IMPROVING ESTIMATES OF EXPORTS AND IMPORTS OF HEALTH SERVICES AND GOODS UNDER THE SHA FRAMEWORK

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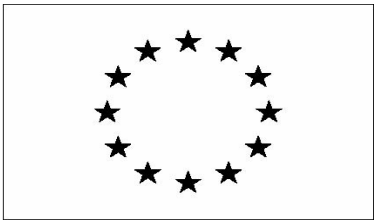

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EXECUTIVE SUMMARY

3. Trade in health services and its most well-known component 'medical tourism' has attracted a great deal of media attention and newspaper column inches in recent years. You could be forgiven for believing that a large part of the population are constantly seeking their health care abroad or buying their pharmaceuticals over the internet from foreign providers. The apparent growth in such 'imports' and 'exports' has been fuelled by a number of factors. Technological advances in information systems and communication allow patients or third party purchasers of health care the possibility to seek out quality treatment at lower cost and/or more immediately from health care providers in other countries. An increase in the portability of health cover, whether as a result of regional arrangements with regard to public health insurance systems, or developments in the private insurance market, is also poised to further increase patient mobility. All this is coupled with a general increase in the temporary movement of populations for business, leisure or specifically for medical reasons between countries.

4. Many of the more scholarly articles and studies to date concur that there is a lack of hard data at present to demonstrate the extent of the provision of services across borders. Much of the evidence tends to be anecdotal and incomplete. However, as agreements on cross-border movement come into force and there is the potential for growing effects on domestic or regional health systems, there is a more immediate need to collect comparative data and monitor trends.

5. *A System of Health Accounts* (SHA) provides a standard accounting framework for the comparable measurement and reporting of health expenditures by the resident population. Most OECD and European Union countries have already implemented national health accounts according to the SHA methodology. In theory, this allows a reporting of those health care goods and services acquired from foreign health care providers – whether hospitals or dentists abroad, or retail internet pharmacies based in another country. In practice, current reporting has been scarce due to a lack of guidance on the specific concepts, definitions and potential sources of information. The original SHA manual, published in 2000, also does not provide any mechanism for explicitly reporting exports of health care goods and services in the standard tables

6. The project 'Improving estimates of exports and imports under the SHA framework' seeks to provide the necessary definitions, concepts and guidelines to respond to this growing need for comparable and timely statistics on the international trade in health. The phases of the project considered the existing statistical frameworks as a starting point for drawing up the conceptual framework and commissioned a number of country case studies to ascertain current practices and potential sources of information, on which to base the guidelines for SHA compilers.

7. As a parallel process with the wholesale revision of the System of Health Accounts, the draft material has been subjected to a wide consultation. The recommendations on supplementary reporting tables and level of detail has also been tested via a questionnaire, which at the same time sought to ascertain current reporting of imports and exports by OECD and EU countries.

8. In developing the final guidelines much of the debate centred on the issue of residency and, in particular, the treatment of certain population groups such as retirees and refugees. For the former, this has particular significance in the EU, although this is an issue also for US Medicare retirees abroad.

Technically retirees abroad are no longer part of the resident population and therefore should not be considered in a country's health spending estimate even though their health spending is still covered under their original health insurance. In the case of refugees or persons without clear residential status, there may be in some circumstances spending on health care which although in theory is not linked to residency could be considered an obligation of the host country and thus should be included. In both cases, there was broad agreement that while such definitions should be at best be adhered to, there should be 'room for manoeuvre' in respect of specific circumstances. Many other services linked to 'health travel' are on the borderline or outside of the definition of health care (e.g. cosmetic surgery, patient transport abroad, etc); it was recommended that the accounting of imports and exports should be consistent with the guidelines set out in the rest of the SHA manual.

9. On the question of the draft guidelines and recommended data sources, it was recognised that, as with many areas of health accounting, no single set of circumstances could apply to all countries or type of statistical system, and as such the guidelines should present an array of possible sources and methodologies, perhaps with some indication of preferable methods or sources. Finally, it was also proposed that in many cases the reporting of imports and exports, certainly at an initial stage, should be partial, beginning with some of the priority areas, e.g. the exclusion of exports of hospital service from overall health expenditures. The final design and recommendations of any supplementary international trade tables reflected all these proposals.

10. The aim of the project was to set in place the framework and guidelines for future reporting of imports and exports of health services and as such the current availability of data in this arena remains patchy. From the existing health accounts collections and through the questionnaire used in the latter stage of the project it appears that for the vast majority of countries the level of trade in health care remains marginal – typically accounting for 0.0 to 1.0% of total health spending, even if this is still likely to be an underestimate. It is however relatively more important for some of the smaller member states where there is a greater need to source care, in particular certain specialist treatment, from abroad.

1. INTRODUCTION

11. This document constitutes the final report for the OECD project *Improving Estimates of Imports and Exports of Health Services and Goods under the System of Health Accounts*. The project was partly funded under EC Grant No. 2008 51 02.

Background

12. The health care sector is gaining importance in the economies of developed and developing countries. This, together with the trend towards globalisation, and reinforced by the removal of regulatory obstacles to economic activities, has seemingly fuelled the growth of international trade in health care goods and services, albeit from a relatively low level. Improved information, communications and transportation have also facilitated the movement of people, both as patients and as health care service providers.

13. The demand for statistics on the trade in health care goods and services is therefore increasing in order to monitor such trends. Moreover, within the European Union, judgements of the European Court of Justice[1] have made it clear that health care services can no longer be regarded as operating in isolation from other EU member states and have thus pushed the issue of cross-border health care up the political agenda. As a result, patients are increasingly moving from one member state to another in order to seek treatment, sometimes as a matter of individual choice, and sometimes through an arrangement offered by third party purchasers of health care services.

14. When it comes to comparable measures of spending on health care, *A System of Health Accounts* (SHA) states that 'Total expenditure on health measures the final use of resident units of health goods and services…' It should, by definition, therefore exclude exports of health care goods and services (*i.e.* those provided by domestic providers to non-residents either on the territory or across the frontier), but include imports of health care goods and services (*e.g.* health spending by residents while abroad or delivered from abroad).

15. However, past experience from international health accounts data collections has shown that the consideration of exports and imports of health care goods and services in the estimation of overall health spending has been generally weak and has been an area that has not been well defined. Moreover, the changing face of delivery and payment mechanisms (*e.g.* e-health, tele-diagnosis, the purchase of pharmaceuticals across the internet) has also led to increased difficulties in the monitoring and tracking of the variety of transactions; the traditional data sources used in the estimation of imports and exports (*e.g.* in the Balance of Payments) have proved mostly inadequate requiring additional data sources and methods to

1. Kohll-Decker Ruling C-120/95 [1998] and C-158/96 [1998] European Court of Justice. A proposed directive for cross-border healthcare in the European Union was published in July 2008 as part of the social agenda package hoping to provide a new legal framework, codify the European Court of Justice rulings on cross-border access to care as well as to ensure that e-Health or telemedicine services can be supplied from one country to another safely and efficiently. The European Parliament approved the amended cross-border health care bill in January 2011 with the law due to become effective in 2013.

be identified.[2] An additional data collection complication for trade in health services is the widespread existence of third party payments for health care services from public sources or private health insurance which should be accounted for in any overall estimation of the overall consumption of health care goods and services abroad.

16. Since 2007, the System of Health Accounts framework itself has also been the subject of a revision process. The forthcoming SHA 2011 manual[3] includes guidelines for health expenditure which relate to both current and future trends in expenditure patterns. In the case of trade in health goods and services, it is important to reflect countries' needs and priorities in future reporting.

Aims of the project

17. The main purpose of the project has been to respond to this growing policy interest by providing clear concepts, definitions and guidelines for the production of reliable, timely and comparable estimates of imports and exports of health services and goods within a standard health accounting framework.

18. Inherent in this has been the need to identify the diverse and developing range of transactions and flows taking place between the domestic health care sector (including third party payers) and non-resident providers of health care goods and services, whether this is, for example, as a result of liberalisation agreements for health care treatment abroad or the application of new technologies for the purchasing and provision of goods and services in cross-border trade. It has also been necessary to recognise that the boundary of health care goods and services goes beyond that of traditional treatment and is consistent with the range of services and goods defined within the health accounting framework. In particular, the project aimed:

- To provide a framework for the recording of exports and imports of health goods and services as an input to the revision of the System of Health Accounts;

- To develop guidelines and best practices in the measurement of exports and imports of health goods and services, including the evaluation of the feasibility of data collection, to be used in future data collections;

- To assess the feasibility of collecting and reporting trade in health services according to different categories of entitlement of non-residents, *e.g.* intra- and extra-regional trade, temporary residency, etc.

Methodology and process of study

First phase

19. The first phase of the project undertook a review in order to develop a suitable framework for the treatment of exports and imports within the *System of Health Accounts*. In developing such a framework, an evaluation of the various concepts and boundaries of trade in health care goods and services, a review of

2. The main data sources for Balance of Payments statistics are traditionally the International Transactions Reporting System (ITRS) and Enterprise surveys. Other sources used in country estimations include the use of tourism and visitor surveys, household expenditure surveys and government administrative sources, e.g. information on government health services provided to non-residents.

3. *A System of Health Accounts 2011* is due to be published as a co-edition of OECD, European Commission and WHO in September 2011. The revision process was started in 2007 and involved a global consultation.

current definitions related to entitlement and residency[4] and an assessment of the various modes of supply in application to health service transactions have been necessary. The review also required a consideration of the linkages and conceptual differences with existing economic statistical systems measuring trade and tourism statistics[5]. Under this first phase, a concept paper was produced to serve as an initial input for the revised SHA Manual. This discussion note was circulated at the 11th Health Accounts Expert meeting (DELSA/HEA/HA(2009)7) and a revised version incorporating received comments was submitted as an input paper for worldwide consultation on the SHA Revision website.[6]

20. An essential part of this initial phase was to reach a better understanding of the concept of residency and patient entitlement abroad and clarify the various data issues relating to trade in health care goods and services from different national perspectives and definitions. Therefore, the project established a number of case studies in order to undertake a wider review of current country practices and to include an inventory of the currently available and possible data sources and methodologies for the accounting and reporting of imports and exports of health care goods and services.

21. In summary, these case studies attempted to:

- Document the current data sources on the extent of, and trends in, trade in health services;
- Describe current and proposed regulations and practices for the import and export of health goods and services;
- Identify some of the key policy developments and challenges effected by an increase in trade in health care services; and
- Propose recommendations and priorities for the future reporting of trade in health care goods and services.

22. An Invitation for Expressions of Interest together with 'A Guide to conducting country case studies' was sent to the network of health correspondents and interested parties in June 2009[7]. As a result, country case studies were produced for Germany, Greece, Hungary, Slovenia, South Korea and partially for the United States (Table 1). In addition, the Secretariat also examined some particular aspects of the regulations and data sources regarding the movement of patients from the French and European perspective, as well as investigating the available sources and trends in trade in health services in a selected number of non-OECD countries, namely Morocco, South Africa and Tunisia.

4. In the methodology from the Balance of Payments Statistics, residency is usually conferred after one years' full residency, except in the cases of foreign students and foreign patients (who have travelled abroad primarily for medical reasons) who may retain non-resident status even after one year. An additional issue to consider is what happens to health expenditure of those who may be defined as residents from the point of view of the Balance of Payments Statistics but are not legally entitled to the benefits of public health insurance. This raises the question of where their expenditure on health services is being captured. Given the sizeable temporary flows of people between countries, both legal and illegal, the expenditure may be substantial.

5. In particular it was important to undertake this first phase with reference to the work being done at an international level through the Interagency Task Force on Statistics of International Trade in Services and the revised Manual on Statistics of International Trade.

