How Health Insurance Inhibits Trade In Health Care

Eliminating the current bias in health plans against treatment abroad could lead to significant cost savings.

by Aaditya Mattoo and Randeep Rathindran

**ABSTRACT:** A range of health care services are tradable, in that consumers can travel abroad for treatment. In this paper we first estimate the gains from trade. An international price comparison of fifteen procedures reveals that there could be savings of around $1.4 billion annually even if only one in ten U.S. patients choose to undergo treatment abroad. We then identify a key impediment to realizing these gains: the nature of existing health insurance plans, which discriminate explicitly or implicitly against treatment abroad. We propose that coverage should be neutral to provider location and that reimbursement should include travel costs. [Health Affairs 25, no. 2 (2006): 358–368; 10.1377/hlthaff.25.2.358]

Is health care so different from other goods and services that it cannot be regarded as tradable? Consumers certainly value both proximity and quality, but that has not prevented them from traveling abroad to obtain various treatments, such as cosmetic surgeries, rehabilitative care, alternative medicine, and even eye and cardiac surgery. For example, in 2003 an estimated 50,000 British medical tourists traveled to Thailand, South Africa, India, and Cuba for a variety of treatments.1

The high cost of health care in the United States relative to that in a number of other countries would seem to provide a strong incentive for trade. For example, an inpatient knee surgery, roughly 400,000 of which are performed annually in the United States, costs more than $10,000 there but less than $2,000, including travel, at the best hospitals in Hungary and India. We estimate that even if only one in ten patients who need one of fifteen highly tradable, low-risk treatments went abroad, the annual savings for the United States would be $1.4 billion. But surprisingly few Americans travel abroad for treatment.

Most travel is for procedures not adequately covered by home-country health insurance; this suggests that a key impediment to trade is the nature of existing health insurance plans. We find that most plans do not cover treatment abroad; if they do, the consumer must bear the full costs of travel and obtains only a fraction

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of any cost savings. Since the costs of travel are usually greater than any out-of-pocket savings, the adequately insured have little incentive to travel, which results in a strong “local-market bias” in the consumption of health care.

There is a simple solution: The terms of insurance coverage should be neutral to the location of the provider, and reimbursement should be based on the costs of treatment inclusive of travel costs. This would be sufficient to ensure that the consumer has an incentive to travel if, and only if, there were any gains from trade.

Two additional concerns will need to be addressed to facilitate trade and to ensure that its benefits are widely shared. First, the scope for trade will be greatly increased if providers in destination countries improve the quality of care and are able to credibly signal these improvements by obtaining accreditation from source-country health regulators. Second, destination countries will need to use at least part of the revenues from increased inflows of foreign patients to ensure improved health care access for their own poorer citizens.

The Tradability Of Health Care

The realization of gains from trade hinges on the consumer’s willingness to travel abroad for health care. There are a number of myths about trade in health care. Here we address two.

■ Myth 1: The sick cannot travel, so care must be delivered at home. It is certainly true that many types of treatment must necessarily be delivered close to home: emergency care following an accident, or when patients are physically incapable of travel. However, for many treatments, such as hernia repairs or eye surgery, the patient can both wait and travel for treatment. That these are not merely hypothetical possibilities is revealed by the growing volume of “medical tourists.” Estimates suggest that in 2003, more than 350,000 patients traveled to Cuba, India, Jordan, and Southeast Asia specifically to seek care. A sizable number were patients from industrialized countries, traveling to a growing number of high-end overseas hospitals to obtain “first-world treatments at third-world prices.”

■ Myth 2: The quality of care available in developing countries is lower than in industrialized countries. This statement is certainly true on average. The relevant comparison, however, is not with the standard of an average developing-country provider but with the standard of a provider likely to be used by a patient from an industrialized country.

