American Surgical Emigration is a Treatable Symptom

Global Travel by Americans Seeking Better Surgical Value Will Grow; Better Coordinated Value Purchasing by the Federal Government, Large Employers and Health Insurers Would Improve Health Industry Performance and Reverse the Flow

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Catalyzed by multiple media reports, several innovative large American employers asked me to assess the feasibility of using technologically advanced hospitals in lower wage countries to provide non-urgent major surgeries for their self-insured health benefits plans serving U.S. residents. They intend to add them to their U.S. hospital networks and use positive economic incentives to reward employees and dependents who use them.

Large Employers Are Pursuing This Option for Three Reasons

Lower Cost: The typical combined facility and physician charges per surgery in these hospitals are 60-85% lower than insurer-negotiated charges in U.S. hospitals (see Exhibit A). For example, an elective coronary artery bypass graft surgery typically cost insurers in California about $60,000 in 2005; a 60-85% cost reduction would easily (1) offset travel and first class hotel costs for a patient and accompanying family member, (2) fund a sizeable economic incentive for the patient to select this option, and (3) generate large residual savings for the sponsoring employer.

Trusted Quality of Care Accreditation: Over the several past years, a substantial number of offshore hospitals have obtained quality of care accreditation from one or both of two trusted accreditation organizations. Accredited ISO (International Standards Organization) certification bodies certify hospital quality control procedures. ISO certification serves as an internationally respected designation of supplier excellence in quality control for large American employers in many facets of procurement. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits most U.S. hospitals for participation in the Medicare program. It has also accredited 88 non-U.S. hospitals via its Joint Commission International (JCI) affiliate. In addition, at many of these ISO-certified and JCI-accredited hospitals, it is possible to select a surgeon and other physicians who trained at a U.S., UK and/or Canadian academic health center

and obtained board certification in the U.S. or other advanced Western health care system (see Exhibit B). Since the U.S. and most other countries do not yet require hospitals to measure and report outcomes or use internationally comparable measurement systems, more nuanced quality comparisons of our hospitals with advanced non-U.S. hospitals are not possible. However the low gross mortality rates reported in Exhibit B suggest that our outcomes advantage in this common, complex surgery may be negligible.

Fiduciary Responsibility: As health benefit plan fiduciaries for their enrollees, American human resource executives feel an obligation to pursue any solution that would dually benefit both employer and employee. This fiduciary obligation is felt especially strongly by employers with substantial numbers of lower and lower-middle income workers who can least afford to pay more for health care or health insurance. They have front row seats in observing the "upward" spread of unaffordable U.S. health care delivery; the fastest percentage point rise in uninsurance among working adults is in the *middle quintiles* of American household incomes (see Exhibit C). In some low wage industries, more than 75% of workers decline health benefits coverage. Their reluctance is not surprising: in 2006, the average health spending for a working family of four exceeded the entire annual earnings of a minimum wage worker.

Symptom or Solution?

The emigration of Americans for non-emergency surgical care is a symptom, not a solution. The emotional benefit of close access to familiar physicians, friends and family will remain important for major surgeries. In addition, many other countries do not offer consumers meaningful redress for health care negligence.

However real health care spending continues to outgrow real GDP by 2.5 percentage points annually. Since wealthier Americans have not been willing to pay enough more in taxes or income-adjusted health insurance premiums to make access to health care universal, non-wealthy Americans and their employers are actively searching for more affordable solutions. Their interests would be far better served by a U.S. health care system that aggressively and perpetually reengineered its processes to deliver an internationally distinguished level of quality at a much lower cost. In their joint fall 2005 report, the National Academy of Engineering and the Institute of Medicine estimated that 30-40% of current U.S. health care spending is attributable to insufficiently engineered processes of care delivery.

However until America's major public and private payers better collaborate in creating a *profoundly* more performance-sensitive environment around American physicians and hospitals, well-engineered care delivery will remain conceptual and our hospitals will continue to fall short in international value benchmarking. And more uninsured, underinsured and insured non-wealthy Americans will board international flights to obtain lower cost surgery at levels of quality that cannot be distinguished from American hospitals.