6. http://www.oecd.org/health/sha/revision

7. Both of these documents were included as annexes to the Interim Report. December 2009.

23. The case studies provided a major input into the second phase of the project, namely the identification of possible data sources and guidelines for future compilation of statistics on trade in health care goods and services. All of the country case studies are provided as supplementary evidence to this final project report and included as annexes.

Table 1.1. Country case studies completed under Phase 1 of the project)

Country	Institute responsible for study	Completion date for final report
Greece	The Health Research Unit and Tourism Research Unit of the Athens Institute for Education and Research (ATINER)	March 2010
Germany	Statistiches Bundesamt	February 2010
Hungary	Hungarian Central Statistical Office (KSH)	May 2010
Korea	Yonsei Institute for Health and Welfare (YIHW)	May 2010
Slovenia	Statistical Office of the Republic of Slovenia (SORS)	May 2010
United States	LBJ School of Public Affairs, University of Texas at Austin	March 2010

Second phase

24. The subsequent phase of the project revised the draft framework and definitions. In addition, a glossary of possible data sources was identified for the various areas of imports and exports (that is, in relation to the type of service, the nature of the transaction, partner country or region, resident status, etc) and proposed tables for the supplementary reporting of imports and exports within the health accounts were proposed for discussion. This work drew heavily on feedback received on the issues raised in the concept paper during the consultation period, as well as the ongoing methodological development work and the final reports and recommendations from the country case studies.

25. An important part of the ongoing methodological development had been to distinguish between imported services and goods destined for intermediate production and those for final consumption. As an example of the former, tele-diagnosis services from abroad may be purchased by a domestic hospital. In this case, the inpatient care provided by this hospital constitutes the service consumed, and the tele-diagnosis would be an import by the hospital sector rather than a direct import of health services by the patient. Existing data sources, such as those used for balance of payments and national accounts do not make the necessary distinction.

26. At a subsequent meeting of the International Health Accounts Team (IHAT)[8] in Luxembourg in March 2010, it was further agreed that the issue of trade in health services should form a separate chapter in the revised SHA manual. In line with the overall aims and deliverables of this project, it was agreed that the content of the chapter should include background and policy issues around trade in health as a rationale for the need to improve the measurement. The concepts and definitions should be set out with an examination of the links to existing concepts that have been developed in the domains of international trade statistics and trade negotiations. Finally, some practical guidelines and best practices for producing and improving estimates of trade in health goods and services are provided with recommended data reporting. The first draft of the chapter, "Chapter 12: Trade in Health Goods and Services", was made available for worldwide consultation along with the rest of the draft manual at http://www.oecd.org/dataoecd/13/29/46420102.pdf in November 2010 with comments requested by 17 December 2010.

8. IHAT consists of experts working in the area of health accounting at OECD, Eurostat and WHO and was originally established in order to manage the joint health accounts data collection. In 2006, its mandate was extended to manage the revision of the System of Health Accounts manual.

Workshop

27. A technical workshop for invited country experts took place on 2 November 2010 in Paris prior to the 12th OECD meeting of Health Accounts Experts. Around twelve OECD countries were represented at the workshop together with experts from Eurostat, WHO and a number of academic institutions. The meeting allowed the experts from the participating countries to present and discuss the six country case studies and for the group as a whole to review the proposed framework and guidelines. The final project report and SHA chapter incorporates the recommendations from the workshop and Health Accounts Experts meeting.

28. Overall the workshop broadly supported the draft guidelines set out in the draft SHA 2011 Chapter on trade. The main conclusions from the workshop discussions centred on the application of existing concepts and definitions of residency and, in particular, the treatment of certain population groups such as retirees and refugees. In summary, there was broad agreement that while such definitions should be adhered to, there should be a certain 'room for manoeuvre' in respect of specific national circumstances. Regarding some of the borderline issues (e.g. cosmetic surgery, patient transport abroad, etc), it was recommended that the accounting of imports and exports should be consistent with the guidelines set out in the rest of the SHA manual.

29. Regarding the draft guidelines and the list of recommended data sources, it was agreed that, as with many areas of health accounting, no single set of circumstances could apply to all countries or type of statistical system, and as such the guidelines should present an array of possible sources and methodologies, perhaps with some indication of preferable methods or sources. Finally, it was accepted that in many cases the reporting of imports and exports, certainly at an initial stage, would have to be partial, beginning with some of the priority areas such as the exclusion of hospital services exports from overall health expenditures. The design and recommendations of any supplementary international trade tables should reflect this.

Final phase

30. A key purpose of the final phase of the project was to test the likely feasibility of implementing the draft guidelines under different health system characteristics and to assess the current data availability across various OECD and EU countries.

31. Therefore, a questionnaire, seeking information on current and future reporting of imports and exports of health goods and services, was sent to all OECD and EU countries on 30 November 2010 to be returned by 31 January 2011. The questionnaire also allowed countries to provide recent data on imports and exports according to the draft supplementary tables in order to ascertain the likely level and detail of currently available data. Chapter 6 provides an assessment of the results from the 22 completed questionnaires. The project recommendations and the final chapter on trade in the SHA 2011 manual reflect the results of the questionnaire, in particular with respect to the design of the supplementary trade tables.

32. The concepts and guidelines presented in the subsequent chapters of this report are fully consistent with the final agreed text of the SHA 2011 manual. A step-by-step strategy will be required concerning the incorporation of these guidelines and best practices into any subsequent revision of the annual Joint OECD, Eurostat and WHO Health Accounts data collection in the medium term.

33. This project was supported by an EU contribution, and therefore interest and involvement was sought from both OECD countries and those EU member and candidate countries that are not members of OECD.

Remainder of report

34. The rest of this report is organised as follows. Chapter 2 presents some of the background issues regarding the increase in international trade in health, discussing some of the rationale behind the need to improve estimates and some of the policy issues. Chapter 3 details the concepts and definitions for measuring imports and exports under a standard health accounting framework. Chapter 4 discusses the boundaries of health care goods and services consistent with the overall measure of health spending and which have particular relevance with respect to imports and exports. Chapter 5 provides compilers with some of the potential sources of information and some practical guidelines for arriving at estimates of imports and exports of health care services and goods. Chapter 6 discusses the reporting of imports under the standard SHA reporting tables together with more detailed supplementary cross-classified tables and indicators on imports and exports. Finally, Chapter 7 provides an overview of the current situation regarding the reporting of expenditure on imports and exports drawing on the results of the questionnaire sent to countries during the final phase of the project.

2. BACKGROUND AND POLICY ISSUES

35. The chapter on Global Boundaries of Health Care in the forthcoming *A System of Health Accounts 2011* focuses on the final consumption of health care goods and services by the *resident* population, irrespective of where this takes place. As a further qualification, this should also be irrespective of who is financing the goods or services consumed. Therefore, current health expenditure should include all final consumption by residents, both in the economic territory and abroad. This means the explicit inclusion of imports (health care goods and services provided by non-resident units, HP.9) and the exclusion of exports (those goods and services provided to non-residents by resident providers, HP.1-8[9]) in order to correctly determine total health spending.

36. Past experience from international data collections for health accounts[10] has shown that the consideration of the exports and imports of health care goods and services in the estimation of overall health spending has generally been weak, and that the issue was not covered sufficiently in the first SHA manual. At the same time, the changing face of service delivery and payment mechanisms (for example, e-health, tele-diagnosis and the development of on-line pharmacies) has also led to increased challenges in monitoring and tracking the great variety of transactions, as the traditional data sources used in the estimation of imports and exports (*i.e.* in the Balance of Payments) become less and less adequate.[11] A further factor complicating data collection for trade in health services is the widespread existence of third-party payments, both from public sources and private health insurance.

37. This chapter first considers the globalisation of health care and trends within this as a rationale for the need to improve the measurement of trade in this area. In order to meet the new requirements, the following chapter sets out concepts and definitions of external trade in relation to health expenditure and, where applicable, the implications beyond this boundary. Where possible, links to existing concepts developed in the domains of international trade statistics and trade negotiations are exploited to ensure close synergy. Some preliminary ideas on guidelines and possible data sources for producing and improving estimates of trade in health care goods and services are discussed. There is a subsequent discussion of the reporting of imports and exports as part of the core SHA tables, including supplementary trade tables, and their relation to other economic statistics.

38. The increasing importance of the health sector, together with the trend towards globalisation, which is being reinforced by the reduction of regulatory obstacles to economic activities, has fuelled a steady growth in international trade in health care goods and services, albeit from relatively low levels.

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9. It is more often the case that for many countries, the governance and administration of the health care system (HC.7.1) is exclusively provided domestically and thus not subject to trade considerations. However, for the reasons of completeness and to cover all possibilities the boundaries of trade considered here cover all functions and all domestic health care providers.

10. For example, the Joint OECD, Eurostat and WHO Health Accounts (the SHA) Data Collection - JHAQ (2006 – 2010).

11. The main data sources for Balance of Payments statistics are traditionally the International Transactions Reporting System (ITRS) and Enterprise surveys. Other sources used in country estimations include tourism and visitor surveys, household expenditure surveys and government administrative sources, *e.g.* information on government health services provided to non-residents.

Improved communications and transportation have also facilitated the movement of people, both as patients and independent service suppliers. While for the most part individuals prefer to receive health care in their home country, under certain circumstances it may be more beneficial for a patient to receive treatment in another country, for example, when the nearest health facility may be across a border, or when there is more expertise available, or if the same care can be provided sooner or at lower cost.

39. Travelling for health care is nothing new – since early times people covered long distances to seek cures and healing. Health care goods and services have traditionally been viewed as non-tradable commodities – amid national concerns regarding the sovereignty of public health provision – or in most cases as negligible in value and volume. In recent years, however, there has been a growing body of evidence that in many countries an increasing number of patients have been travelling across international borders specifically for the purpose of receiving treatment (commonly termed "medical or health tourism"), *e.g.* Thailand reported that over one million foreign patients were treated there in 2006 (Thai Board of Investment, 2008). Independent studies have provided wide-ranging estimates of the global level of activity. A report by Deloitte (2008) estimated that in 2008 the value of the world medical tourism market was around US$ 60 billion, and it expected this figure to continue to grow at a double-digit pace over subsequent years. In this context, a number of countries have actively promoted their comparative advantage as medical travel destinations, hoping to attract patients from both neighbouring countries and further afield through the promise of high-quality, technologically-advanced and competitively-priced health services. Individual hospitals and clinics or clusters of health care providers have also sought international accreditation in order to put themselves on the map of the international health insurance and purchaser networks.

40. There have also been examples, particularly in the European Union, of cross-border contracting between health care purchasing authorities and foreign providers. One example of this was an agreement in 2003 between the NHS in England and various Belgian hospitals that aimed to reduce some of the waiting lists in England at that time (Glinosa *et al.*, 2010). Other regional contracting arrangements and cross-border cooperation have existed in various border regions, *e.g.* between the Netherlands and Belgium, France and Spain, and among the Nordic countries.

41. However, the consumption of health care goods and services abroad goes beyond planned care abroad. Much of the activity between non-resident providers and residents can be of an unplanned nature, that is, the use of a country's health system while temporarily in the country on business or leisure travel. In addition, the movement of short-term, seasonal or border workers is another important area to be considered. For some smaller countries or border regions that experience large flows of persons and workers across their borders, the import and export of health care goods and services can be significant. Increasing levels of travel and tourism can put strains on the health system of a country or region. For example, past agreements between the UK and Spanish governments resulted in lump-sum payments that were linked to the number of UK tourists travelling to Spain and were intended to cover their use of Spanish health care services (Legido-Quigley and McKee, 2006).