First of all, a sizable number of foreign-educated medical professionals have been deemed to be adequately qualified to practice in the United States. International medical graduates (IMGs) now account for a quarter of the 853,187 U.S. physicians. Interestingly, the top eight countries of origin of foreign physicians in the United States are all developing countries, with Indian-educated physicians constituting the largest group (21 percent), followed by those educated in the Philippines, Cuba, Pakistan, Iran, and Korea. Also, foreign-graduate faculty now account for almost a fifth of total U.S. medical school faculty members. Moreover,
the share of foreign-educated nurses among newly licensed registered nurses (RNs) in the United States has been rising since 1998, exceeding 14 percent in 2003. Filipino nurses dominate the numbers of foreign nurses at 43 percent, followed by nurses from Canada, the United Kingdom, India, Korea, and Nigeria.

Further, the Bumrungrad (Bangkok), Apollo (New Delhi), and Crossroads Center (Antigua) are all examples of reputable medical facilities in developing countries that are comparable to the best in industrial countries. These facilities treat many foreign patients annually, have internationally trained physicians and nurses, and maintain high surgical success rates. For example, the Apollo hospital chain has reportedly maintained a success rate of 99 percent in more than 50,000 cardiac surgeries performed, which is on par with the surgical success rates of the best U.S. cardiac surgery centers (such as the Cleveland Clinic).

**Coverage Of Care Received Abroad Under U.S. Health Plans**

While most U.S. health plans cover emergency care received during travel abroad, nonemergency care received abroad is rarely covered. Medicare and Medicaid, which cover almost 26 percent of the U.S. population, do not pay for treatments received abroad, as a matter of policy, except when the beneficiary is a U.S. border resident and lives closer to the foreign hospital than to the U.S. hospital. Although Medicare beneficiaries can purchase supplemental “Medigap” insurance, it covers emergency treatments abroad during only the first sixty days of overseas travel. Other U.S. federal health plans, such as TRICARE, which covers military personnel and their families, cover both emergency and nonemergency care received while the beneficiary is stationed overseas.

Approximately 60 percent of the U.S. population receives employment-based health insurance. A majority of these health plans are managed care plans, which do not cover treatment abroad, except in the event of medical emergencies. In the few instances where nonemergency care abroad is covered (for example, by multinationals and international organizations), overseas providers are treated as being out-of-network, which leaves consumers responsible for higher deductibles and copayments if they receive treatment abroad.

**Estimating The Gains From Trade: An Illustration**

A cost comparison of selected medical treatments reveals the potential gains from trade in health care for the United States.

- **Identifying tradable medical procedures.** The first step is to identify the medical procedures that are clear candidates for consumption abroad. It is only for surgeries that the cost savings are likely to be large enough to cover the cost of travel. In collaboration with medical professionals at the World Bank’s Health Services Department, we developed the following set of criteria: (1) The surgery constitutes treatment for a nonacute condition; (2) the patient is able to travel without major pain or inconvenience; (3) the surgery is fairly simple and commonly performed.
with minimal rates of postoperative complications; (4) the surgery requires minimal follow-up treatment on site; (5) the surgery generates minimal laboratory and pathology reports; and (6) the surgery results in minimal postprocedure immobility.

Applying these criteria stringently to the list of the 230 most commonly performed procedures in U.S. community hospitals, published by the Agency for Healthcare Research and Quality (AHRQ), we selected fifteen procedures for price comparison purposes (Exhibit 1).