Creating a Profoundly Performance-Sensitive Environment Around American Hospitals and Physicians via Payer Collaboration

As I testified last month at a hearing of the Joint Economic Committee, the most important first collaborative step in creating a more performance-sensitive domestic health care environment is *Medicare claims data release*: access in beneficiary-anonymized format to the physician-identifiable full Medicare claims data base. It would rapidly enable American consumers and purchasers to identify readily and better reward physicians who excel in quality and efficient health care resource use. This, in turn, would send a constructive new message throughout America's entire health care supply chain, including to investors in new biomedical and health care information technology: *improvements in both quality and affordability will be rewarded best.*

Close behind in importance is *expanded performance transparency*: rapid expansion of publicly-reported standardized measures of quality and average total cost of care per episode of acute illness (and per 24 months of chronic illness) for every hospital, physician organization and individual physician in the U.S. A top priority should be public reporting of "NSQIP" (National Surgical Quality Improvement Program), the surgical outcome measures developed by the Veterans Health Administration (VHA). It was used by the VHA to drive outstanding reductions in surgical mortality for U.S. veterans. The American College of Surgeons now makes it available to all hospitals; but absent encouragement by public and private U.S. payers, few non-VHA hospitals participate. Full performance transparency is the fuel for public and private payers' two engines of performance-sensitivity: pay-for-performance and performance-tiered provider networks.

Even in advance of such strategic public and private collaboration, a few visionary American physicians and hospitals, such as the Virginia Mason health system in Seattle, are moving forward to delivery performance breakthroughs. They are demonstrating through comprehensive application of classic industrial engineering methods that "better, faster *and* leaner" can indeed apply to American health care delivery.

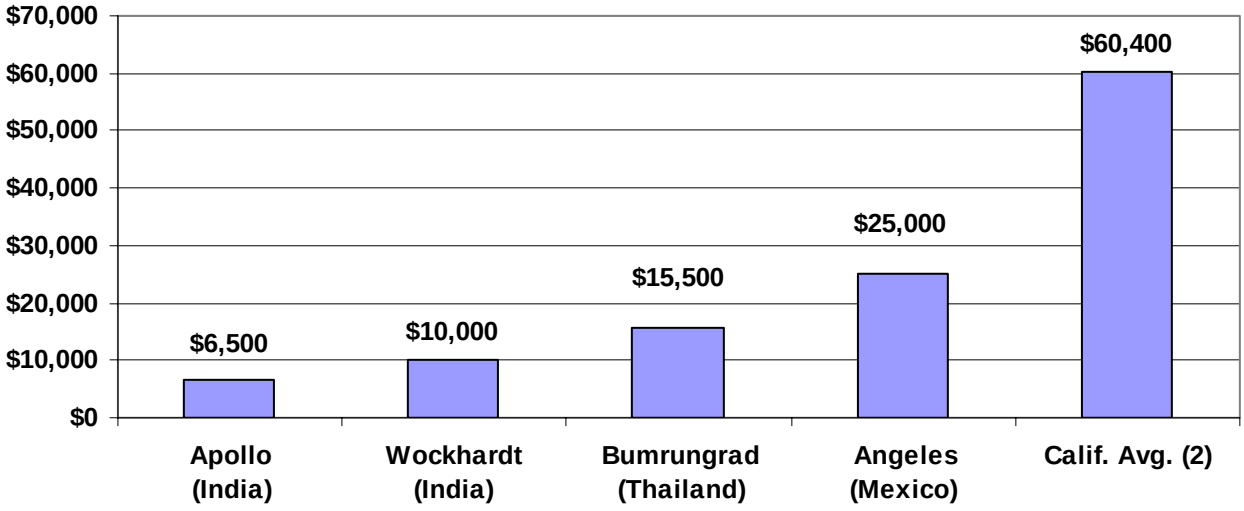
Advances in telemedicine will diminish the importance of a common physical location in health care delivery and eventually enable U.S. clinical teams to treat increasing numbers of non-U.S. patients in their home countries. By creating a highly performance-sensitive environment around our domestic health industry now, we can staunch, and eventually reverse, the flow of American's traveling abroad to find more affordable care.