42. Rising health care costs at home and a lack of health insurance cover are among the major incentives for patients to seek treatment abroad, where procedures and treatments sometimes cost only a fraction what they would at home. But technological advances, market openings and obstacles to accessing health care treatment at home (for example, waiting times, quality of treatment and legal/ethical obstacles) have all been cited as factors behind the increase. Continuing economic and political cooperation between states is likely to lead to the increased movement of patients and health care professionals. Indeed, past ambiguities regarding the right of European Union citizens to seek treatment in other Member States have helped to push the issue of cross-border health care towards the top of the European health agenda in

recent years (Box 1.1).[12] In summary, the flow of patients from one country to another has been increasing, sometimes as a matter of individual choice, sometimes organised through contracting abroad by purchasing authorities.

Box 1.1. Regulations guiding access to health care in the European Union

Based on article 42 of the EC Treaty, under the heading of "free movement of persons", a Community mechanism was set up in 1958 to coordinate social security entitlements for migrant workers moving within the European Economic Area. This social security coordination system enshrined in EC Regulations 1408/71 and 574/72 determines which legislation is applicable for social security (usually that of the country where the professional activity takes place), it aggregates periods of insurance, employment or residence established in other Member States for the purpose of social security law, prohibits discrimination based on nationality or place of residence, and enables recognition of social security benefits elsewhere in the Union.

In the area of health care, the primary aim of social security coordination is to guarantee access to care in the state of residence for migrant workers and their dependants. Article 22 of Regulation 1408/71 (= Articles 19-20 in the new Regulation 883/2004) also provides avenues for statutory cover of treatment received outside the State of residence or affiliation. This access to cross-border care is subject to certain conditions:

- Occasional care: when temporarily in another Member State, a person is entitled to care becoming necessary during their stay. To prove his/her entitlement in the home state, the patient should submit an E111 form in the host state.

- Planned care: Patients moving to another Member State specifically to obtain care need to gain prior authorization from their competent institution in their home state. This authorization, certified by an E112 form, must be given if the treatment is covered at home but cannot be provided there within medically justifiable time-limits.

Under these rules for coordination, the patient is treated in the host Member State as if he or she was covered by the host statutory scheme. This means that the reimbursement conditions and tariffs of the state of treatment apply. Financial compensation for the treatment delivered is exchanged between Member States either on the basis of real expenses billed or on a flat-rate basis in respect of all patients involved during one year. Some Member States also mutually waive claims between each other.

Modernizing the coordination tool

In 1998 a process was launched to revise and simplify the entire coordination mechanism under Regulation 1408/71, which includes all branches of social security. An important element of this modernization is the European Health Insurance Card (EHIC). The establishment of this card was decided at the Barcelona European Council (March 2002) to promote occupational mobility in the context of the Lisbon agenda and to demonstrate the benefits of Europe to its citizens. The EHIC, designed to replace all existing paper forms required for occasional health treatment when in another Member State (E111, E110, E119, E128), was presented as a way to simplify procedures for patients, providers and administrations.

European Union Directive of Patients' Rights in Cross-border Healthcare

In July 2008, the European Commission, as part of a social agenda package, presented a proposal on patients' rights in cross-border healthcare. The Directive focused on the triple objective: to guarantee that all patients have care that is safe and of good quality; to support patients in the exercise of their rights to cross border health care; and to promote cooperation between health systems. The aim of the second objective was in particular to codify the case law

12. A proposal for cross-border healthcare in the European Union was first discussed by the College of Commissioners on 25 June 2008 as part of the social agenda package, and it is hoped that the report will provide a new legal framework for the area in order to meet European Court of Justice rulings (Kohll-Decker Ruling C-120/95 [1998] and C-158/96 [1998] European Court of Justice) on cross-border access to care, as well as to ensure that e-Health or telemedicine services can be supplied from one country to another safely and efficiently.

of the European Court of Justice case law on patients' rights in accessing cross-border healthcare and clarify its application.

The Directive set out the legal framework for patients seeking access to healthcare in another Member State. The broad outline of the Commission's proposal was that in cases of patients accessing cross-border care, the 'home' state has responsibility for deciding what healthcare it will fund and for setting up a system of cost reimbursement. The patient will then be entitled to reimbursement of costs, up to the amount the home state would have paid to treat that person at home. Where a patient is treated in another Member State, that country's legislation and standards applies – this includes redress arrangements should anything go wrong. The draft Directive did not alter the right of Member States to define the benefits that they choose to provide.

Despite many amendments and substantial progress, the Council of the European Union was unable to reach agreement by the end of 2009. A compromise text from the Spanish presidency sought to bring a balance between the rights of patients to seek healthcare and the responsibilities of states to organise the delivery of health services. This centred on two areas – the reimbursement and prior authorization with regard to non-contractual healthcare providers and Member State responsibilities with regard to pensioners living abroad. A final amended text was agreed by the European Parliament in January 2011 and expected to come into operation during 2013.

Apart from the rules regarding reimbursement and flows of patients, the Directive also sets out provisions for increased cooperation between member states in the fields of e-health and the development of European reference networks and, on a voluntary basis, specialized centres in different member states. Also it sets out improved recognition of prescriptions across the EU to ensure that prescriptions issued in one member state can be dispensed in another. However rules governing the sale of medical goods over the internet are not covered under this directive.

Source: European Observatory on Health Systems and Policies (2005), Policy Brief; Cross Border Health Care in Europe, WHO. UK Department of Health (2009), Cross Border Healthcare & Patient Mobility - Revised advice on Handling Requests from Patients for Treatment in the European Economic Area - GUIDANCE FOR THE NHS.

EU regulation for statistics on patient mobility

As part of the statistical obligations of EU member states, Regulation (EC) No 1338/2008[13] of the European Parliament and of the Council on Community Statistics on public health and safety at work of 16 December 2008 established a common framework for the systematic production of statistics in the area of public health and health and safety at work. Under "Health care" one of the five statistical domains covered, the regulation makes specific reference to "The mobility of patients, namely their use of health care facilities in a country other than their country of residence, and of health professionals, such as those practising their profession outside the country where they obtained their first licence, shall be considered in the data collections."

As part of the implementation of the Council Directive on patients' rights, the implementing provisions set out the requirement for reports every three years which 'shall in particular include information on patients' flows, financing dimensions of patients' mobility'.

43. The regulatory liberalisation of health services may have important effects on a country's health system, offering new opportunities, but also posing risks. For example, foreign patients can provide considerable revenues for the receiving country, but they may also draw critical resources away from local patients, leading to a two-tier health service. Blouin *et al.* (2006) analysed in detail the possible implications of trade in health services on public health systems.

44. For exporting countries, there may be a risk that there exists high-quality richly resourced care for foreign patients in contrast to low-quality poorly resourced care for nationals, or that scarce public funds in the form of tax breaks, incentives and subsidies for private providers are diverted away from primary care needs. Another possible concern is the possible brain drain of trained health professionals from the domestic public health system to private providers, and from rural to urban areas.

13. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:354:0070:0081:EN:PDF

45. Public health issues in the patients' countries have also been well documented. In addition to the possible indication of an inadequate domestic health system that is unable to meet the needs of its own population, there are questions over equity, as patients who can afford the expense are able to access certain services abroad or to jump waiting lists, and care sought abroad may be a substitute for needed health care reforms or investment in the domestic health system. There may also be concerns over the lack of controls or regulations on certain treatments abroad as well as question marks over the quality of treatment and aftercare, with the domestic system left to deal with any resulting complications or malpractice.

46. On the other side, there can be potential benefits of medical travel for both sides. For the recipient (exporting) country, there are foreign earnings from increased health and tourist flows and increased employment and improved infrastructure resulting from health provider investment. With the diffusion of new technologies and treatments, a "seepage" effect may be envisaged that helps raise the health standards of the local population. Some anecdotal evidence has also pointed to a "reverse brain drain" whereby health professionals return to their country of origin. For the importing country, there may be important economies of scale and cost savings to be made, and rather than a substitute for reform, it can be seen as a catalyst or a necessary introduction of external price competition in the domestic market.

47. Apart from the physical movement of patients between countries, trade in health services can also take other forms, notably the cross-border delivery of health care goods and services directly to patients or other health care providers. Technological advances, in particular the widespread use of the Internet, mean that individuals are able to seek out health information and to purchase medical goods and services remotely. A study of Internet use for health purposes in Norway over the period 2000-2007 showed a dramatic rise in usage, with 67% of the population using the Internet for health information in some way, and this is forecast to rise to more than 80% by 2010 (Wangberg *et al.*, 2009). While much of the on-line activity is to gather supplementary information regarding illness and health, there was also a tendency towards purchasing medicines or health-related products, with almost a quarter of those who used the Internet for health purposes reporting this in 2007. Diagnostic services and health administrative services are also increasingly being outsourced, including to overseas organisations. The increase in the number of medical websites and Internet pharmacies has highlighted current gaps with respect both to existing legislation on the purchasing of prescription medicines and to the lack of data to monitor this trade.

48. Finally, trade can also involve the movement of health care personnel or service providers themselves across borders rather than the patient. This may come under the scope of direct foreign aid in kind or technical assistance (TA) provided by foreign governments or international organisations with the provision of medical teams to needy areas, but can also be linked to individuals or groups of health professionals who move independently across borders to provide health services to patients.

49. While much of the trade in health care goods and services based on figures to date continues to remain marginal – for the most part, a direct patient-provider contact close to home is still the norm for most treatments – there are areas where consumption abroad or cross-border supply may account for an increasing part of the total consumption, such as in the area of dental care or fertility treatments. There is also a growing awareness in some countries that parts of domestic health service demand are increasingly being met by foreign providers of health care or *vice versa* – a sizeable part of domestic health care provision is satisfying the health care needs of non-residents, and as such needs to be monitored and analysed further.

50. There is also a wider policy interest in trade in health services from the viewpoint of trade negotiations and the World Trade Organisation General Agreement on Trade in Services (GATS).[14] The

14. See Annex 1: International standards and classifications of trade and tourism.

interest from a number of countries in developing health service exports as a potential currency earner has also contributed to the need to better assess levels and trends in this trade. Policy makers and trade negotiators need reliable data to better understand the dynamics of trade liberalisation and the impacts on public health. This data would enable analysts to gauge trade flows as well as a country's openness to trade in health services. Most importantly, it would make it possible to assess the risks and opportunities related to liberalisation commitments on public health, and thus to craft appropriate policies in order to move towards coherent health and trade objectives.

3. CONCEPTS AND DEFINITIONS

51. The System of Health Accounts requires a conceptual basis for the reporting of imports and exports of health care goods and services that is in line with the established boundaries of health expenditure. To ensure that SHA statistics are compiled on a basis that is in line with other macroeconomic statistics as much as possible, it is reasonable for the SHA to take its lead from the standard definitions and concepts already well developed within the System of National Accounts (SNA) and in the Balance of Payments and International Investment Position Manual of the International Monetary Fund (IMF), known as BPM6. The different perspectives can lead to different definitions of international trade: on the one hand, trade that falls within the core framework of the SHA, and on the other, trade in health care products in a wider economic sense.

52. In addition, reference is also made to the concepts and definitions outlined in Tourism Satellite Accounts (TSA), with an assessment of the existing survey instruments and methodologies employed in developing estimates of tourist consumption of health care goods and services.

53. Within the central accounting framework of the SHA, health care goods and services are defined according to a clear set of criteria (Box 3.1) and delineated according to the functional classification (Box 3.1). The same boundary considerations and treatment of borderline cases should therefore be applied in estimating the value of imports and exports of health care goods and services. Furthermore, in the interests of completeness, the universe of health care providers must include all providers irrespective of whether the provision of health care is a primary or secondary activity. One of the challenges not limited solely to matters of external trade, is to adapt existing product and activity classifications to the functional classification of the SHA. Additional consideration of extended boundaries, so as to analyse the part of non-resident consumption in areas such as health education and training, may also be of interest.

