1 Problem

In recent years, efforts to keep costs down have begun to push some facets of health care overseas. What began as the outsourcing of relatively benign tasks—like medical coding and dictation transcription—has expanded to include more cognitively complex tasks like radiological interpretation and even open-heart surgery.

Given the high cost and limited availability of health care in the United States, it makes sense to pursue measures that will reduce the impact of these problems. Teleradiology implementations have been successful in increasing the turnaround time for radiograph interpretation, saving hospitals money and taking the pressure off the limited supply of American radiologists[13]. Some uninsured Americans, drawn by the low prices abroad, have flown to places like New Delhi to receive surgical procedures for one tenth of the price back home[4]. Due to an insufficient supply of local, qualified medical transcriptionists, this field has been moving offshore for years. In fact, a recent estimate suggested that as much as ten percent of U.S. medical transcription is done abroad[1].

The benefits of moving some aspects of medical care to countries with lower labor costs seem clear. If the health care industry could streamline their operations by tapping the personnel resources of a country like India, an enormous amount of money could be saved and health care made much more affordable.

However, with the promise of an efficient global market for health services comes a host of problems. First, one reason medical care is so affordable in India stems from its liability-limiting malpractice laws. In cases where a physician’s overt negligence results in a poor outcome, there is little a patient can do. Second, patient privacy is a great concern since, for work to be done overseas, extremely personal health information
must be transmitted thousands of miles away to locations with unknown data security policies. This issue is compounded by the fact that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which enforces certain procedures and precautions when working with patient data, doesn’t apply outside of the United States’ borders[15]. Third, while offshore surgicenters often strive to maintain the same level of care as their national counterparts, there have been reports that easily avoidable mistakes are occurring at some offshore facilities[9][2]. Thus, any money saved by having a procedure done abroad will be spent anyway, treating infections and fixing other mistakes in a domestic hospital. Finally, there will be extremely undesirable consequences if, in an attempt to streamline medical care, implementers of outsourcing solutions make local health care economically unsustainable. Not everything can be digitized and sent overseas—there will always be a need for bedside physicians and local hospitals. Sending work offshore has the potential to force local hospitals to shut down, causing irreparable harm to small communities[12].

2 Evidence

The problems and challenges associated with the outsourcing of medical care are not theoretical. Examination of issues related to discrepancies in patient care, privacy, and offshore liability have been addressed in both the literature and the popular press.

Gone are the days when the intimate details of one’s health history existed in a physical file at one’s doctor’s office. With the advent of electronic health records, this information exists in various forms in databases around the world. To prevent unauthorized data-mining, insurance company access, or even direct marketing campaigns, the government put in place a set of laws—HIPAA—to protect the privacy of one’s Protected Health Information (PHI). Noncompliance with these laws can result in fines or even a criminal investigation, so it is in a hospital’s (or covered entities in HIPAA parlance) best interest to keep patient health information private.

HIPAA permits the forwarding of PHI to “business associates” (e.g., lawyers, coders, software vendors, medical transcriptionists, etc.) without patient consent. Contracts specifying the handling of any PHI must be in place to enable these companies to act as business associates. Of course, since HIPAA is a U.S. law, its jurisdiction is limited to the United States. Offshore companies acting as HIPAA business associates have no legal obligation to maintain the privacy of digitized medical dictations, radiographs, or other information. Without the possibility of legal recourse, the contracts with offshore companies “lack teeth”. Thus, the possibility of information misuse or even extortion is very real.
One such mishandling of PHI occurred in 2003 when a Pakistani transcriptionist, doing offshore work for the University of California, San Francisco Medical Center, threatened to post confidential medical files to the Internet if her wage was not paid. UCSF (and its patients) were at that time completely unaware that their patients’ information was in Pakistan. Having outsourced it locally to a Sausalito firm, they had no idea that it had been subsequently re-outsourced to Florida, then to Texas, then finally to Pakistan. When Lubna Baloch, the Pakistani transcriptionist, was paid, she retracted the threat[5].

A similar incident occurred a few weeks later when an Ohio medical transcription firm received threats from India that patient information would be divulged. These employees were apprehended before they could carry out their threat[6].

Outsourcing of medical care is a relatively new phenomenon and is not adequately addressed in U.S. law. Former state senator Liz Figueroa, author of the comprehensive California Confidentiality of Medical Information Act of 1999, articulates the situation: “We thought we had taken care of everything having to do with medical privacy information. We didn’t foresee the problem with outsourcing. Now we have to start all over again”[15].

