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The Democrats' Dilemma: Choice between Loving Healthcare and Hating Trade

By

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Healthcare reform has acquired political salience in the forthcoming Presidential election, with the widespread anxiety over wages and jobs making the economy a leading issue. Yet, while the Democratic contenders, Senators Clinton and Obama, claim credit for offering alternative comprehensive plans, they both leave important gaps regarding two key questions. The first concerns the availability of doctors to meet the needs of the newly-insured, a problem that Governor Mitt Romney ran into when he introduced comprehensive medical coverage in Massachusetts. The second is regarding the fiscal costs of comprehensive coverage, a problem that killed (in January 2008) yet another Republican Governor Arnold Schwarzenegger's ambitious attempt at healthcare reform in California

To address these questions effectively, both the candidates can ill afford to ignore exploiting the potential offered by international transactions in medical services. But to do this, they will need to abandon the Democratic Party's growing antipathy to an embrace of openness: loving healthcare and hating trade are incompatible positions. The containment of costs, using all existing modes of cross-border service transactions can be expected to save sizeable sums annually. Besides, the problem of finding doctors for the newly-insured can be overcome by taking a leaf from President Lyndon B. Johnson's ambitious Great Society program importation of doctors and other professionals to serve in the backward regions of the United States that enjoyed little access to available personnel within the US itself.

I: Containing Costs

The full potential of saving medical costs, for any specification of eligible medical relief, can be obtained by looking systematically at the four modes of service transactions distinguished by the WTO's 1995 General Agreement on Trade in Services. Mode 1 refers to "long distance" or "arm's length" services that are typically today online: the provider and the user of services do not have to be in physical proximity like with haircuts. The other three modes require proximity, however. Mode 2 relates to patients going to doctors elsewhere. Mode 3 refers mainly to creating and staffing hospitals in other countries. Mode 4 encompasses doctors and other medical personnel going to where the patients are. All modes promise varying, though substantial, cost savings.

Mode 1 can help save a significant fraction of the current administrative expenditures conservatively estimated by experts at $500 billion annually, by shifting claims processing and customer service offshore: nearly half of such savings are already in hand. If foreign doctors are further allowed to provide telemedicine, that can reduce the demand to see primary physicians. Again, diagnostic radiology offers yet-unrealized savings, through both cheaper prices paid abroad and through the beneficial price-reducing effects in the US itself. We estimate that the savings in healthcare costs could easily reach a magnitude of $70-75 billion.

Mode 2, where US patients go to foreign medical facilities, was considered an exotic idea when one of us (Bhagwati) proposed fifteen ago in 1993 (Journal of Commerce) that American patients could go to India and fix their dental afflictions and see the Taj Mahal for much less than what the dentist would cost in the United States:

now this is a reality, known as “medical tourism”. Today, many foreign hospitals and physicians are offering world class services at prices that are a fraction of the US costs. Costly yet standard procedures with short convalescence periods, which today include heart and joint replacement surgeries, are candidates for such treatment abroad. By our estimates, thirty such procedures, costing about $220 billion in 2005, could have been “exported”. Even if this was done with only 25% of the procedures, the annual cost savings would be in the range of $40-45 billion.

Mode 3, with hospitals established abroad, would seem to offer our doctors and hospitals considerable opportunity to earn abroad: a “gain” that could balance off the “loss” under Modes 1 and 2. But here also, the reverse establishment of medical facilities in the US is possible and could lead to price reductions, mainly by offering competition to the increasingly concentrated medical industry. A Report in February 2006 from the Robert Wood Johnson Foundation has described this trend to concentration since 1990 and has concluded that 90% of the larger metropolitan areas now face concentrated markets. Admittedly, however, the cost savings from such competition are unlikely to be very large.

Mode 4, where the provider goes to the user of services, concerns doctors and other medical personnel going where the patients are, however offers substantial cost savings since the earnings of foreign medical personnel are typically lower than those of comparable suppliers in the United States. This is true even vis-à-vis Europe where the US Census shows the net income of doctors averaged $206,000 in 2,000, which inflation adjustment raises to $230,000 currently, which is twice the average income of doctors in Western Europe.

II: Importing Doctors

But Mode 4 is far more important in meeting supply needs rather than in providing lower costs if healthcare reform is to be viable. According to the Census, the US had an estimated availability of 2.4 doctors per 1,000 population whereas the number was 3.3 in leading developed countries tracked by the OECD. But this is a crude comparison. What is more pertinent is that anything like a comprehensive coverage of the over 40 million uninsured today --- assuming that most of them can be dragooned into becoming insured even if they would rather not be--- will require that they can access doctors and related medical personnel. In short, an IOU that cannot be cashed in is almost worthless.

Governor Romney ran into this problem: few doctors wanted (or were able, given widespread shortages in many specialties) to treat many of the indigent patients qualifying under the program. The Wall Street Journal (July 25, 2007) reported, with telling stories and reference to reporting by the Massachusetts Medical Society, on how "Doctor Shortage Hurts a Coverage-For-All Plan". The answer lies in simultaneously allowing imports of medical personnel tied into tending to the newly-insured.

This is precisely what the Great Society program did in the 1960s, with imports of doctors whose visas tied them, for specific periods, into serving the remote rural areas. In particular, waivers were granted from J-1 obligation to return home to physicians practicing for a specified period in an "underserved" area. Faced with the choice of

having to expand doctor-producing US facilities (which would augment the supply permanently), the American Medical Association preferred the alternative of creating a segmented market and a policy of imports that could be terminated by lobbying when necessary.

The Great Society program carried enough moral weight for the politicians then to overcome entry-restricting lobbying demands. With the political attention being lavished on healthcare reform today, would it be too much to expect that our reform-minded politicians do the same?