Box 3.1. Four criteria for inclusion within the SHA health expenditure boundary

1) The primary intent of the activity is to improve, maintain or prevent the deterioration of the health status of individuals, groups of the population or the population as a whole as well as to mitigate the consequences of ill health;

2) Qualified medical or health care knowledge and skills are needed in carrying out this function, or it can be executed under the supervision of those with such knowledge, or the function is governance and health system administration and its financing;

3) The consumption is for the final use of health care goods and services of residents;

4) And there is a transaction of health care services or goods.

54. Key to being able to determine the level of international trade in health care goods and services are the concepts of economic territory and residence. The following definitions are for the most part in accordance with those set out in the BPM6,[15] where further detail and clarification can be sought.

15. The same concepts and definitions are adopted in the System of National Accounts.

Box 3.2 The classification of health care functions at the first-digit level

HC.1 Curative care
HC.2 Rehabilitative care
HC.3 Long-term care (Health)
HC.4 Ancillary services (non-specified by function)
HC.5 Medical goods (non-specified by function)
HC.6 Preventive care
HC.7 Governance and health system and financing administration
HC.9 Other health care services not elsewhere classified (n.e.c.)
Memorandum items: Reporting items
HC.RI.1 Total Pharmaceutical Expenditure
HC.RI.2 Traditional Complementary Alternative Medicines
HC.RI.3 Prevention and public health services (According to SHA 1.0)
Memorandum items: Health care related
HCR.1 Long-term care (Social)
HCR.2 Health promotion with a multi-sectoral approach

Economic territory

55. In its broadest sense, an economic territory refers to any geographic area or jurisdiction for which statistics are required. In the case, for example, where health systems are organised and financed at a regional level and the interest is in building regional health accounts, it could be desirable to define the territory as a sub-national region. On the other hand, the economic territory may consist of more than one country, for example, the Economic Union of Belgium and Luxembourg, or supra-national territories such as the European Union (EU). The definition of economic territory is important in determining resident and non-resident entities with respect to the consumption and provision of health services, and therefore what should be included or excluded in an overall estimate of health expenditure.

Residence

56. The concept of residence is subsequently determined by the delimitation of the economic territory. A unit is said to be resident in a country when its "centre of economic interest" is situated within that country's economic territory. BPM6 further defines: "The residence of each institutional unit is the economic territory with which it has the strongest connection, expressed as its centre of predominant economic interest." Each institutional unit is therefore a resident of one and only one economic territory determined by its centre of predominant economic interest.

Households

57. A household's centre of economic interest is determined based on "when members of that household maintain, within a country, a dwelling or succession of dwellings that the members treat and use as their principal residence". All individuals belonging to the same household must be residents of the same economy. It is important to make the distinction between the concept of residence in economic terms and concepts based on nationality or legal criteria. An individual considered to be a resident of a particular economy may not necessarily be a citizen of that country. A differentiation between the resident population and the covered or insured population is also of particular relevance to health care. Public health care insurance coverage may not cover the whole population or may extend beyond the resident population, *e.g.* cross-border workers who work in Luxembourg but reside outside the economic territory may be included in the insured population of Luxembourg, or retired EU citizens who are still covered under their national insurance scheme but are resident in another EU country (see resident versus covered population).

58. The criterion for residence is nominally based on a period of one year, which can be seen as an objective, if arbitrary, benchmark for determining a person's status. Therefore, a member of a resident household who leaves the economic territory and returns to that same household after a limited period of time (*i.e.* less than a year) continues to be a resident even if that individual makes frequent journeys outside the economic territory. On the other hand, if an individual stays or *intends* to stay in an economy for a year or longer, he or she is considered a resident of that economy. If not, he or she is considered a non-resident. All such individuals are classified as being in travel status and as having their centres of interest outside the economies to which they have travelled. In the most obvious case, foreign tourists who visit for a short period (generally a few weeks) are not counted as resident. Similarly, seasonal workers coming from another country to work for a few months a year in a country are not regarded as resident.

59. Certain categories, such as diplomatic representatives, members of the armed forces, students and – of particular relevance here – patients undergoing medical care abroad, do not change their centres of interest and therefore remain residents of their home economies. Border workers – persons who cross the border between two economies on a regular, frequent basis because they work in one economy but have homes in the other – are classed as residents of the economy in which they have their homes and not of the economy in which they are employed. Persons living in Belgium but crossing daily into and out of France for work would continue to be regarded as residents of Belgium rather than residents of France.

60. Refugees are considered residents if they stay or, importantly, *are expected to stay* for one year or more in their host countries. Persons taking refuge in another country for only a short period remain residents of their home economies.

61. As stated, an exception to the one-year rule is made in determining the resident status of students and long-stay medical patients, because application of the one-year rule could lead to problems with the interpretation and availability of data. Students are generally expected to return to their home economies upon completion of their studies. However long they study abroad, students should be treated as residents of their countries of origin if they maintain economic attachments to their countries. The factors to be considered in determining whether such an attachment has been maintained includes whether a student is dependent on funds from his/her country of origin to finance his or her studies; whether he or she is funded by the host country under foreign aid or similar programmes; and whether he or she plans to return home upon completion of study. This is important to note regarding expenditure on health education and training of medical professionals abroad.

62. The same rules regarding residence apply to patients who are expected to return home after the period of treatment. That is, they are considered – regardless of the length of stay in the economies in which they are receiving treatment – to be residents of their economies of origin. While this is likely to be of significance only to a very small minority of medical patients, consideration should be given to the residential status of Long-term care patients in nursing care homes abroad, in light of the inclusion of such care within the definition of health under the SHA. This is of relevance where persons from one country have retired to another country but continue to be covered under their "home" social security system. This is considered in the following section.

Resident versus covered population

63. Confining the boundary of health expenditure to that of the resident population has a number of direct consequences on the inclusion or exclusion of certain groups of the population, in particular, with respect to the financial obligations of social security and government spending. In some cases, the differences between the resident population and the insured population can be significant.

64. It may be the case, such as in the European Union that persons receiving a state pension or other long-term benefit who reside in another country may still depend on their "home" nation for paying for their health care. This is also the case for those living abroad, but dependent on someone working in another member country. In this case the obligation of the home social security system covers a part of the non-resident population and *vice versa* – a portion of the resident population may be covered by a foreign government. In this case, adjustments may have to be made to conform to the definitions of residence above, which may not be wholly desirable in measuring the financial obligations of a country regarding their health spending.[16] Any deviations in this respect should be made transparent in reporting.

65. Another issue concerns refugees as well as those who may be defined as residents from the point of view of the Balance of Payments definitions but are not legally entitled to the benefits of public health insurance. This raises the question of where their consumption of health services is being captured. Given sizeable temporary flows of people between countries, both legal and illegal, the expenditure may also be sizeable. Coupled with the fact that in these cases the moral obligation and therefore the cost of providing health services falls onto the host country, it may be arguable whether such expenditure should in fact be deducted from the country's health accounts as an export.

66. BPM6 provides further detail on the status of other categories of persons, such as diplomats, employees of international organisations, military personnel, etc., which are also adopted by the System of Health Accounts.

67. To classify a provider of health care – whether government agencies, enterprises or non-profit institutions – as resident generally requires that they have undertaken activity in the territory over a period of time, usually interpreted as one year. Classifying a provider as resident or non-resident is synonymous with deciding whether or not the final expenditure by resident households on goods or services from these providers is classed as imports.

68. For the most part, the classification into resident and non-resident providers poses few problems, such as in the case of residents receiving care from hospitals or buying medical goods from pharmacies whilst abroad. The short-term provision of services to residents abroad, by health care professionals or as part of foreign government or international aid efforts may be less straightforward. Similarly, foreign-owned institutions and the use of commercial agents require careful consideration.

Enterprises

69. An enterprise has a centre of economic interest and is therefore a resident unit of a country (or economic territory) when the enterprise is engaged in a significant amount of production of goods and/or services there. This means that it maintains at least one establishment in the country and plans to operate that establishment indefinitely or over a long period of time (that is, one year or more). Other considerations – such as whether there is a complete and separate set of local accounts, whether taxes are paid to the host government, or whether funds for the local operation are locally managed – must also be considered in determining the residence of an enterprise. In practice, these additional conditions are generally satisfied for enterprises engaged in longer-term activity.

16. When the health spending of certain groups of the population (*e.g.* those retired or living abroad) is still covered by their country of origin, then the transfers made from the country of origin to the country of residence will be shown in the table HFxFS of the receiving country; the revenue of the financing scheme will be either FS.2 or FS.7.1 (see the Classification of Revenues of Financing Schemes in SHA 2011). From the point of view of the reimbursing country, a sectoral account of the "Total health-related revenues and expenses of government" can detail the payments made to foreign governments for non-residents.

70. The term enterprise includes (1) corporations, which are entities engaged in production for profit and recognised as legal entities separate from the owners, and (2) quasi-corporations, which are unincorporated entities owned by resident or non-resident institutional units and managed as separate entities, which is the case for many self-employed doctors and dentists.

Commercial agencies

71. Agencies representing non-resident principals should be treated as resident in the economies in which they are located. For example, new burgeoning areas include health tourism facilitators and medical travel agents as well as commercial offices that have been set up abroad to represent medical institutions. Most agents charge the providers a fee for each client sent abroad based on a commission percentage of the package price or a set fee per patient. Other models are also possible, including a service fee direct to the client (patient) or a payment from a third-party payer as a share of the cost savings, *i.e.* the difference between the cost of the procedure at home and the cost abroad (Stephano and Cook, 2010). If the agent is a resident of the same economy as the patient, then the margin or commission is a resident-to-resident transaction. The net amount payable to service providers resident in other economies (after the margin or commission receivable by the agent is deducted) should be recorded as a resident-to-non-resident transaction. However, in other cases, the gross amount is payable to the non-resident provider, who subsequently pays the resident agent's commission.

Non-profit institutions

72. Like enterprises, non-profit bodies are resident entities of the economic territories in which they are located or conduct their affairs. Non-profit bodies generally provide health and other social and community services free of charge or at prices that do not fully cover the costs of production. Examples of non-profit bodies can be private hospitals, churches, foundations, universities, colleges and charities such as the Red Cross.

73. In practice, the residence of the vast majority of non-profit institutions can be determined without ambiguity. However, when such an institution is engaged in charity or relief work on an international scale, it is necessary to specify the residence of any branches the institution may maintain in individual countries. In this case, it is appropriate to use the guideline of length of time to determine the residence of such branches. If a non-profit institution maintains a branch, or similar unit, for a year or more in a particular country, that branch should be considered a host country resident that is, however, financed largely or entirely by transfers from abroad. On the other hand, short-term medical emergency work or specific health campaigns in another country may be classified as being provided by non-resident units.

Government

74. The general government agencies of an economy include all central, state and local government departments, establishments and bodies located in the economic territory and all general government embassies, consulates, entities and military establishments located elsewhere. In the case of imports and exports of health services, the provision of medical treatment to residents abroad in foreign government health facilities and the provision of services by public health institutions to non-residents in the territory are the most obvious examples of imports and exports, respectively.

75. In the case of government agencies involved in foreign aid programmes, this type of expenditure comprises goods and services provided by foreign governments to resident units and *vice versa*. It should be reiterated that it is the provision of goods and services, and not the financing by the foreign government that is important in determining whether this is an import or export. For example, if a government donates money to other countries or to international organisations, this amounts only to a transfer of funds. If,

however, the government provides health care goods and services for final use directly to a foreign country, this will be a health export for the country and a health import for the foreign country (and should be reflected in that foreign country's health accounts). The core of this type of expenditure is represented by government aid programmes for enhancing health in foreign countries. It should be noted that if the provision is led by the military, for example, only health expenditures should be taken into account.