■ U.S. prices. The price for a procedure is made up of the insurer’s payments for the hospital, physician, anesthetist, and other professional services and the patient’s copayment. We used Medicare hospital payment rates reported by DRG Expert (2005) for inpatient hospital surgeries. For outpatient procedures, the hospital/facility fee was obtained from the Medicare outpatient prospective payment system (OPPS) data set.9 Physician and anesthetist payment rates were calculated from the Medicare physician and anesthetist fee schedules. We then calculated inpatient prices in the United States by adding hospital payments, physician fees, and anesthetist charges for 2004. Since outpatient treatments under Medicare are also subject to a copayment, we calculated outpatient prices as the sum of hospital fees, physician fees, anesthesia charges, and copayments for 2004.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>U.S. inpatient price ($)</th>
<th>U.S. inpatient volume</th>
<th>U.S. outpatient price ($)</th>
<th>Estimated U.S. outpatient volume</th>
<th>Foreign price including travel cost ($)</th>
<th>Savings if 10% of U.S. patients undergo surgery abroad instead ($)</th>
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</thead>
<tbody>
<tr>
<td>Knee surgery</td>
<td>10,335</td>
<td>399,139</td>
<td>4,142</td>
<td>60,000</td>
<td>1,321</td>
<td>376,698,470</td>
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<td>Shoulder arthroplasty</td>
<td>5,940</td>
<td>23,300</td>
<td>7,931</td>
<td>330</td>
<td>2,217</td>
<td>8,674,829</td>
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<td>TURP</td>
<td>4,127</td>
<td>111,936</td>
<td>3,303</td>
<td>88,064</td>
<td>2,413</td>
<td>27,029,437</td>
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<td>Tubal ligation</td>
<td>5,663</td>
<td>78,771</td>
<td>3,442</td>
<td>621,229</td>
<td>1,280</td>
<td>168,834,441</td>
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<td>Hernia repair</td>
<td>4,753</td>
<td>40,553</td>
<td>3,450</td>
<td>759,447</td>
<td>1,651</td>
<td>149,254,906</td>
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<td>Skin lesion excision</td>
<td>6,240</td>
<td>21,257</td>
<td>1,696</td>
<td>1,588,884</td>
<td>805</td>
<td>153,078,349</td>
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<td>Adult tonsillectomy</td>
<td>3,398</td>
<td>17,251</td>
<td>1,931</td>
<td>102,749</td>
<td>1,006</td>
<td>13,641,759</td>
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<td>Hysterectomy</td>
<td>5,783</td>
<td>640,565</td>
<td>5,420</td>
<td>1,588,884</td>
<td>865</td>
<td>243,163,366</td>
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<td>Hemorrhoidectomy</td>
<td>4,945</td>
<td>12,787</td>
<td>2,081</td>
<td>137,213</td>
<td>865</td>
<td>21,893,438</td>
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<td>Rhinoplasty</td>
<td>5,050</td>
<td>7,265</td>
<td>3,417</td>
<td>42,735</td>
<td>1,936</td>
<td>8,590,926</td>
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<td>Bunionectomy</td>
<td>6,046</td>
<td>3,139</td>
<td>2,392</td>
<td>41,507</td>
<td>1,502</td>
<td>5,120,817</td>
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<td>Cataract extraction</td>
<td>3,595</td>
<td>2,215</td>
<td>2,325</td>
<td>1,674</td>
<td>1,006</td>
<td>13,641,759</td>
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<td>Varicose vein surgery</td>
<td>7,065</td>
<td>1,957</td>
<td>2,373</td>
<td>148,043</td>
<td>1,411</td>
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<td>Glaucoma procedures</td>
<td>3,882</td>
<td>1,974</td>
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<td>75,838</td>
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<td>Typanoplasty</td>
<td>4,993</td>
<td>754</td>
<td>3,347</td>
<td>149,246</td>
<td>1,404</td>
<td>29,258,785</td>
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</tbody>
</table>

SOURCES: Healthcare Cost and Utilization Project (HCUP) database; DRG Expert (2005); Current Procedural Terminology (2004); Vanbreda International; and authors’ calculations. Outpatient volume was obtained from the American Association of Orthopedic Surgeons, the American Urological Association, the National Center for Health Statistics, the U.S. Centers for Disease Control and Prevention, the American Society for Dermatological Surgery, the American Academy of Otolaryngology, the American Podiatric Medical Association, the American College of Phlebology, and Ethicon Endosurgery.

NOTES: Patient volume data pertain to 2002, while the prices pertain to 2004. Total savings would be $1,384,414,741. TURP is transurethral resection of the prostate.

