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Lilac Nachum

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Healthcare: An Industry Unlike Any Other Goes Global¹

Professor Lilac Nachum²

The Globalization of Healthcare

The healthcare (HC) industry³ has been transformed in recent years from what was traditionally an entirely domestic industry into one that has now become a global industry increasingly defined by market-oriented principles. Against the forces that have driven the globalization of the industry others are arrayed that have resisted globalization and anchored the industry in national systems of HC delivery and consumption. This interplay between the global and the local is emerging as a predominant feature of the industry that is shaping its contemporary dynamics and will likely have significant consequences in the years to come. In this paper, I seek to explicate this development and examine the opportunities and challenges that it holds for New York City healthcare providers and the policymakers who oversee the industry.

Healthcare: An Industry Unlike Any Other

The HC industry is distinctive in at least three ways. For one, in contrast to most other industries in which the ultimate goal of firms is profit-maximization, it is not clear what HC providers maximize. As an industry whose value creation lies in extending lives and enhancing their quality, there is a strong moral dimension attached to value creation, producing a delicate balance between this imperative and the different and often conflicting demands of economic performance and survival. The vague notion of what is to be maximized challenges the development of performance measurement and creates scope for different points of view as to the appropriate indicators that should be used.

Further, the industry is characterized by distinctive structural issues. The consumers - patients with symptoms - are typically ignorant about the cause of their symptoms and the treatment for relieving them; the suppliers – HC professionals, in affiliation with HC institutions or on their own, who diagnose the cause of the symptom, prescribe the treatment and may implement it - are usually not paid by the consumers. Typically, market transactions involve one and often more intermediaries who administer the payment. These intermediaries themselves vary in terms of their goals, agency and power in shaping the engagement between the HC provider and the patient receiving treatment.

¹ This Occasional Paper is derived from a course on the globalization of healthcare developed and taught by Professor Nachum as part of Baruch College MBA program for Healthcare professionals.

² Lilac Nachum is a professor of international business at Baruch College. She specializes in the study of globalization and multinational companies, topics she has been researching, teaching and consulting for three decades. In conjunction with her position at Baruch College, Nachum has held visiting positions at business schools around the world, and consulted with firms and governments, including most recently Japan's Deloitte Tohmatsu and the President of the UAE. She was the co-founder and the Director of the Center for the Study of Russian Multinational Firms at St. Petersburg State University.

³ The health care industry is defined broadly to include health care professionals (doctors, nurses etc.), healthcare institutions (hospitals etc.), pharmaceutical companies, and producers and suppliers of equipment for healthcare.

Lastly, the HC industry stands out in terms of the demand for its output. Given the complex structure of the industry, identifying the actual source of demand is a challenge as it includes the patient, the doctor who prescribes the treatment and may implement it, and the payer for the service. Demand is often inelastic (what is the monetary value of life?), and is prone to information asymmetries of numerous kinds that influence the transactions and place much power in the hands of the intermediaries who pay for the service.

The distinctive attributes of the HC industry assume additional complexity as the industry globalizes. The ambiguity regarding the ultimate goal of HC, and the subsequent difficulty of devising adequate performance measures, are magnified by country-specific philosophies of life and mortality and varying perceptions regarding universal access. The United Nations (UN) Universal Declaration of Human Rights has long declared access to HC a basic human right: *'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care'*.⁴ Although more than half a century old, this assertion has not been adopted in a comprehensive way. Variations in moral philosophy surrounding HC and the extent to which it is seen to be a universal right, introduce stark differences in the HC industry across countries. These variations are reinforced by varying views of human ability to influence life quality and longevity versus those of faith and religion, including different perceptions of the value of life itself.

These philosophical and cultural differences bring about varying views as to who should be responsible for healthcare provision and who should pay for it. The UN International Covenant on Economic, Social and Cultural Rights assigned the responsibility for the provision of HC to national governments: *'[every nation is responsible for] 'the creation of conditions which would assure, to all, medical service and medical attention in the event of sickness'*.⁵ But this obligation has not been universally practiced. Country-specific approaches vary in terms of the ultimate provider and payer for HC, whether private or public, and in terms of access to HC services. These variations are accentuated by differences in the level of economic development and thus affect the availability of both services and their quality.

