal with GE Healthcare (Chalfont St. Giles, UK) involving plans to open at least 25 cancer clinics in Europe and the Middle East. And Cleveland Clinic has recently broken ground in Abu Dhabi, United Arab Emirates, on a state-of-the art facility targeted for completion in 2011, in conjunction with its partner Mubadala Healthcare.

Jeon considers why such international partnerships are gaining momentum. "I think academic medical centers are in the international arena for a number of reasons," he observed. "One is common to all. We're all educators, so [the goal is] to extend the missions of the organizations internationally, whether post-graduate education, continuing education, or professional development. I'd like to say everyone has that altruistic mission."

Johns Hopkins also began with the mission of providing clinical care, research, and education globally, says Benny. "At Hopkins, a large part of what we do incorporates the school of public health and nursing, and to some extent the school of business, so it's really a group of medical institutions coming together." Benny points to projects in the United Arab Emirates that include "smoking cessation, diabetes, road traffic accidents... these are public health issues and they affect the entire country."

Extending the mission pays, too. "There's a very real business aspect to this," notes Jeon. "What [else] are academic and medical centers going to do? They're king of the hill in their respective cities, the markets are essentially saturated, there's going to be increased constraints at containing costs, so where or how else are they going to expand?" he reasons. "There's only one logical answer to my mind, and that's internationally."

"There's no doubt that there are many more academic medical centers in the United States that are interested in pursuing international work," Benny observes. However, "I also have been seeing a higher level of [global] interest to utilize the services of American academic medical centers, so both of these are trends," he adds.

Still, Jeon notes some conservatism in this market. "Very few places that I'm aware of are ready to hang their hospital brand internationally," he observes. "Some have been more aggressive than others." In fact, "some have been successful, others have not. We have taken an extremely conservative approach to date, but it is something we're all watching very carefully." ▶

the costs of necessary follow-up care upon return to the United States.

- *Patients should be informed of their rights and legal recourse before agreeing to travel outside the United States for medical care.*
- *Access to physician licensing and outcomes data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the United States.*
- *The transfer of patient medical records to and from facilities outside the United States should be consistent with Health Insurance Portability and Accountability Act guidelines.*
- *Patients choosing to travel outside the United States for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.*