A WORLD OF IDEAS

Around the globe, innovations in healthcare are coming from private enterprise. These successful projects could lead the way to many others.

VICTORIA RICH FOR *FTI JOURNAL*

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From a patient's perspective, all care is local and personal. But healthcare is a global industry, so declining resources and physician shortages in one country may be acutely felt in others. In the United States, almost 25% of the 680,000 practicing physicians were born or trained in other countries, and some of those physicians are heading home, lured by higher salaries. To take one example, more than 1,200 physicians will be recruited from around the world to staff a $1.3 billion public-private enterprise sponsored by the government of Kuwait, which has the resources to pay very well.

Such market-driven shifts in medical manpower come on top of demographic trends that could also lead to imbalances. In many developed countries, older doctors are preparing to retire just as those nations' aging populations need more and more care. But solutions to physician shortages aren't likely to come from cash-strapped government health ministries. Rather, private enterprise, well-funded and free to innovate, will increasingly fill the gap.

MORE THAN GOVERNMENT CAN DO

Poland is a good example of a nation where entrepreneurs are adding capacity to a system that has struggled to keep up with demand for medical services. Two years ago, the government delivered all of the country's healthcare; there were waits of six months or more for some surgical and diagnostic procedures.

But because the government lacked the resources to develop enough specialty care capacity, it began to aggressively engage private industry, physicians and investors to develop and run such healthcare enterprises. Now, medical specialty facilities are springing up, both in cities that had lacked healthcare services and in densely populated areas where there haven't been sufficient physicians and hospital beds. Many of the new clinics are single-specialty facilities — for orthopedics and cardiology, among others — that have been able to leverage specialized staffs and equipment to achieve stellar clinical outcomes.

For investors in both the operations and real estate of healthcare, meanwhile, such ventures often provide substantial returns. Specialty clinics in two cities in western Poland aim to earn more than 20% for the investors who own the real estate (comparable projects in the United States routinely see returns in only the high single digits and low teens). In just two years, 7% of Poland's specialty care has been privatized, and the government projects — probably incorrectly — that within another four years, 40% of such care will be delivered privately.

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India, in contrast, has a long history of private healthcare, which

Hospital beds per 1,000 people

Germany 8.3
U.S. 3.2
China 2.5
India 1.5

now accounts for 80% of all medical expenditures and the majority of new enterprises. Government-run facilities are vastly overcrowded and have a reputation for delivering substandard care. India continues to struggle with access to care: There are only 1.5 hospital beds per 1,000 people, compared with 2.5 beds in China, 3.2 in the United States and 8.3 in Germany. Meanwhile, the rapid growth of India's middle class has led to escalating demand for higher-quality medical services.

Until two years ago, there was just one comprehensive diabetes clinic to serve the 7.5 million people in Chennai. (India has the world's highest prevalence of diabetes, which affects 50 million people.) That meant many cases went undiagnosed until complications had set in. A newly planned diabetes clinic, ambulatory surgery center and hospital in Chennai, funded by a group of investors that includes physicians, an insurance company and real estate developers, will help meet that demand. Soon many patients will be diagnosed earlier and will be better able to manage this condition.

Telemedicine can help mitigate the physician shortage. Yet how should providers in Turkey be paid to diagnose a patient in Algeria?

These new facilities are marketed to those who can afford to pay for care out of pocket (only 6% of Indians have private insurance), employers offering employee benefits, and state governments seeking to meet their social mandate through the provision of private insurance to citizens. It's possible that as more patients with private insurance or the ability to pay flock to new private clinics and hospitals, the government will be able to redirect its resources to providing care for the poor.

STRETCHING TECHNOLOGY

Using private equity to finance medical services is only one solution to providing greater access to healthcare. Another approach, undertaken by the owners of the Aravind Eye Care System in India, is to use technology more effectively. As part of its mission, the nonprofit eye institute serves the poor in rural areas, but rather than send an ophthalmologist to small villages, it dispatches a mobile kiosk and a technician to take digital photos of villagers' eyes and record their symptoms. Then an ophthalmologist can use that information to make a diagnosis and determine whether treatment is required. Because of its strong reputation, 40% of Aravind's patients pay for care, enough to allow it to subsidize care for the rest of its patients.

Integrating less expensive providers (such as nurse practitioners and physician's assistants) with physicians can also reduce costs without sacrificing quality of care. Technicians can be trained to take patients' blood pressure, for example, and nurses can handle many aspects of routine patient care. Telemedicine and other digital technologies can help mitigate the physician shortage by connecting patients with medical consultants in another locale or even another country. But governments and private payers have to be willing to create a regulatory environment and payment schemes that support such entrepreneurial solutions. How, for example, should providers in Turkey be paid to diagnose a patient in Algeria? And how will liability for care or misdiagnosis through digital and telemedicine consultations be handled? Without answers to such questions, digital technologies may fall short of their considerable potential.

THE HEALTH DIVIDEND

Private healthcare enterprises may also eventually upend conventional reimbursement practices that reward providers for treating patients and performing procedures rather than for keeping them well. The public-private integrated health maintenance organization that the Hammes Company and FTI Consulting are involved with in Kuwait will charge a single annual premium to cover all care that a patient may need. Organized as a public company, the HMO will own its hospitals and clinics and employ its own physicians, helping it manage costs and boost quality of care while enhancing the return on investment.

In Kuwait the expatriate population will have only one HMO choice, but in other countries patients may choose among HMOs, private insurance and other private enterprises, all competing on the quality of their care. It seems reasonable that in integrated systems such as HMOs, in which the enterprise collects a premium and provides care, owners will decide which resources will be allocated to treatment and promoting good health. For example, if yoga is proven to keep patients healthy — and to make them less likely to require high-cost treatments — then offering yoga classes will make good business sense.

Crisis, too, can be the mother of invention, and the global health system is close to a crisis point. It's time to let the entrepreneurial process work to improve healthcare for all. ■