Country differences also express themselves in the nature of demand. Varying perceptions of HC versus healing by forces of faith and religion, coupled with different views of modern versus traditional medicine, often determine the level of demand for HC services and its nature. In addition, education levels influence information asymmetries between participants in the complicated transactions that define the industry. Lastly, differences in life style, diet, etc. affect the types of diseases prevalent across countries and their frequency.⁶ Table 1 presents selected indicators of supply and demand for HC across countries and demonstrate some of the variations outlined above (Table 1).

The Tension between the Global and the Local: Demand and Supply for Healthcare Services

The HC industry is distinctive in at least three ways. For one, in contrast to most other industries in which the ultimate goal of firms is profit-maximization, it is not clear what HC providers maximize. As an industry whose value creation lies in extending lives and enhancing their quality, there is a strong moral dimension attached to value creation, producing a delicate balance between this imperative and the different and often conflicting demands of economic performance and survival. The vague notion of what is to be maximized challenges the development of performance measurement and creates scope for different points of view as to the appropriate indicators that should be used.

⁴ Article 25, 1948

⁵ Article 12, 1966

⁶ Farmer et al., *Reimagining Global Healthcare: An Introduction*. 2013; Holtz C. (ed.), *Global Health Care: Issues and Policies*. 2017; Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*. 2010.

Table 1: Selected Healthcare Indicators by Country
Latest available, 2014-2016

	Demand Characteristics			Supply Characteristics					Performance		
	Per capita Health expenditure, \$ [% change last 5 years]		Out-of pocket	Total Health expenditure, %GDP			Skilled professionals, per 1,000 people		Life expectancy at birth, years		Maternal mortality
	US\$	PPP US\$	% total health expenditure	Total	Private	Public	Physicians	Nurses/midwives	Total	Healthy	per 100,000 live births

Emerging Markets

Brazil	947.4[0.03]	1318.2[0.13]	25.5	8.3	4.5	3.8	1.9	7.4	75	65.5	44
China	419.7[0.91]	730.5[0.62]	32.0	5.5	2.5	3.1	..	..	76.1	68.5	27
Ethiopia	26.6[0.27]	73.0[0.01]	32.3	4.9	2.0	2.9	..	..	64.8	56.1	353
India	75.0[0.27]	267.4[0.43]	62.4	4.7	3.3	1.4	0.7	2.0	68.3	59.5	174
Indonesia	99.4[0.16]	299.4[0.32]	46.9	2.8	1.8	1.1	..	..	69.1	62.2	126
Kenya	77.7[0.97]	169.0[0.71]	26.1	5.7	2.2	3.5	0.2	0.9	63.4	55.6	510
Mexico	677.2[0.14]	1122.0[0.15]	44.0	6.3	3.0	3.3	2.1	2.5	76.7	67.4	38
Nigeria	117.5[0.46]	216.9[0.25]	71.7	3.7	2.7	0.9	..	..	54.5	47.7	814
Russia	892.9[0.23]	1835.7[0.31]	45.8	7.1	3.4	3.7	3.3	4.6	70.5	63.3	25
Turkey	567.6[0.00]	1036.5[0.15]	17.8	5.4	1.2	4.2	1.7	2.5	75.8	66.2	16

Developed Countries

France	4959.0[0.08]	4508.1[0.12]	6.3	11.5	2.5	9.0	3.2	10.6	82.4	72.6	8
Germany	541[0.15]	5182.1[0.16]	13.2	11.3	2.6	8.7	4.1	13.5	81	71.3	6
Japan	3703.0 [-0.10]	3726.7[0.15]	13.9	10.2	1.7	8.6	..	..	83.7	74.9	5
Switzerland	9673.5[0.24]	6468.5[0.20]	26.8	11.7	4.0	7.7	4.1	17.8	83.4	73.1	5
UK	3934.8[0.13]	3376.9[0.03]	9.7	9.1	1.5	7.6	2.8	8.4	81.2	71.4	9
US	9402.5[0.14]	9402.5[0.14]	11.0	17.1	8.9	8.3	..	..	79.3	69.1	14