International organisations

76. International organisations and enclaves, limited to those created by governments (such as embassies), are resident in an economic territory of their own, and not of the economy in which they are physically located. This treatment applies to both international organisations located in only one territory and those located in two or more territories. Therefore any transactions with an international organisation or enclave should be treated as international trade.

Rest of the world and trade in health care

77. Having determined the residence status of all units, the Rest of the world is thus composed of all non-resident units carrying out transactions with the reference country. Regarding trade in health accounts, the Rest of the world comprises all non-resident units that provide health care goods and services to resident units (these transactions being imports) and the non-resident units that consume health care goods and services provided by resident units (these transactions being exports).

Valuation

78. In the case of transactions between residents and non-residents, the values of exports and imports denominated in foreign currencies should be converted into national currency using market rates of exchange. In principle, the most appropriate exchange rate to be used in converting transaction values from the currency of transaction to the currency of compilation is the market rate prevailing at the time that the transaction takes place. The use of a daily average exchange rate for daily transactions provides a very good approximation. If daily rates cannot be applied, average rates for the shortest period should be used.

79. With regard to the provision of non-market services to non-residents by general government or non-profit institutions,[17] such services should be valued consistently using the methodology in the SHA Manual, *i.e.* by their total cost of production and not by the subsidised price.

80. The SHA records expenditure on goods and services in purchasers' prices. It should be noted that total figures for imports and exports in the national accounts are normally reported at FOB ("free on board") prices, and detailed foreign trade statistics are valued at CIF (cost, insurance, freight) for imports and FOB for exports (see Box 3.3). The difference between the two can vary widely, but can be up to 10 per cent (Eurostat, 2004). From this it would be expected that the import value would exceed the export value, but even this cannot be guaranteed. One reason is timing differences, whereby a basket of goods cleared as exports from one country in a particular year need not be cleared as imports into the receiving country in the same year.

81. Transactions in health services, for example between governments, should be recorded on a gross basis, that is, total claims and reimbursements should be separately compiled, rather than recorded net. One issue relates to the valuation of externally provided goods and services when there is a large differential

17. In the absence of any reimbursement of this cost/expenditure, this may result in reported deficiencies in the providing country, as the consumption of resources does not match the capacity and consumed resources. Hence it will be under-reported or not reported at all.

between the valuation of the recipient (importing) and donor (exporting) country, *e.g.* health system consultancy services provided by a higher-income country in a lower-income country. In this case, in a departure with BPM6 (Para. 3.75), the valuation should be made in terms of the recipient country's market prices. However, a memorandum item based on the donor country's market valuation is also deemed to be appropriate.

Box 3.3 The CIF/FOB adjustment in trade statistics

Imported goods registered by trade statistics are valued CIF (cost, insurance and freight) which includes three different components:

Imported goods FOB;

Transport services rendered by both resident and non-resident transporters;

Insurance services rendered by both resident and non-resident insurers.

The two latter components represent services that can be rendered by either resident or non-resident units. If rendered by residents, this is domestic output and thus should not be treated as imports. If no adjustment is introduced, imports are obviously higher than they should be according to the total value of transport and insurance services rendered by both residents and non-residents. One must be careful about the treatment of the value of transport and insurance services rendered by residents on imports. If these services are bought and paid for by non-resident exporters to resident carriers and insurers, their value will be recorded as the export of services in the balance of payments, and therefore must be excluded from the import of services.

Timing

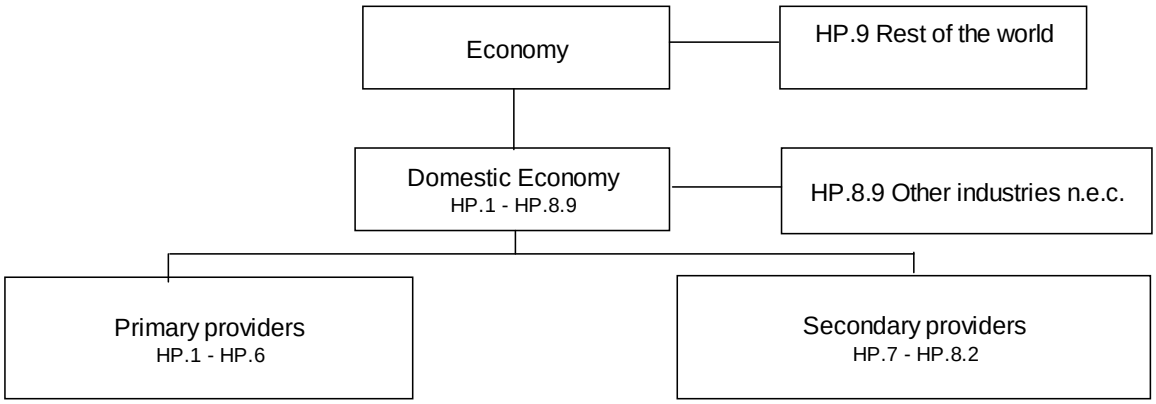
82. In line with national accounting rules, exports and imports are to be recorded on an accrual basis, that is, at the time when a service is delivered or, in the case of medical goods, when the change in ownership occurs. There may be practical issues of data collection in that for the most part the movement of goods is a reasonable proxy for the change of ownership. However, in the case of patients travelling abroad to receive treatment, the fees may be paid in part or in full either before or some period after the service is consumed. Moreover, concerning bilateral agreements, there are often significant delays – sometimes a couple of years – between the time of treatment and the time of payment or claim for reimbursement.

4. BOUNDARIES OF TRADE UNDER SHA

83. SHA 2011 establishes a conceptual basis for statistical reporting rules that is compatible with other economic and social statistics and that uses the International Classification for Health Accounts (ICHA), which covers three dimensions: health care by functions of care; providers of health care services; and health care financing. The System of Health Accounts (SHA) therefore follows a different logic than the one proposed in international trade statistics (that is, according to the type of service industry and mode of supply) (see Annex 1).

84. In the System of Health Accounts, a category related to non-resident units exists in both the provider and financing schemes classifications. Both classifications refer to the "Rest of the world". However, with respect to the imports and exports of health care goods and services, it is important to clarify that it is the provision by non-resident units that is of relevance to trade, rather than the financing. For example, if a foreign government or NGO pays for services for residents, then these services are financed by the Rest of the World but may still be provided by a domestic provider and are therefore not imported. If, however, the service is also provided by a foreign government to a resident (irrespective of who pays for it), then this is indeed an import.

Figure 4.1 Overview of the classification of health care providers ICHA-HP



85. The primary classifications of imports and exports under the System of Health Accounts are by function (purpose of consumption) and provider. The classification of functions distinguishes *inter alia* the different services of care[18] (*e.g.* curative, rehabilitative and long-term care), medical goods dispensed to outpatients as well as services delivered collectively to the population, such as health promotion campaigns and the governance of the health system. The main reconciliation of this definitional classification with the System of National Accounts at an aggregate level is via the "functional" or "purpose" classifications (COICOP, COFOG and COPNI). The corresponding provider classification is linked to the International Standard Industrial Classification (ISIC, Rev. 4). This is important in terms of source data since the ISIC provides the basis for business, survey, employment and census statistics. International trade statistics are

18. In addition, the basic functions of care can also be classified by the mode of production (*e.g.* inpatient, day care, outpatient and home care).

more aligned with the analysis of production and as such, classifications are based on the standard classification of products (CPC).

Examples of trade in health care goods and services under the SHA

86. Imports and exports cover a wide range of health care goods and services for final consumption; coverage extends beyond the standard provision of medical treatment abroad, in line with the boundaries of the functional classification. It may be useful to consider the following examples, using the different modes of supply applied to both goods and services.

Individual health care services

87. Regarding the provision of health care services to individuals, this could be remote health counselling (which comes under many names, such as telemedicine, e-health, e-medicine, etc.) provided over the phone or Internet by a doctor in one country directly to a patient in another. This type of remote patient monitoring may involve a patient who has undergone surgery abroad and then returned to their home country. Note, however, that health care goods and services delivered from a provider in one country to a provider in another are considered as intermediate consumption and as inputs to a resident-to-resident service (*e.g.* diagnostic tests or blood products sent from a laboratory abroad to a hospital in the patient's country) and are therefore not recorded as imports under the SHA.

88. However, most of the relevant transactions relating to international trade in health care under the SHA concern the consumption by patients who are abroad either due to planned treatment (*e.g.* dental treatment, knee surgery, rehabilitative stay, etc.) or as a result of an unplanned need while abroad. This could be a patient from Country A receiving planned medical treatment in a hospital in Country B. This would be an entry in the total health spending of Country A – treated as an export for Country B and an import for Country A. Similarly, the cost incurred by a tourist who purchases medicines while abroad or falls sick and visits a GP should also be included in the health spending of the tourist's home country.

89. The temporary movement of health professionals from one country to another is also an example of international trade in health services. This could be an individual health care professional or a team of doctors or specialists working for a non-resident provider fulfilling a short-term contract to deliver services in another country. This is also relevant in the domain of foreign aid programmes, where goods and services may be provided directly to residents by foreign governments or NGOs. Again, it is the provision and not the financing that is of importance here.

90. The temporary presence of health professionals can also lead to some grey areas regarding inclusion under trade due to the employment and/or resident status of the provider. This may be particularly difficult to establish in areas of personal care, for example, when non-resident caregivers may be providing long-term care services.

Medical goods

91. With respect to medical goods, this could simply be the provision of health goods (pharmaceuticals, other medical non-durable and durable goods) directly to the patient/consumer from a non-resident provider by telephone, mail order or, increasingly, via the Internet. The rise of Internet pharmacies and the increased recognition of prescriptions and reimbursements across borders, *i.e.* in the European Union (Ruth *et al.*, 2003), are likely to expand the range of delivery mechanisms for medical goods beyond the traditional local pharmacy.

92. Otherwise, the consumption of medical goods abroad is the main channel for trade. Much of this will be incidental purchases of tourists and visitors while abroad (which in terms of international trade

statistics are reported under the "travel" category). Large price differentials and the liberalisation of prescription regulations between countries can also lead to large cross-border movements to purchase pharmaceuticals in neighbouring countries (Byrd and Law, 2009).[19]

Collective health care services

93. The provision of health insurance to residents by non-resident insurance companies and *vice versa* should also be considered as examples of foreign trade under the SHA. However, in line with the general SHA treatment of health administration and insurance, this includes only the service charge element of the premium paid by households. Any payments made by a non-resident insurer to or on behalf of residents for health care services would only be treated as foreign trade if the care is also provided by non-resident health-care providers. For example, if a US resident takes out health insurance with a Mexico-based health insurance company and receives dental care from a Mexico-based dentist, then both the insurance service charge and dental care are regarded as imports.

94. In the realm of public health, and for certain aspects of health system governance and administration, it may be that some areas are outsourced or provided by non-resident entities. For example, health system planning and reform may be provided as consultancy services or may directly involve international organisations in public health and prevention measures. Similarly, part of in-kind technical assistance (TA) provided by a foreign entity would be considered as an import to the recipient country.

Borderline issues relevant to trade in health care goods and services

95. There are a number of borderline cases that may be gaining in importance for trade in health services. It may be that a greater proportion of the treatments being received while abroad or delivered by foreign providers arise due to legal restrictions in the home country or the non-availability of certain specialist treatments or stigmas attached to them.

96. A higher proportion of **cosmetic surgery** may be performed abroad, partly to preserve anonymity. Cosmetic or plastic surgery may be for reconstructive purposes or purely for aesthetic reasons in special clinics. Even though treatments for aesthetic purposes are provided by health professionals using medical technology, they are considered outside the health boundary (see Chapter 4 of SHA 2011). However, when it is not possible to separate the types of cosmetic surgery or there is a doubt about the purpose, it is recommended that all services of this nature be included under health spending and thus reflected in estimates of total imports and exports.