*Data not available.
**Magnitude of demand.** We obtained patient volume data from the Healthcare Cost and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS) database. The latest year for which HCUP data were available was 2002. For outpatient surgeries, we obtained volume data from various medical professional associations.

**Foreign prices.** Vanbreda International, a Belgium-based employee benefit consulting and administration firm, provided prices for the selected procedures in twenty-one countries from its own claims data. To compare U.S. and international prices from a trade standpoint, we added the cost of round-trip airfare to these countries from the United States to the international prices.10

**Quality control.** Price comparisons would be much more credible if we could effectively control for differences in quality. However, in the absence of more information, we can only implement two implicit controls. First, as our selected procedures are routine and relatively uncomplicated, they do not require a relatively high level of surgical expertise. Hence, there is a presumption that there are not large quality variations for these procedures between the best hospitals in developing countries and those in developed countries. Second, since Vanbreda’s clients abroad are mainly international organizations that employ citizens from industrial countries, their claims data from foreign countries reflects prices of procedures in the best hospitals in that country, thereby mitigating the concern over quality differentials. Although these implicit quality controls are imperfect, no superior alternative was feasible, given the lack of data on quality of care in developing countries.

**Price comparisons.** The results of the cost comparison are illustrated in the last column of Exhibit 1. If one in ten patients undergoing these fifteen procedures in the United States instead were treated abroad, the savings would amount to approximately $1.4 billion dollars annually.11 Based on the volume of Medicare patients in the HCUP sample, we estimate that $690 million of these savings would accrue annually to the Medicare program alone. If we added coronary artery bypass graft (CABG) surgery to the list of tradable procedures, the estimate of annual savings would exceed $2 billion. Even if we assume that inpatients are less likely than outpatients to go overseas for care—say, 5 percent of U.S. inpatients and 10 percent of U.S. outpatients—the savings would still be in excess of $1.03 billion.

Although these figures amount to only a small proportion of total U.S. health spending, the savings are nevertheless impressive, for three reasons. First, the savings pertain to only fifteen treatments drawn out of a large universe. Given that patients from the United States and United Kingdom are traveling to India for major procedures such as cardiac surgery, the list of tradable procedures is arguably much wider.12 Second, our estimate of cost savings is understated to the extent that we have used Medicare payment rates to calculate U.S. prices, which are lower than those paid by private insurers and the uninsured.13 Third, patient volume data were not available for all procedure categories, and a fuller accounting would certainly magnify the estimate of savings.
Realizing The Gains From Trade In Health Services: The Problem And A Proposed Solution

Insurers often discriminate against treatment obtained abroad, and this obviously inhibits trade. But the problem of underconsumption of health care abroad would arise even if insurers offered identical coverage of the costs of treatment, irrespective of location. Home-country consumers with insurance pay a deductible and copayment out of pocket only if treatment is received in the home country. However, if they undergo treatment in the foreign country instead, they face other costs such as travel costs and the interest cost of waiting for reimbursement.

**Even coverage of only medical expenses abroad could encourage some trade.** Consider a numerical example. An inpatient hernia repair costs $5,000 in the United States but only about $1,300 (excluding airfare, which is about $600) in Hungary. Consider an insurance scheme that had a 20 percent coinsurance rate (assuming no deductible, for simplicity) but did not cover treatment abroad. Then a consumer would prefer to pay $1,000 out of pocket for treatment in the United States rather than $1,900 for treatment abroad, and potential cost savings of $3,100 would remain unrealized.

In contrast, if the insurer offered identical coverage for treatment abroad, then the consumer would have some incentive to travel abroad for care. This is because the cost of treatment abroad is now $860 ($260 out of pocket for the treatment and airfare of $600), which is below the out-of-pocket costs of $1,000 in the United States. However, the financial incentive to go abroad is evidently not strong and might not overcome consumer inertia.