Global and Local Demand

A major development that has globalized demand for healthcare has come to be known as 'medical tourism', that is, the travel by patients for medical treatments to other countries. While this phenomenon has existed for decades and by some accounts centuries, until recently it was small and confined to wealthy people from developing countries traveling to Western countries for medical treatment. What is new is the recent emergence of medical tourism from developed countries to emerging markets (Figure 1), driven by the development of local HC institutions in emerging markets and improvement in the quality of their HC services. These institutions offer medical services for a fraction of the costs in developed countries (Figure 2) and minimal waiting time.⁷ Combining a low-cost labor force with efficient delivery, assisted by state-of-the-art technology, hospitals in emerging markets have managed to cut costs and shorten delivery time to levels unimaginable in the developed world.⁸ Accreditation by U.S. and global accreditation associations provides quality assurance for patients and payers, and removes major obstacles for the growth of medical tourism. By 2016 more than 600 hospitals worldwide were accredited by the Joint Commission International, a number that has been growing by about 20% annually. In 2015 medical tourism amounted to an estimated \$40-75 billion worth of economic activity, or about 1% of global HC expenditure.

Figure 1. Medical Tourism
Destination countries by number of patients, 2015, (in thousands)

Patients Beyond Borders, <http://www.patientsbeyondborders.com/medical-tourism-statistics-facts>
Based on estimates by Deloitte, McKinsey, Gallup, the Economist, host countries health and tourism ministries

⁷ Siciliania, Moranb and Borowitz. Measuring and comparing health care waiting times in OECD countries. Health Policy, December 2014

⁸ Wall Street Journal, The Henry Ford of Heart Surgery: a Factory Model for Hospitals. 11/25/2009; Health City Cayman Islands. Harvard Business School Case #714510, 2014; Hub and Spoke, HealthCare Global, and Additional Focused Factory Models for Cancer Care. Harvard Business School Case #313030, 2015.

Figure 2. Cost Variations of Medical Procedures
US\$, 2015

Patients Beyond Borders

These developments have captured the attention of HC insurance services in the developed world. Large U.S. insurers have examined these offshore developments as low-cost alternatives for U.S. services, and some have incorporated them in their offerings. Britain's National Healthcare Service is considering partnerships with leading players in India and Thailand as a way to cut waiting times.

At the same time that demand for healthcare continues to expand globally, the type of demand varies significantly across countries. The number one cause of death in the developed world, for example is heart disease, accounting for more than 12% of total death, whereas in mid- and low-income countries most deaths are caused by cerebrovascular disease (14%) and respiratory infections (11%).⁹ Likewise, the incidence of cancer is three times higher in China than in India. The disparity in Africa is even greater.¹⁰

Global and Local Supply

The major providers in HC, notably HC professionals, hospitals, and pharmaceutical companies, have vastly broadened their global reach in recent decades. Movement of HC professionals, predominantly from emerging markets to developed countries, is not new, but its magnitude has grown considerably, fostered by reduction in traveling costs and the liberalization of immigration policies for HC professionals. These developments have been driven by mismatches between supply and demand around the world – according to the World Health Organization (WHO) by more than 7 million healthcare professional

⁹ WHO: The Global Burden of Disease Project.

¹⁰ International agency for research on Cancer, http://globocan.iarc.fr/Pages/fact_sheets_cancer.aspx

providers in 2016, and this number is estimated to double by 2035. Leading U.S. hospitals have been 'importing' nurses since the 1980s in the face of a large nursing shortage. Initially, nurses came predominantly from the Philippines, but more recently, they have come from other countries as well.¹¹

The movement of doctors across countries has also been prevalent, although less common than with nurses due to different qualification requirements. According to one estimate almost 40,000 Nigerian doctors practice outside Nigeria, three-quarter of them in the UK.¹² Whereas for the most part, these moves are initiated by individuals seeking to further their careers and better their lives, in some cases they are assisted by governments. The Cuban government, under the auspices of the WHO, exports local doctors to Brazil, pays their salaries and receives payment for their services from Brazilian authorities, turning these transfers into a major source of foreign currency for the Cuban government.¹³