97. Another treatment area that tends to attract consumers from overseas is **assisted reproductive technologies (ART)**. Since this is usually provided by *bona fide* institutions and professionals, it is recommended that this be included under health spending.

98. One major driver of "medical tourism" is the borderline area of **well-being** and health. Many tourists visit a country to take advantage of establishments that promote wellness. These can range from spa/fitness centres to hotel/resort spas to traditional-type spas linked to a country's natural resources to more medical-type institutions employing healthcare professionals (SRI International, 2008). Often the distinction between health and well-being is not made in tourist surveys, but generally inclusion should be restricted to cases in which a clear curative, rehabilitative or preventive nature can be identified through insurance reimbursement, prescription and/or provision by a health professional.

19. The study by Byrd and Law highlights the practice of US residents crossing the border to purchase antibiotics, which are available without prescription in Mexico.

99. Similarly, many visitors may be drawn to a country to take advantage of alternative therapies and **traditional medicine** unavailable in their home country. Reference should also be made to the section on TCAM in Chapter 5 of SHA 2011 regarding the inclusion or exclusion in health care spending and as a health-related item.

100. In terms of the consumption of medical goods, the same boundaries set out in SHA 2011 should be applied for trade in medical goods, whether these are purchased directly while abroad or delivered from overseas. This refers to recommendations regarding nutritional products and other "health" products, which should only be included on a restrictive basis – *i.e.* on the advice of health professionals, and vitamins and minerals in the case of prescription and distribution by health care providers. The exclusion of sun creams, for example, is a particular case, given the special link with holiday tourism.

101. Travel abroad for the specific purpose of receiving treatment incurs other costs that may or may not be linked to health care. One example is the linked **transport costs,** which may be particularly high if air travel is included. When travel is an integral part of the medical care "package" (for example, some UK residents are sent abroad by the National Health Service for certain operations) and covered by private or social insurance, then it should be included in the overall spending. However, the transport of a resident patient, if it can be separately identified, should not be regarded as an import if the service is provided by a resident carrier. In the case of private travel, or travel without the specific purpose of receiving medical treatment, then it is proposed that the transport costs should be excluded from health spending. Other costs may also be attached to medical travel that is organised through a medical travel agent or facilitator, as is often the case in the United States. Since such agents are normally resident in the patient's own country, any fee or commission paid to arrange a medical travel package is a resident-to-resident transaction and should not be included as international trade.

102. In certain cases, patients travelling abroad may be accompanied by one or more persons (especially in the case of children requiring treatment). Often the costs involved will also be covered by public budgets or health insurance. Unless there is a particular medical role of the **accompanying persons,** it is suggested that such expenditure not be included under health care but rather under a health care-related item – non-health travel-related services.

103. One area of growth in medical travel abroad has been **illegal or unethical trade** (*e.g.* organ transplantation). While such trade may be undesirable or illegal, if it meets the criteria of the health care boundaries then it should in principle be recorded in the accounts in the same way as legal actions. For example, although the provision of abortion may be illegal in certain countries, it is still provided, albeit illegally. In such circumstances, whenever the service is paid, which is most likely the case, the payment should be recorded in the SHA. Other activities could be deliberately concealed from the public authorities, even though they clearly fall within SHA boundaries and are also legal.

Intermediate use versus final use of health care goods and services

104. The **final consumption** approach adopted within the SHA framework highlights a notable difference between the scope of external trade that is of primary interest to health accounts and the broader measure of trade in the balance of payments and national accounts. Even though international trade statistics do not make a distinction for imported health care goods and services destined for intermediate use (*e.g.* provided by a foreign provider as an input to a service provided to a patient by a domestic provider), they should be excluded in the case of health accounts.

105. The distinction between final and intermediate use becomes relevant only for goods and services delivered across borders, which currently forms a minor although expanding part of trade in health (through the development of e-health, Internet pharmacies, etc.). For the direct consumption by residents

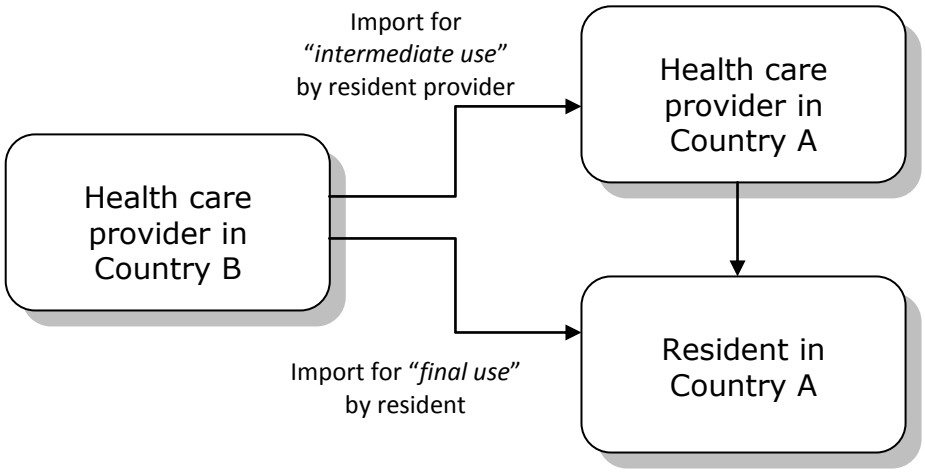
abroad (considered as imports of health services) and by non-residents within the country (considered as exports of health services), these are for all intents and purposes provided directly to patients (*e.g.* a planned visit by a non-resident to a specialist or hospital) and are thus considered as final consumption.

106. For health services delivered across borders, the situation may be different. Some of the recent growth in cross-border trade of health services has been in the provider-to-provider category *e.g.* the provision of diagnostic services from foreign laboratories to resident hospitals, instead of delivery directly to the patient. For one country, the imports of medical services may be primarily destined for intermediate consumption, whereas for another, perhaps smaller country, the imports of health services for final use may well be relatively high. The difference in approaches between the SHA and national accounts highlights two different concepts that may be relevant to imports of health services:

107. First, in the SHA, occupational health is included in the national totals of health care spending. In the SNA, this item is recorded as ancillary services and as part of the intermediate production of enterprises. Therefore, the use of non-resident health services by resident businesses for their employees (or the use of health services abroad by employees on business travel) would be counted under intermediate consumption in national accounts, whereas it should be included as final consumption and as an import under the SHA.

108. Secondly, the view of consumption in the SHA requires a different approach than the view of production in national accounts. National accounts make no distinction between medical goods imported by wholesalers and pharmacies and destined for sale and medical goods imported directly by households for own use. This approach contrasts with the SHA, whereby only household purchases of medical goods from overseas retailers for personal consumption are treated as imports – imports by wholesalers and pharmacies are treated as inputs into the function of health care provision of medical goods and services of pharmacies and other medical goods retailers (Figure 4.2).

Figure 4.2 The treatment of imports under the SHA



109. These differences should be taken into account with regards to comparisons with import and export figures in the balance of payments and national accounts. However, in any further analysis it may be of interest to examine the total imports and exports within the health care system and reconcile the figures with international trade figures.

5. DATA SOURCES AND GUIDELINES

110. For the most part, the data sources used to compile international trade and balance of payments statistics will be the principal sources of information for health accountants to estimate flows of health care goods and services between countries, despite the minor conceptual differences outlined above. Indeed, the "health-related travel" and "health services" components of the EBOPS classification (see Annex 1) theoretically provide a good starting point to estimate a large part of the trade under the SHA. Moreover, EBOPS 2010 future reporting recommendations will further group together and isolate "health services" from other travel-related consumption, which will help to further harmonise the definitions with the SHA.

111. That said, current data on trade flows in health services remain quite sparse, with gaps in country coverage and likely under-reporting. The quality of existing data varies considerably from country to country and according to the mode of delivery. One of the main purposes of this section is therefore to give guidance on how to collect and improve data on trade in health services by reviewing existing standard sources of information and identifying new potential sources. Improving trade statistics in the health area should be viewed not just in terms of how this benefits health accountants, but instead as a collaborative venture aimed at improving the measurement of international trade in general, so as to assist compilers of balance of payments and health accounts alike. That said, for the most part the value of the imports and exports of health services is still relatively marginal for most countries and for most types of health care, which means that the investment of resources to identify or develop new data collection tools and instruments needs to be considered carefully. This also has to be reviewed in the light of international reporting obligations and perceived trends.

112. The compilation and data sources for the EBOPS health categories and for imports and exports under the SHA share many common features, but as has been seen, there are also some differences in concepts and boundaries that should be kept in mind. Health accounts require additional information and detail over and above that needed for balance of payments, but one of the guiding principles should be to show the clear links and correspondence between the different systems for their mutual benefit.

113. As in many areas of health accounts compilation, the measurement of international trade in health services presents many challenges. The choice of the best data sources is very much linked to the organisation of the health care system. No one data source will fit all needs. In addition, different approaches will be required to estimate imports and exports. In the case of exports, generally, but not always, information from foreign providers will not be available. Typically, estimates of imports and exports are compound statistics that do not come from single sources but rely on a number of different sources, and in many cases on assumptions and hypotheses.

114. One of the initial tasks in compiling estimates of imports and exports of health care goods and services should be to inventory the current and available data sources and to assess whether they are suitable and sufficient. In an ideal situation, they should match the definitional, geographical and/or temporal (*i.e.* period of residency) scope outlined in this chapter and elsewhere in the Manual. In reality, however, existing data is unlikely to be fully concordant with the compiler's needs. For example, tourist surveys may not make the necessary distinction between "tourists" and other non-resident categories, such as border or seasonal workers, or they may include medical care and well-being within the same activity. As a minimum requirement, differences should be well-documented. Otherwise, it may be necessary to adjust or calibrate data using other information and sources, including non-financial data. However, there

is a need for care in handling the trade-off between forcing a breakdown into detailed categories and the resulting validity and quality of the estimates.

115. In the first instance, no separation by the mode of supply is made, although this may be desirable as an additional reporting item for national purposes. The structure of the SHA requires in the first instance a breakdown of imports by function (HC) and by financing scheme (HF) and then if possible by mode of supply. From the point of view of exports, the primary dimension may be by function (HC) and provider (HP), with mode of supply again secondary.

116. Different compilation approaches can be taken, reflecting the different data sources, so as to achieve a full disaggregation between functions and providers. In some cases this might involve a top-down approach, so that there is a degree of confidence in the overall estimate, but with a distribution applied, using information from a different source or year to allocate across other categories. In other cases, where there are a number of different valid data sources covering the components, the total can be built up using a bottom-up approach. Finally, the most likely outcome is a mixed approach, where some parts of the puzzle might be available from detailed administrative data and other parts may be missing.

Enterprise and business surveys

117. From the point of view of services provided by domestic health care providers to non-residents, enterprise or business surveys can be useful. These can vary from small irregular sample surveys to more exhaustive annual administrative data collections with mandatory reporting by providers.[20] One could conduct a short intensive study on a sample of representative providers, find out how many foreign patients have been treated and how much their treatment has cost, how it has been paid, etc. An estimate for the national level could be obtained from this sample. Alternatively, if the provision of health care goods and services is concentrated in a few providers, the results of a study of these few providers would constitute the national estimates. Non-monetary information, such as numbers of non-resident admitted patients, may be all that is available. In some cases, it may be valid to assume that the cost per treatment does not vary between resident and non-resident patients, thus allowing for an estimation of the total cost.