**To realize the full gains from trade, insurance must cover the total costs (medical plus travel expenses) of obtaining treatment abroad.** Say U.S. insurers cover a proportion (80 percent in our example) not just of the cost of health care obtained abroad, but of the “full” price inclusive of travel costs. Then the consumer faces an effective out-of-pocket cost of treatment abroad of $380 (that is, 20 percent of the total cost of treatment in Hungary, which is $1,900) instead of $1,000 in the United States. The consumer would thus save $620 if he went abroad. Further, the insurance company would pay $1,520 for the treatment (instead of $4,000 in the United States) and save $2,480. It is conceivable that the insurance company could pass on some of these savings as additional incentives to the consumer to travel. One possibility is to modify the “effective” copayment for a treatment received abroad, for example, by the inclusion of a tourism package. Another possibility is to offer a lower premium up front to consumers who agree to travel abroad for a prespecified set of treatments. Irrespective of how the gains from trade are shared between insurer and consumer, the main point is that a simple modification of insurance schemes can help realize the gains from trade.

It is important to note that the proposed modification does not in any way oblige consumers to go abroad for treatment. Nor does the proposal necessarily require any special incentives to be given to consumers to induce them to travel.
proposal is designed merely to eliminate the existing bias in health plans against treatment abroad, which has the effect of distorting consumer choice.

Possible Reasons For Denying Coverage For Overseas Care

Given that there are large gains from trade in health care, it is puzzling that insurers in countries with expensive health care deny coverage for nonemergency treatment obtained abroad instead of encouraging patients to seek care overseas. We cannot rule out a protectionist motive, where denial of coverage is government policy, as in the case of Medicare and Medicaid. However, our investigations reveal no policy restrictions that would prevent private health plans from covering overseas care. We consider here possible reasons that have emerged from discussions with insurers.

Insurers’ concerns about quality of overseas providers and malpractice law. Insurers might care about the quality of providers because of a potential negative spillover effect in the consumption of health care. A consumer’s decision to receive care from low-cost overseas providers could prove costly to the insurer if the treatment worsens health problems and the insurer is obliged to cover the costs of subsequent treatment. The insurer also might be concerned that malpractice could occur in a foreign jurisdiction where the legal regime makes it difficult to sue providers. It would make sense to deny the consumer the option of receiving cheaper treatment abroad for these reasons if two conditions hold. First, the insurer cares more about potential future cost implications of poor provider quality than consumers care about the impact of provider quality on their own health. Second, the insurer is more concerned than the consumer about the difficulty in seeking compensation for malpractice abroad. These conditions cannot be ruled out but do not seem very plausible. Moreover, if these concerns really exist, then it should be possible to write contracts that insulate the insurer from any additional costs that arise from the consumer’s decision to go abroad. Quality concerns can be more directly addressed by creating provider networks abroad, as we suggest below.

Cost of monitoring health care consumption abroad. Insurers might face high costs of monitoring care received overseas. However, an insurer could institute the requirement for objective verification ex ante by a U.S. doctor (possibly in the insurer’s network) of the need for treatment, as well as an objective verification ex post of the receipt of treatment, to minimize fraudulent claims. It should also be possible to deal with administrative concerns about treatments received abroad, such as the difficulties with incorrectly coded or improperly translated claims, by collaborating with insurers in destination countries.

There also might be a concern that lower foreign prices of health care per se worsen the moral-hazard problem created by insurance. If it were infeasible to control for moral hazard directly, incentives for overconsumption abroad could be neutralized by offering the consumer a choice of two different contracts, a standard contract if the consumer prefers to seek health care only at home, and a
lower-premium, higher-coinurance contract, if the consumer is willing to travel abroad for certain types of care. The lower premium would provide the incentive to travel, while the higher coinurance rate would discourage overconsumption.