Outsourcing in the health care industry is not limited to clerical work. Radiology is a relatively unique field in that it is not essential for the physician and patient to be in the same place at the same time. The asynchronousness afforded by this specialty combined with the recent shift from film to digital radiographs have made Radiology a prime candidate for outsourcing. In fact, domestic teleradiology, radiology that has been outsourced to another U.S. radiologist, has been going on for years and has fairly straightforward legal ramifications. Since the radiology consultant is operating within the borders of the United States, any violation will fall under state law. Radiology service can also be outsourced offshore where they typically follow either the “Nighthawk” or “Indian” model. The Nighthawk model of offshore teleradiology isn’t such a far cry from the domestic model. The radiologists are U.S. board certified and work for U.S. companies. They work out of Spain and Australia not because their labor is cheaper (it isn’t) but rather to exploit the time zone difference. These Nighthawks can read films at 10 A.M. Sydney time while their domestic counterparts sleep. Using this system, U.S. hospitals can achieve 24/7 radiological “uptime” while reducing on-call time for its staff.

Things become complicated, however, when the offshore radiologists are not licensed to practice medicine in the United States, as is the case in the Indian model. These physicians receive a fraction of the pay, enabling their companies to charge much lower prices for their services. This raises two issues. First, the livelihood of U.S. board certified physicians is in jeopardy. After all, as one U.S. radiologist lamented, “Who needs to pay
us $350,000 a year if they can get a cheap Indian radiologist for $25,000 a year?"[13] Second, because these
Indian model radiologists are not licensed to practice U.S. medicine, they are considered medical lay-people
and, thus, shielded from any malpractice suits. This places the liability either with the treating physician
(who may not even know his patient’s film is being read overseas) or with the hospital (which presumably
enacted the outsourcing venture to save money, not open itself up to more litigation)[7].

Clearly, hospitals must be thorough in their research of the legal implications of sending work overseas.
They must also be up front about their outsourcing policies to prevent any legal surprises in the event of a
mistake. Mistakes do happen, and while there is no clear evidence that outsourced medical procedures are
inherently less safe, there have been reported concerns about the quality of work done at offshore facilities.

In the Spring of 2004, the Centers for Disease Control was informed of a mycobacteria outbreak in patients
who had undergone elective cosmetic surgeries outside the United States. Twelve women between the ages of
19 and 59, having undergone abdominoplasties, liposuctions, or mastopexies in the Dominican Republic, were
admitted to U.S. hospitals with abdominal pain and purulent drainage[9][2]. The patients recovered after
being put on antibiotics, but having such a rare infection can be both dangerous and frightening. Whether
the infections, many of which were traced to the same hospital, were caused by non-sterile instruments or
contaminated water remains to be seen. The fact remains, however, that surgeries performed in an unfamiliar
environment can cause unexpected or exacerbated negative outcomes.

However, not all forms of medical outsourcing are riddled with privacy and safety issues. Sometimes the
financial benefits of moving medical care offshore far outweigh the potential for harm. For Wayne Steinard,
a contractor in his fifties, this was certainly the case. Lacking private health insurance, but not qualifying for
Medicaid, he had few options when he learned he would need to pay $60,000 to have an arterial stent installed.
Instead, he travelled to New Dehli, to have the operation performed. A double bypass was performed (the
artery turned out to be 90% occluded), but the bill still only came to $6,650[4].

Companies, too, are looking offshore to help lighten the load of health care costs. North Carolina’s
Blue Ridge Paper Products is looking at reduced margins stemming from, of all things, global competition.
Blue Ridge’s health benefits manager is exploring a novel, solution to the company’s financial woes: moving
employees’ medical care to India. Of course, having procedures done across the globe will by no means be
mandatory in this proposed plan. Rather, it will be incentivized by splitting the savings—up to $10,000—
with the employee. The flight, hospital, and hotel stay for both the patient and a guest would be covered
by the plan.
3 Viewpoints

Dr. Arnold Milstein, chief physician at Mercer Health and Benefits, a human resources firm, sees offshore surgical care as a win for both patients and employers. First, regarding the purported differences in quality of care: Milstein points to the fact that 80 non-U.S. hospitals abroad, the type of which an American would likely visit, are accredited by JCI. This is the international affiliate of the Joint Commission on Accreditation of Healthcare Organizations, the group responsible for accrediting U.S. hospitals for Medicare. Also, he notes that many of the hospitals employ physicians trained in the United States. There aren’t any hard numbers—in the U.S. or abroad—that could be used to compare surgical outcomes in either locale, but Dr. Milstein doubts the differences are significant. Interestingly, he has actually found patients more pleased with the care they received abroad than at local hospitals. In summary, Dr. Milstein sees great opportunities for patients having surgeries done offshore. With health care so expensive in the U.S., it is only logical to seek out less expensive options. He hopes that offshore care will not become the standard, but rather drive health care providers back home to be more efficient[8].