118. In most cases, designing a new questionnaire or study may not be a viable option, which means that the use of existing surveys and data collections may need to suffice. While such data may be available for large providers such as hospitals and clinics, it may be more problematic to obtain data for smaller and individual health care providers, such as private dentists[21] and specialists – often people travelling for health reasons buy goods and services from specialised private health clinics. Some information may be available on an ad-hoc basis through umbrella and trade organisations, charity groups, etc. This may be the case regarding health and travel insurance services provided to non-residents for the estimation of administrative services provided to non-residents.

119. Other specific surveys may focus on obtaining data from NGOs and charities that perform a role in providing health services to persons in irregular situations, such as refugees and immigrants. Data will typically be of a non-financial nature (Médecins du Monde UK, 2007).

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20. In Korea, for example, Article 27-2 of the Medical Affairs Act stipulates that a medical institution intending to treat foreign patients should register with the Minister of Health and Welfare and report to the same on the results for the previous year by the end of March each year, providing detailed information on each treatment, including nationality, age, sex, type of treatment, period of treatment and cost.

21. To compile the Austrian balance of payments, a survey of dentists near the Austrian border with Hungary was used to model cross-border flows. Source: Balance of Payments Country notes (http://www.esds.ac.uk/international/support/user_guides/imf/bops.asp).

Retail industry and e-commerce (see OECD, 2009)

120. Information on the total revenue from dispensing chemists and the retail sale of suppliers of optical glasses, hearing aids and other medical appliances may be available from administrative tax statistics. However, these data sources do not normally include any hints about the share of revenues stemming from the purchases of non-residents. Any use of pharmacy sales data should also take account of increasing parallel imports and exports of medical goods.

121. Significant pharmaceutical price differentials between countries belonging to free trade systems, such as in the EU, have led to a rapid increase in what are called "parallel" imports and exports. Intermediaries, such as wholesalers, pharmacies and other traders, can take advantage of these price differences to buy up prescription medicines from pharmacies in countries where they are cheaper and then resell them still below the official price in the countries to which they import. In the EU, it has been estimated that this accounts for a tenth of the European medicine trade (FT.com, 7 June 2010).

122. Much of the information on purchases of goods abroad will come from visitor and tourist surveys and perhaps be applied to information on the total revenues of retailers.

123. For individual members of households, e-commerce presents an alternative method of purchasing (and increasingly selling) goods and services for private use. The statistical and policy interest for the household sector concerns the use of the Internet for such transactions, with particular interest in purchase rather than sale transactions. Surveys of ICT use in households typically collect information on individual purchasing activity via the Internet, with details often including the nature of the goods and services purchased, the value of those purchases, the value of online payments and/or the barriers to purchasing over the Internet.[22]

124. The reliability of the reported value of online sales has long been a concern to statisticians. As with purchasers, the split of Internet commerce transactions by the customer's location (international versus domestic) is similarly problematic. Evidence indicates that businesses have trouble reporting these splits as, firstly, they will not necessarily know the destination of their sales, and secondly, even if they did, they would not necessarily record this information in a way that is readily retrievable.

125. Since, for the most part, information from foreign providers regarding health care goods and services will not be available, the main source of information will be linked to the financing of consumption abroad – notably, reimbursements by public and private insurance.

Government administrative sources (liaison offices)

126. Government sources may maintain data and records on services provided both to non-residents by resident health providers and to residents (or insured persons) by non-resident providers. In countries where bilateral or regional agreements are in place, data may be available on the numbers and expenditures both of residents abroad and of non-residents in the country. Where lump-sum transfers are made between countries based on waiver agreements, these should be taken as the gross payments and not the net transfer. Where bilateral or regional agreements exist (such as EU citizens' entitlements to benefits in kind during a

22. The collection efforts of OECD countries vary in this area. In particular, because of changes to Eurostat's model household survey, fewer European countries are collecting the value of purchases over the Internet. The 2005 OECD model survey has nominal value of purchases as a non-core question reflecting the low priority and difficulty respondents have in recalling the value of purchases. In addition to purchasing activity, the model questionnaire asks individuals whether they have sold over the Internet, for example, using auction sites. It also asks about the types of products purchased over the Internet and about barriers to Internet purchasing.

stay in another EU Member State), administrative data may be obtained by the various ministries (Ministry of Finance or Health or another relevant ministry that keeps track of the health care imports and exports, as specified by regulations). In some countries, data may be available from the health insurance funds (both public and private) where reimbursements for foreign-provided health care have occurred.

Social security schemes and international liaison offices

127. The records of the social security liaison offices are a potentially rich source of information about the health care goods and services consumed by the *insured* population. The information available is increasingly detailed in terms of type of treatment and country for both insured persons abroad and non-residents in the country.[23] However, these institutions handle only the claims based on certain international legislation and bilateral agreements. Claims for reimbursement by patients addressed to health insurance funds based on national legislation are not recorded by the liaison offices, and this will need to be supplemented with information from the health insurance funds themselves. However, an important qualification is needed regarding the records in both cases, in that at the base level the information reflects the insured population rather than the resident population. The insured population is not necessarily identical with the resident population as defined under the SHA.[24] Without controlling for expenditure caused by non-residents, the use of the financial records will lead to an overestimation of the consumption of health care goods and services abroad.

128. Another point to bear in mind is that the information relates to the reimbursement of treatment abroad rather than to the full cost. In optimal cases, additional information may be available on the total cost of services allowing assumptions to be made regarding the cost-sharing or direct out-of-pocket element. In most cases though, travel and household surveys may need to be used to obtain more information about private insurance reimbursement and out-of pocket payments.

Other administrative sources

129. In some countries, public health care purchasing authorities and ministries of health have organised contracts with non-resident health care providers, under which patients are sent for certain treatments abroad. Annual reports at an individual purchasing authority level or nationally should be available to give patient numbers and costs.

130. Further administrative information may also be held in various ministries on the "free" treatment of some particular population groups, such as refugees, and of other non-residents in countries with universal health care systems and no payment at the point of delivery. Expenditures abroad for military personnel, overseas embassy staff,[25] etc., may be collected separately. Data on overseas assistance may also be available from development agencies and ministries.

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23. For example, the EU liaison offices CLEISS in France and DVKA in Germany provide information on the claims of the health insurance funds for the treatment of non-residents on behalf of where the person is insured (export of services) and claims from international liaison offices for the treatment of persons insured in Germany abroad on behalf of the German health insurance funds (import of services).

24. In the case of the German statutory health insurance scheme, close to 300 000 people who are covered under it and therefore cause expenditures borne by it are non-residents (*e.g.* a German pensioner spending his retirement in Spain). Unfortunately, expenditure caused by non-residents cannot be separated from expenditure caused by residents.

25. The Balance of Payments Compilation Guide includes a model collection form to collect expenditure information from embassies and international institutions on various services.

Private health insurance

131. The financial records of private health insurance companies that provide primary or complementary insurance (including travel insurance) may be a potential source of information on the number of claims by insured persons abroad. This depends very much on the statutory obligations to provide data, and the detail of the data regarding a split into type of treatment and country will vary accordingly. The national association of private insurers may have the responsibility for collating and publishing data from its members.[26]

Household and tourist surveys

132. The basic data sources for private out-of-pocket payments are usually household surveys. These surveys can be institutionalised household budget surveys or specialised household surveys that rely on self-reported information and are typically provided on a voluntary basis.

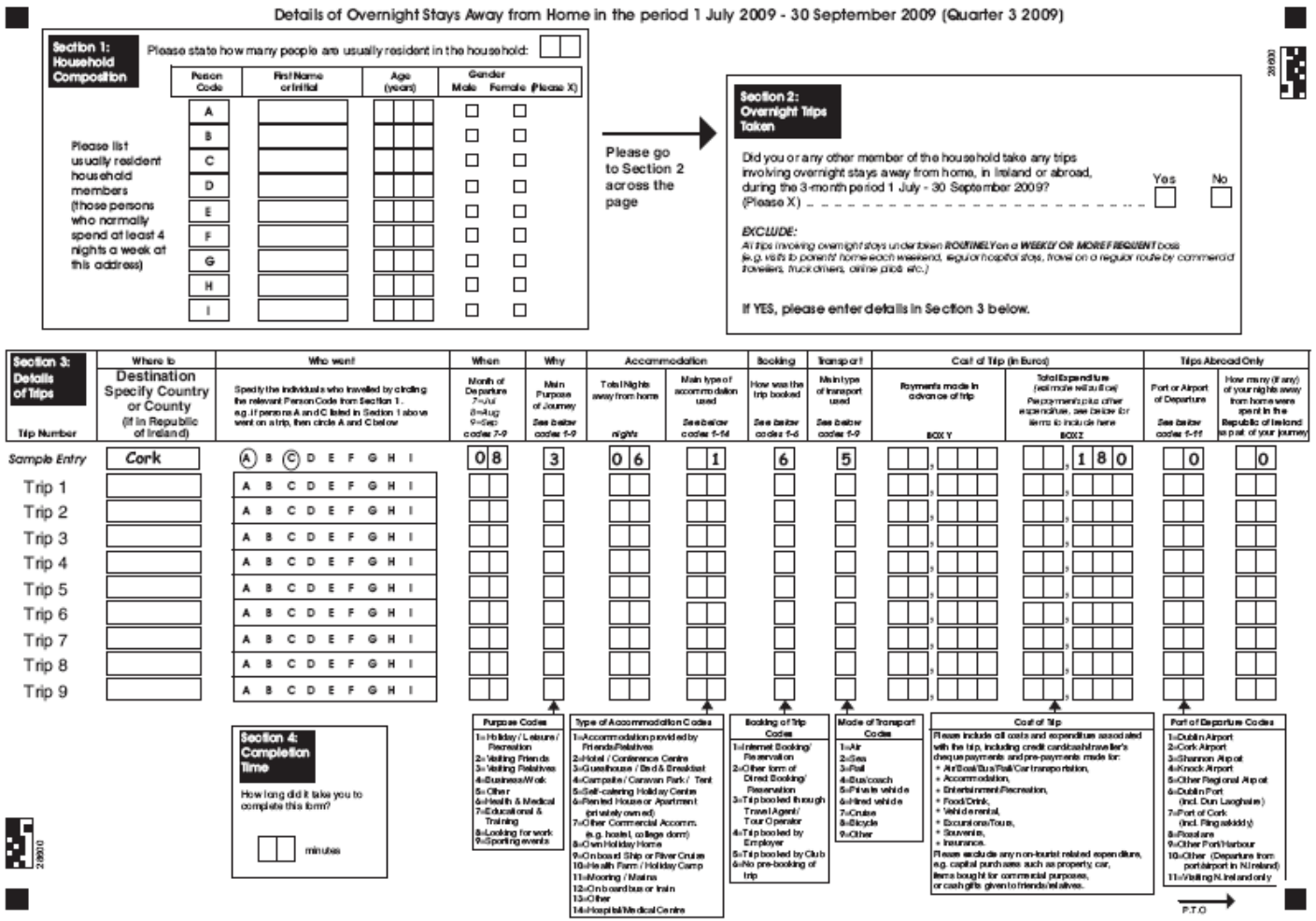
133. Caution must be exercised when analysing self-reported data on expenditure as to whether the reported amount spent is the gross or net value. People with primary private health insurance typically have to cover the costs of medical treatment upfront and get the total costs or parts of the costs reimbursed by their insurance company. Not deducting reimbursement by other schemes is a potential source of double-counting and overestimation of private out-of-pocket payments. What makes correct accounting even more challenging is the fact that usually some time passes between the payment of the bills and their reimbursement, *i.e.* the two payments can occur in different accounting periods. Furthermore, information on health spending abroad may not systematically be requested or may result in unrepresentatively low samples. The addition of new questions to existing surveys (*e.g.* Health expenditure surveys, Household budget surveys, etc.) would be more cost-effective and easier than building a whole new questionnaire. Additional questions may only need to be asked fairly infrequently, as an add-on module, which would reduce extra costs further.