- **Increased costs for the public health care system.** It is difficult to find an explicit rationale for Medicare and Medicaid’s refusal to cover treatment abroad. One possible concern today is the cost of providing coverage to the sizable number of U.S. retirees who live abroad and do not benefit from Medicare. However, any cost increases would likely be more than offset by the cost savings from allowing access to cheaper care to retirees who live in the United States. Moreover, if treatment abroad were covered, it would eliminate a disincentive for people to retire abroad and could thus produce additional savings.

Another possibility is the existence of cross-subsidies in the domestic public health care system. In these circumstances, a decision by “profitable” patients to go abroad could increase costs for those left behind. However, if the true cost of care is lower abroad than at home, it should be possible to continue to finance the subsidy by imposing a tax on treatment abroad and still leave consumers who seek care abroad better off. A similar problem could arise if there were sizable economies of scale or scope in the provision of health care. The decision by some consumers to obtain treatment abroad could again increase costs for those who cannot travel. In this case, we would need to compare the diseconomies from allowing trade with the gains from trade.

In any case, public health schemes such as Medicare and Medicaid face institutional impediments to extending coverage for health care received abroad. These are government-controlled schemes, and allowing the participation of foreign providers would require an amendment of the Social Security Act. Medicare, however, has built-in waivers, such as the Section 1115 research and demonstration waiver, which could be used to study alternative programs of cost-effective health care delivery overseas. Coverage for care received overseas, especially in a neighboring country such as Mexico, could be extended through the introduction of a point-of-service option for Medicare beneficiaries, or through the introduction of a medical savings account (MSA).

- **Distorted incentives in oligopolistic markets.** The fact that federal programs such as Medicare and Medicaid do not offer coverage for health care received overseas could reflect implicit protection for domestic providers. The bigger puzzle is why private insurers deny coverage for treatment abroad. One reason could be the insurer’s inertia in a changing world (opportunities for trade are new, while insurance practices are old). Another speculative explanation could be the oligopolistic nature of the health insurance industry. In a competitive market, insurers have no choice but to seek out the slightest cost advantage. Under an oligopoly, a different market equilibrium is possible. One health insurer might benefit by offering consumers the possibility of using cheaper health care. However, if other firms follow suit, then its advantage would disappear. Overall profits could be lowered if health
care costs declined as a result of the introduction of the possibility of using health care abroad. The reason is that although firms would benefit from health care cost reductions, they could lose more from heightened competition in a low-cost environment. In these circumstances, it is conceivable that the industry will gravitate toward an equilibrium where each firm chooses the strategy of not offering consumers the possibility of cheaper care abroad as long as other firms behave the same way.21

What Can Developing Countries Do?

How can industrialized (source) countries increase the scope for trade and ensure that its benefits are widely shared? Although this paper focuses on what inhibits foreign demand for care in developing countries, action is also clearly needed on the supply side.

Facilitate trade. The scope for trade would be greatly increased if the quality of services provided abroad were improved, and this improvement were credibly signaled. We have two suggestions. First, hospitals in developing countries that seek to attract foreign patients could credibly signal their quality by obtaining accreditation from the Joint Commission International (JCI). Hospitals that undertake high volumes of relevant procedures are likely to be stronger candidates for accreditation, because studies have shown that surgical complications and mortality rates are inversely related to the volume of procedures.22 JCI-accredited hospitals have to renew their accreditation every three years and must collect and report outcome data on services rendered as well as quality indicators. Studies have found a positive association between hospital performance reporting and quality improvement efforts.23

Second, doctors and nurses in export-oriented health care organizations could credibly signal quality by passing, respectively, the U.S. Medical Licensing Exam (USMLE) and the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Since foreign medical graduates who practice medicine in the United States are obliged to pass these examinations, a natural extension from a trade in health care perspective would be to institute a similar requirement for foreign physicians in export-oriented health care organizations abroad. It is also possible that as part of the residency program for physicians, foreign medical boards could form partnerships with medical centers in developed countries involving an exchange of medical experts, for example, as in the partnership between the Methodist Health Care System of San Antonio and Mexico.24