The obvious proximate root causes of American hospitals' loss of domestic market share are lower wages in less developed countries and discriminatory pricing policies by drug, device and equipment manufacturers. One step upstream in the causal chain is insufficient collaboration by America's public and private payers to shape a U.S. health care industry that delivers world-class value through superior process engineering.

EXHIBIT A

Comparison of Hospital-Reported Combined Average Expected Facility and Professional Fees in 2005 for Elective Coronary Artery Bypass Graft Surgery[(1)]

These four advanced hospitals in low wage countries are among those that have attained either Joint Commission International accreditation and/or ISO quality certification



(1) Data gathering was enabled by a grant from the California HealthCare Foundation

(2) Average allowable charges reported by a large PPO insurer and adjusted to exclude emergency surgeries

EXHIBIT B

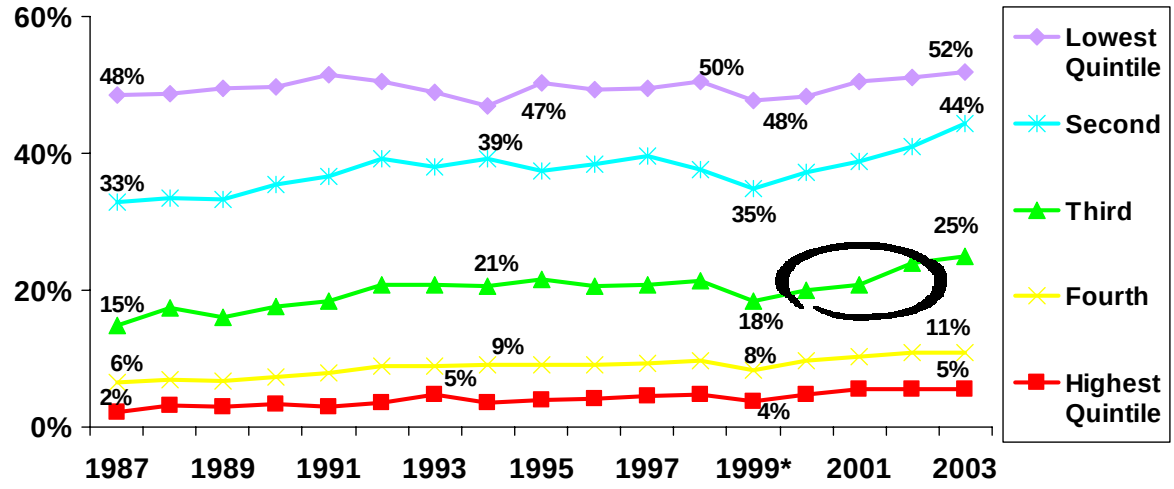
Hospital-Reported Status on Familiar Quality Standards for Elective Coronary Artery Bypass Graft (CABG) Surgery(1)

Meet Standards for Hospitals <u>and</u> Surgeons				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Apollo	India	Chennai	JCI accredited; and ISO 9000 and IS0 9002 certified	Fellowships at Cleveland Clinic, Univ. Wisconsin-Milwaukee & Brigham and Women's Hospital; CABG mortality rate <1%.
Bumrungrad	Thailand	Bangkok	JCI accredited	Half of cardiac surgeons are U.S. board certified
Wockhardt	India	Mumbai	JCI accredited	Residency/fellowships at Harvard and Lahey Clinic; CABG mortality rate <1%.
Meet Standards for Hospitals <u>or</u> Surgeons				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Angeles	Mexico	Mexico City	ISO 9001 certified	Cardiac surgeons board certified in Mexico
California High Volume Hospital Average				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Multiple	U.S.	Multiple Calif. Cities	All JACHO accredited. None are ISO certified.	Most high volume CABG surgeons are U.S. board certified

(1) Data gathering was enabled by a grant from the California HealthCare Foundation

EXHIBIT C

Percent of working adults *uninsured*, by household income quintile 1987–2003



* In 1999, CPS added a follow-up verification question for health coverage.
Source: Analysis of the March 1988–2004 Current Population Surveys by Danielle Ferry, Columbia University, for The Commonwealth Fund.

Adapted from "A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency," compiled by A. Gauthler and M. Serber, The Commonwealth Fund, October 2005.