Pharmaceutical companies have always been global. The high cost of drug development that gives rise to vast scale economies, coupled with the short span of patent protection, have pushed pharmaceutical companies to expand the market for their drugs across the globe. Most recently, hospitals, which were traditionally deeply grounded in particular localities have started to globalize too. Leading hospitals in emerging markets are rapidly expanding overseas. India's Apollo Hospitals Group, the largest private hospital group in Asia, operates 55 hospitals with 9,215 beds, and has facilities in India, Sri Lanka, Bangladesh, Ghana, Nigeria, Mauritius, Qatar, Oman and Kuwait, and plans for further global expansion. Some of the most prestigious U.S. hospitals, among them Johns Hopkins, Cleveland Clinic, Harvard and Duke, have formed partnerships that offer combined treatments in the U.S. and overseas.

The major barrier for the globalization of HC supply is country regulation. Doctors are tied to the locality in which they receive their medical training by varying qualification requirements that raise the cost of movement across countries. Foreign hospitals' expansion is also limited by country restrictions. For example, this has prevented Indian hospitals from establishing themselves in the U.S.¹⁴ Likewise, the regulatory environment that surrounds drug development, testing and approval varies vastly around the world, raising the costs of global scale. Varying levels of patent protection across countries are another challenge for the further globalization of these companies, and variations in diseases and their prevalence impact global standardization of drug development.

Implications for New York City's Healthcare Industry

As the home of some of the U.S.'s and the world's most prestigious hospitals and HC professionals, New York City is well-positioned to gain considerable benefits from the globalization of the HC industry. Global developments increasingly make it possible to scale the reputational assets of hospitals and professionals globally and exploit them on the world market. In particular, they can attract more patients from around the world to their New York City facilities and thus increase the gains from the growth of medical tourism.

¹¹ Brush et al., *Imported Care: Recruiting Foreign Nurses to U.S. Health Care Facilities*. Health Affairs 2004

¹² <https://www.vanguardngr.com/2017/12/medical-tourism-ambode-harps-retraining-medical-practitioners/>

¹³ https://www.nytimes.com/2017/09/29/world/americas/brazil-cuban-doctors-revolt.html?_r=1

¹⁴ Health City Cayman Islands. Harvard Business School Case #714510, 2014; Hub and Spoke, HealthCare Global, and Additional Focused Factory Models for Cancer Care. Harvard Business School Case #313030, 2015.

In addition to attracting patients to New York City, these constituencies should also be able to expand their scope globally by establishing themselves overseas, by either direct investment or through various forms of partnerships with local providers in foreign countries. This process will vary according to the type of services provided and their comparative advantage in different countries. Some New York City hospitals have recently been experimenting with such endeavors, and will undoubtedly pursue these further as a means to employ their expertise and increase market share.

At the same time, global developments could also pose considerable challenges to New York City hospitals and HC professionals. The forces that enable them to broaden the potential market for their services also increase cost pressures and put them in competition with low cost providers, transforming the scope of competition from the local to the global. New York City providers have little experience in cost-driven competition and this could pose a serious threat. The strongest impact of these forces will probably be felt in what are today the most lucrative parts of the industry, namely the highest cost operations and procedures. The high cost of these treatments compared to the emerging alternatives overseas will increase the incentives to travel elsewhere. These developments will put pressure on New York City to improve the consumer experience (for instance, by providing rehabilitation facilities for medical tourists and accommodation for accompanying relatives), and at the same time cut costs in order to stay competitive.

Weissman Center for International Business, Director:

Terrence F. Martell, Ph.D.
Saxe Distinguished Professor of Finance

Project Editor:

Lene Skou
Weissman Center Deputy Director

Design and Layout:

Rachael Cronin

For more information about this report contact the

Weissman Center for International Business

Zicklin School of Business, Baruch College/CUNY
(646) 312-2070

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