Dr. Robert Wachter, a physician and professor at UCSF, sees the shift into a more globalized health care system as a good thing. He reasons that by increasing competition in the medical marketplace, local providers will be forced to streamline their processes, thereby eliminating some wasteful spending. Also, assuming the quality of care is comparable, he sees the lower prices offered at offshore clinics as a way for patients with expensive copays to get medical treatment without suffering financially. However, Dr. Wachter does anticipate some problems with medicine practiced in this remote, somewhat anonymous way. Lacking the ability to speak to one’s doctor, face to face, makes it more difficult to “[distinguish] competent providers from hucksters”[12]. He is also wary of the ramifications of being treated by a physician who ascribes to a different system of values. In the United States, we value patient autonomy above all else. This is not the case in other cultures, leaving the door open for miscommunication or faulty assumptions. In the end, Dr. Wachter sees a benefit that reaches beyond financial efficiency and other technical outcomes. The best way for local physicians to compete is to develop what he calls the “low-tech” practices of medicine: empathy, compassion, personalized followup, etc. After all, a radiologist who never leaves his office to discuss a patient with another physician may as well be living in India. A patient who does not feel she has established a relationship with her doctor might be more influenced by the price differences abroad. “Competition,” he writes, “may make [physicians] more responsible to the needs of our patients and colleagues, even as it extracts waste from the system”[12].
4 Stakeholders

Outsourcing of medical care influences so many stakeholders, it’s hard to know where to begin. Certainly patients are affected, particularly those in low to medium-range income households. These groups are less likely to have comprehensive health insurance coverage and are thus more likely to benefit from inexpensive procedures performed abroad. For the uninsured, the ability to get a lifesaving procedure for one tenth the price is definitely a positive. Regarding quality of care, the performance of offshore providers has, for obvious reasons, a greater impact on the patients that on any of the other stakeholders. If anything goes wrong, the patient will clearly suffer the most. Adding insult to injury, in cases where a mistake was the result of gross negligence, a patient has little legal recourse available. This is, in fact, one of the reasons health care is so cheap in developing nations. In the end, as long as patients are given a choice about their health care options in India or Thailand—that is, their insurance policy does not require them to travel abroad—patients will benefit from increased health care options. The benefit will be even greater if, like the employees at Blue Ridge, they have the opportunity to share the savings with their employer.

A great deal of U.S. companies are self-insured and the rising cost of health care is hurting their bottom line. By adopting insurance plans that would cover comparatively inexpensive procedures performed at foreign hospitals, these companies could simultaneously protect the health of their workers and save a substantial amount of money. So long as the quality of care is the same, there doesn’t seem to be a downside to medical outsourcing from an employer’s point of view.

Hospitals are under constant pressure in the areas of both finance and time. Outsourcing the reading of radiographic films can solve both of these problems. Sending work to a firm in India or Australia can be cheaper than keeping an extra person on staff or on call. Using a teleradiology solution also enables 24/7 access to radiological expertise, improving patient care for those who are injured or sick after normal business hours. However, the outsourcing of surgical procedures is likely to hurt hospitals financially. Increased global competition, while good for the consumer, will make things difficult for American hospitals.

Physicians, particularly those with little patient “face time”, are also affected by medical outsourcing. Nighthawk radiology operations have proven effective in hospitals requiring their services at night. It is not a giant leap to think these offshore services could be used during daytime hours as well. The economies of scale for the Nighthawk model and the larger talent pool for the Indian model of teleradiology mean that expert advice can be had for less than the salary of a staffed radiologist. At the same time, these doctors are currently spared a good deal of the on-call night and weekend work that used to be more common. Whether this is a blessing or a curse remains to be seen.
Domestic clerical workers in the medical field are at an even greater risk for having their jobs outsourced. Their jobs are more clearly defined than those of physicians and require less high-level thinking or training. Unless the government enacts privacy laws to keep patient information within our borders, this work will continue to move overseas.

5 Opinion

Expensive, non-elective medical procedures are starting to move beyond the financial means of many Americans. With some estimates suggesting that 15% of our citizens are uninsured[11] and the recent statistic showing the average health care expenditures for a family exceed an year’s earnings at minimum wage[8], it is no surprise that many patients are taking their chances abroad. If the care given at these remote facilities is indeed comparable to that of American hospitals, enabling or encouraging our citizens to get treatment abroad may temporarily ameliorate our current health care crisis. However, requiring our poorer fellow citizens to travel to India for procedures should not be a long-term goal for our country. Rather, the offshoring of care should act as an impetus to streamline operations here at home. It is thought that between 30 and 40% of money spent in the U.S. on health is wasted on services that do not help the patient at all[8]. Reducing the inefficiencies and redundancies in our current system will decrease the cost of care and increase the availability of affordable insurance plans, enabling more Americans get the care they need here at home. Additionally, if global competition drives the price of local care down, the possibility of a universal health care plan will be made more real.

References