The receipt of JCI and USMLE accreditation by foreign providers could be used as the basis for selection to join the provider network of an industrialized-country insurer. Foreign hospitals could also signal quality by establishing affiliations with reputed hospitals in industrial countries and mirroring their procedural standards, guidelines, and clinical pathways. Foreign investment in the health care sector, sometimes inhibited by developing-country restrictions, could also be a powerful vehicle for improved technology, management, and overall standards.
Ensure equitable access. One concern pertains to the effect of trade in health care on the local health care system of the destination country. Might the inflow of industrialized-country consumers crowd out poorer local patients? Many developing countries already have a two-tier health care system, with large disparities in access for rich and poor citizens. There is a real danger that the increased foreign demand could raise domestic prices and thus accentuate these inequalities.25

Increased demand, however, also creates opportunities for developing countries to improve access to health care for all citizens. First of all, as previously discussed, a large number of developing-country doctors and nurses emigrate every year to industrialized countries. Inflows of rich-country consumers could lead to higher incomes at home and a reduced incentive to emigrate. Our estimates suggest that a representative health care destination country would gain approximately $400 million annually in export earnings even if trade were restricted to the treatments and numbers assumed in Exhibit 1. In these circumstances, governments could cross-subsidize care for the poor by taxing these export revenues or by requiring providers also to extend care to the poor.

Second, health care capacity (especially private capacity) in destination countries need not remain fixed but is likely to expand as increased foreign demand leads to greater domestic and foreign investment. Data from Malaysia suggest that in the late 1990s, hospital capacity (as measured by the number of beds) increased by an average of more than 5 percent a year, with private hospital capacity increasing at almost three times the rate of public hospital capacity.26 Countries such as India, Indonesia, and Sri Lanka have also become increasingly open to foreign investment in health care.27 However, developing countries can do more to eliminate remaining impediments to foreign investment and improve the overall investment climate. At the same time, they can put in place universal access policies that require private providers to contribute to a health care fund or directly provide a proportion of their services to the poor.

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NOTES
2. Compiled from sources such as the British Medical Journal, Tourism Authority of Thailand, Singapore Health Ministry, Malaysian Department of Statistics, Confederation of Indian Industry, South Asia Network of Economic Research Institutes, Jordan Times, and Cuba Travel USA. Also see J. Arunanondchai and C. Fink, “Trade in Health Services in the ASEAN Region” (Unpublished paper, World Bank, 2005).


10. Airfares were obtained online from Expedia.com and averaged over peak and off-peak rates.

11. If 5 percent of U.S. patients were to go overseas, the savings would be about $692 million. If 20 percent of U.S. patients were to go overseas for these surgeries, the savings would be more than $2.7 billion.


14. Through our discussions with insurers such as Vanbreda, we have learned that there are insurance laws in some countries, such as Belgium, that prohibit making the insured person richer than he or she was before purchasing insurance.

15. A California Blue Shield health maintenance organization (HMO) covers all of its members for nonemergency care in Mexico. See S. Geis, “Passport to Health Care at Lower Cost to Patient,” Washington Post, 6 November 2003. The difference can translate into more affordable premiums for U.S. businesses. According to HealthNet company officials, the cost of insuring a family of four whose treatment was covered in the United States is $631 a month, but only $306 a month if they used physicians in Mexico.

16. It is reported that in Texas, legislators explored the possibility of allowing HMOs to operate also in Mexico, but physicians in South Texas lobbied against the changes, arguing that local doctors could not compete with the lower costs in Mexico. Geis, “Passport to Health Care.”

17. The absence of an explicit restriction was confirmed by the NAIC.


27. Chanda presents evidence of several specialty corporate hospitals that are being built in India in collaboration with foreign companies, including a $40 million cardiac centre set up under a consortium between Australia, Canada, and India. Chanda, “Trade in Health Services.” Corporate hospitals in developing countries are also establishing commercial presence overseas.