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The unwritten price of cosmetic tourism: An observational study and cost analysis

K. Miyagi, D. Auberson, A.J. Patel, C.M. Malata*

Department of Plastic and Reconstructive Surgery, Addenbrooke's Hospital, Cambridge University Hospitals NHS Trust, Cambridge CB2 2QQ, UK

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Summary *Introduction and aims:* Cosmetic tourism, driven by the promise of inexpensive operations abroad, is increasingly popular despite warnings from professional bodies regarding associated risks. Increasing numbers of individuals have presented to our department requesting NHS treatment of complications from such surgery. We set out to characterize these patients and evaluate costs incurred through their assessment and management.
Material and methods: An observational study was conducted from 2007 to 2009 on patients presenting to a tertiary referral Plastic Surgery practice with complications of cosmetic tourism surgery. Demographic characteristics, as well as those related to the operation, were recorded. Hospital patient flow pathways were constructed, cost analysis performed using *Patient Level Costing*, and expenditure and profitability calculated.
Key results: Nineteen patients presented within the study period. Most operations were performed in Europe or Asia, and were primarily breast augmentation procedures ($n = 13$). The principal complications were wound infection or dehiscence, and poor cosmetic results. Eleven patients received NHS treatment, at a cost of £120,841. The mean cost for all patients' management was £6360 (range: £114—£57,968), rising to £10,878 for those accepted for treatment. For 8 of the 9 patients (89%) for whom full patient level costing was available, the hospital incurred a financial loss.
Conclusion: The costs to the NHS of managing complications of cosmetic tourism are substantial, and underestimated by central funding agencies.
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Introduction

Substantial public demand for aesthetic surgery exists despite very limited opportunities accessible on the NHS. Most of this shortfall is met by individuals paying for operations in the private sector, with an increasing proportion of procedures now conducted outside the UK. The process of travelling to obtain medical care has been termed

* Corresponding author. Tel.:+ 44 1223 586672; fax:+ 44 1223 257177.
E-mail address: cmalata@hotmail.com (C.M. Malata).

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"medical tourism", with "cosmetic tourism" specifically referring to aesthetic surgery.[1,2] This can be subdivided into *outbound* (domestic patients seeking treatment abroad), *inbound* (foreign nationals attending for treatment in the UK) and *intrabound* (travelling within a country to receive care outside of their home geographic area) practices.[3] Medical tourism is a predominantly price-driven phenomenon, with potential cost-savings that can be as high as 90%. Other drivers include comparable or occasionally better quality care, shorter waiting lists, and increased "consumerism" (whereby individuals desire greater scope to dictate the medical treatment they receive, including procedures not offered on the NHS - which, in the current financial climate, includes practically all cosmetic surgery). An industry has arisen whereby medical treatments abroad may be combined as "package deals" with inexpensive flights, hotel accommodation, and often holidays.[1]

The initial reduced financial outlay often overshadows potential longer-term considerations for the patient.[4] All surgical procedures have complication rates, and these may be higher in countries with less stringent healthcare regulation. There may be limited or no prospects to meet a surgeon, cosmetic surgery advisor or specialist nurse in advance, reducing or abrogating preoperative counselling. The same applies to postoperative monitoring and review.[5] This creates both practical and logistic problems for the patient,[5] especially in the event of complications or suboptimal outcomes necessitating further intervention.

The scope of this problem remains poorly defined, and in particular the total number of patients using such services is unknown. Consequently, in 2007, BAPRAS commissioned an audit to establish whether patients with complications of cosmetic tourism surgery were presenting to the NHS.[7,8] One-third of the 240 plastic surgical consultants contacted reported having reviewed such cases, with respondents having each seen a mean of 3.4 patients. The most common complications followed breast augmentation, abdominoplasty and face/neck lifts, likely reflecting the relative frequencies at which these procedures are conducted. Europe and Asia were the predominant locations where initial surgery was performed, but other continents were also significantly represented. The majority of patients were referred to NHS plastic surgeons as unplanned admissions via emergency departments or for urgent outpatient review by general practitioners. These patients not only need clinic assessment but also utilise valuable inpatient beds and consume expensive theatre resources. The same principles extend to patients undergoing initial aesthetic operations in the private sector in the UK outside their immediate geographical area, as the net effect to the NHS is equivalent.[9]

There is no clear policy or consensus regarding who should bear the case load and financial burden of such complications, especially for procedures that would not initially have been offered on the NHS.[7,8] As the latter is free at the point of use, there remains considerable potential for abuse of the system. In fact, the low cost of many operations may be illicitly underwritten by covert use of the NHS for postoperative review and management of adverse events.[6] The cost burden remains undocumented.

In this study, we set out to characterize individuals presenting to the NHS for treatment of complications of aesthetic surgery performed in the private sector, either abroad or intrabound in the UK. In addition we evaluated costs to the hospital, and therefore the taxpayer, incurred by assessment and management of such patients.

Patients and methods

An observational study was conducted to identify patients presenting between 2007 and 2009 to a tertiary referral Plastic Surgery practice at Addenbrooke's University Hospital for management under the NHS of complications of aesthetic surgery tourism. Patient demographics were recorded, as were details of the initial operation and geographical location where it was performed, the nature of the complication, any general treatment that was administered, and whether they were accepted for revisional surgery under the NHS.

For each individual, data were sought to chart a patient flow pathway. This included point of entry to the NHS (emergency department, general practitioner or referral from private sector), planned and unplanned hospital admissions, interaction with different surgical or medical departments, use of operating theatre services, and outpatient clinic reviews.

Patient Level Costing (PLC)[10] and reimbursement were determined prospectively. For some individuals in the early part of the study retrospective estimates had to be made; these data are indicated in the results section. PLC analysis included use of hospital resources (emergency department, wards, operating theatres, outpatient clinics), staff (medical, theatre and allied health professionals), diagnostics (including pathology, radiology and cardiology), and non-surgical therapeutic interventions (medication, and interventional radiological or endoscopic procedures). Theatre time was calculated from the time the patient entered the anaesthetic room until the patient left the operating room, and calculations based on average theatre running costs per minute. Staff pay was estimated according to the number of hours required for each intervention. In patients in whom there was insufficient data to calculate accurate Patient Level Costs, estimates were derived based on available information.

Total cost to the hospital was then calculated. Revenue is provided by the Primary Care Trust (PCT) according to tariffs determined by the Department of Health based on reference costs from the hospitals and on Market Forces Factor. Profitability was derived as the difference between actual expenditure and the level of reimbursement.[11]

Results

A total of 19 patients were identified over the three year period who met the criteria for this study. The mean age was 43.5 years (range: 30—60), and all were female. Of the initial operations, 12 (63.2%) were performed in Europe (of which 8 intrabound tourism in the UK, 2 elsewhere in Western Europe and 2 in Eastern Europe), 4 (21.1%) in the Indian subcontinent, 2 (10.5%) in Southeast Asia (China and Thailand respectively), and one (5.3%) in the Middle East

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