134. Travel or tourist surveys are conducted in various forms by many countries to measure the activities of travellers. For an example of a Household Travel Survey for Ireland, see Figure 5.1 .Some surveys may be designed purely to meet balance of payments requirements for measuring travel and, possibly, other forms of expenditure and income. In most cases the information is unlikely to meet the needs of the SHA exactly and should be adjusted or noted. Travellers can be surveyed when they arrive or depart or sometimes after they have returned to their home countries, thus providing the possibility for information on both imports and exports. Surveys of arrivals measure actual expenditures abroad of residents returning home and anticipated expenditures of non-resident visitors. Conversely, surveys of departures measure actual expenditures of departing non-resident visitors and anticipated expenditures of departing resident visitors. Some surveys of returned travellers collect data from residents some time after they return. Surveys often include a category for purpose, including for "health and medical" reasons, and for how much was spent on treatment. Again, care should be taken in analysing spending to avoid double-counting with later reimbursements.

135. Additional information can also be found from patient surveys conducted by health insurance groups. In a prime example, TK (Techniker Krankenkasse), one of the main insurers in Germany with over 7 million insured persons in 2009, carries out a regular annual survey of its patients that provides detailed information on cross-border care (Techniker Krankenkasse, 2009).

26. For example, in Germany the PKV, the association of private health insurance companies that organises 46 private health insurers. It provides the combined financial results of the primary and complementary health insurance branches of the organised insurers and can provide information on claims abroad for categories such as inpatient, ambulatory and dental services.

Figure 5.1. Household Travel Survey for Ireland, 2009



Other sources

136. In some cases, data published by other countries (mirror statistics) may be used, possibly to reconcile or validate other data, or as a source for exports. This may be the case for some of the claim and reimbursement data compiled under international and bilateral agreements.

137. Health services provided by professionals abroad could be delivered by either non-migrants (going abroad for less than one year) or short-term migrants (admitted in another country for at least 3 months, but less than 12 months). In order to fall within the boundary of imports or exports, the health service professionals need to supply a health service abroad without seeking access to the employment market of the host country. The data collected should include the number of health service providers, the type of health services delivered, the occupation of the health professionals, and their length of stay. Helpful sources to collect this data could be professional registers, hospitals, industry surveys or government agencies that issue working permits.

138. The supply and use tables of national accounts describe in detail the sale and purchase relationships, both final and intermediate, between producers and consumers, either in terms of industry or product outputs. A supplementary table that on the face of it could be of use to the compiler of health accounts is the use table for imports, which is compiled to separate the use of imported goods and services from domestically-produced goods and services. Such a table is not necessarily a core feature of the input-output framework and therefore is likely to be available only for a reduced number of countries.[27] A number of important points need to be taken into consideration when assessing information from supply, use and input-output tables:

- First, the difference in the concepts and definitions of imports in national accounts and the SHA. As noted in the previous section, with regard to goods, the SHA has a much narrower definition of imports, which is restricted to medical goods imported directly by households for own use. Thus, information on total imports of pharmaceuticals and the split between intermediate and final use from import matrices will be of limited value. In the case of health services, the different treatment of imported occupational health needs to be considered, in that in the national accounts this will typically be treated as intermediate consumption, whereas under the SHA this should be accounted for as final consumption.

- There is a separate treatment for the direct purchases of goods and services abroad by residents on personal trips. In practice, most countries are not able to break these expenditures down into product types without using stylised assumptions that preserve input-output balances that are of questionable analytic value – and so they are often shown in a single adjustment row in the supply table to arrive at total imports and are added to household final consumption in the use table.[28] Any spending on health services by business travellers is treated as intermediate consumption and in theory is allocated to the branch of activity as *imported* intermediate consumption, rather than final consumption.

- Similarly, purchases in the domestic territory by non-residents are treated as exports and deducted from households' final consumption expenditure. Thus the corresponding total is entered in the exports column with a positive value and deducted in the same amount in the column of final consumption expenditure of households. Methodologies vary considerably on

27. The OECD Input-Output Database provides input-output tables for an increasing number of OECD and non-OECD countries on a harmonised basis, that is, industry-by-industry, basic prices and industry classifications. See OECD (2006a): DSTI/DOC(2006)8.

28. ESA 1995 recommends that direct purchases abroad should be broken down by product.

how to break down this total spending by non-residents amongst products. For example, the expenditure of foreign visitors to the UK was analysed in a special survey. Although this gave only broad expenditure headings, it was possible to sub-divide them further using the expenditure patterns of UK residents on similar groups of products, although the results therefore had a relatively weak basis (UK Input-Output Balances: Methodological Guide, 1997).

- Directly collected information for compiling import use tables is rare. Thus, in most cases assumptions must be made and various modelling techniques may be used to populate the tables. Very small values may be estimated in certain cells, but the statistical accuracy of these data cannot be verified. Often countries will make use of the import proportionality assumption in the construction of their import matrices. This technique assumes that, for any product, the share of total expenditure on that product that is made up of imports is the same for all consumers, whether final demand or intermediate – with the share determined by the contribution imports make to the total supply of the product in the economy. For example, if 10% of all health services sold within an economy is imported, it is assumed that the share of expenditure on health services that is made up by imports is 10% for any consumer.

- Finally, the set of supply and use tables may sometimes, albeit infrequently, be available only at basic prices, whereas the SHA tables require purchasers' prices.

Other balance of payments data sources

139. Compilers of balance of payments statistics use many of the data sources and methods listed above, some of which can be particularly relevant to compilers of health accounts. However, the conventional information coming from International Trade Statistics and International Transactions Reporting Systems are unlikely to provide the sufficient detail necessary for health accounts purposes.

International Trade Statistics

140. The traditional source of information for international trade statistics (ITS) regarding the movement of goods between countries has been the custom records. For the European Union, procedures have been developed for enterprises to make direct declarations for intra-union trade. ITS provides little information of direct use to the SHA, since it covers in principle the movement of all goods in and out of a country and conforms to the wider concept of trade. In principle, this should include postal items. However, for the most part individual consignments of, for example, mail-order pharmaceuticals are generally not considered significant and are not subject to declaration and will be neither recorded nor separately identifiable.

141. Individuals arriving in a country are also required to complete a customs declaration for ITS purposes. Again, individual purchases of pharmaceuticals or medicals goods are unlikely to be captured in such statistics and in any case would be recorded under the travel services item of the balance of payments.

142. Detailed as trade statistics might be, there still remain some serious shortcomings that will affect their usability for estimating exports and imports of health care goods in the SHA framework:

- Imports are valued with their CIF-price, which excludes taxes. The SHA requires goods and services to be valued at the purchaser's price, which includes value-added taxes.

- With regard to intra-community (*e.g.* within the EU) trade, private households are exempt from the obligation to provide information about exports and imports for trade statistics purposes.

Likewise businesses are exempt from this obligation, if their exports and imports do not exceed a volume of 400 000 euros per year.

- The available information from trade statistics do not allow for splitting the traded commodities based on use in final consumption or intermediate consumption.

International Transactions Reporting Systems

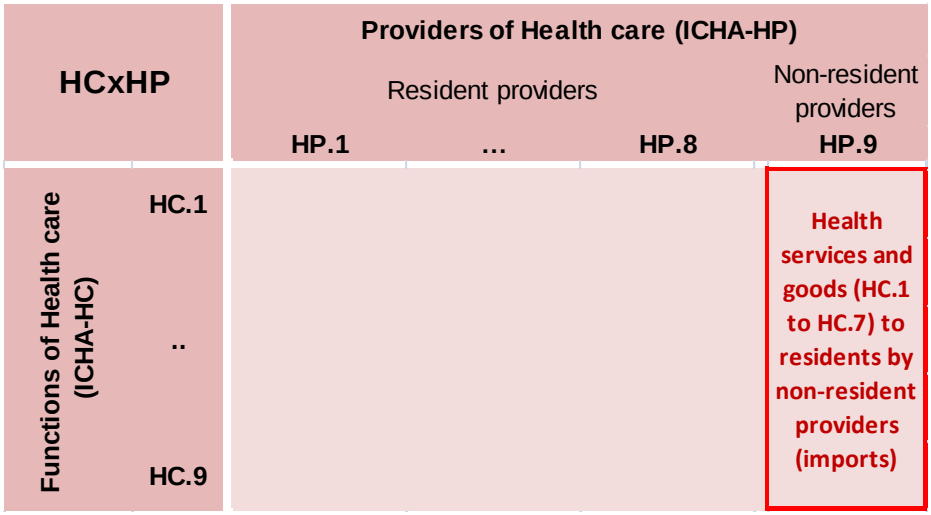
143. An ITRS includes individual cash transactions between resident and non-resident banks. Data is collected from forms submitted to banks and forms submitted directly from enterprises. The forms will likely include information on the value and purpose of the transaction and the country. However, a number of problems arise. Firstly, the classification conforms to the BOP classification and is therefore insufficient for SHA needs. The data will cover transactions involving intermediate goods and services, and again certain thresholds apply such that many private transactions are not considered separately but are part of a sample survey. There is also a question of the timing since payment may not coincide with the timing of service delivery.

6. DATA REPORTING UNDER THE SHA FRAMEWORK

144. In the SHA table cross-classifying health care functions by providers (HCxHP), the classification of health care providers (ICHA-HP) contains a category "HP.9: Rest of the world" for "non-resident units providing health care for final consumption to resident units".[29] Thus, health care goods and services from non-resident providers are explicitly recorded and can be classified according to the various functions – since the same boundary of health care applies for those goods and services consumed by residents abroad (Figure 6.1). Similarly, cross-classification of the provider and financing classifications provides a breakdown of who is paying for the function (*e.g.* government, private insurance, out-of-pocket, etc.).

145. Exports, however, are not included, since the health expenditure of an economy is restricted to consumption by its residents only. In practice, from the provision perspective the direct purchase of health care goods and services by non-residents will need to be explicitly excluded from domestic provider revenues. For reasons of transparency and to allow the compiler and user to report consumption by non-residents, such exports should also be recorded. Therefore, goods and services consumed by non-residents could be reported under a supplementary table.

Figure 6.1 Health care goods and services from non-resident providers in the HCxHP table



Supplementary tables and reporting

146. The supplementary tables on trade provide further information on health care goods and services consumed by residents abroad and the provision of health care goods and services to non-residents (Tables 6.1 and 6.2). For imports, there is a cross-classification of imported health care goods and services by the

29. The distinction between the "Rest of the world" category under the financing scheme classification should also be made. For example, if a foreign government or NGO pays for health services consumed by residents, then these services are financed by these non-resident units but may still be provided by a resident entity and therefore not an import.

financing scheme. For exports, since the prime source of information is resident health care providers, a table cross-classifying the function of health care by provider is recommended.

147. To reflect the areas of main policy interest as well as possible data limitations, the HC categories are limited to the main categories of individual health care services (HC.1-4), medical goods (HC.5), preventive care (HC.6) and governance and health system and financing administration (HC.7), with selected categories for inpatient, outpatient and dental care, as defined in Chapter 5 of SHA 2011.

148. Because of the relative importance of some health-related items in imports and exports, it may be of interest to report expenditure on TCAM as a reporting item supplemented by additional health care-related items, such as "spa and well-being" and "non-health travel-related services".

149. Spas encompass a myriad of different services and providers, making international comparisons difficult, but in general they can be defined as "establishments that promote wellness through the provision of therapeutic and other professional services aimed at renewing the body, mind and spirit" (SRI International, 2008). However, where a clear curative, rehabilitative or preventive nature can be identified, either through a prescription and/or provision by a health professional then this should be included in health spending. For example, some "medical spas" operate under the full-time on-site supervision of a licensed health care professional.

150. "Non-health travel-related services" refers to expenditure that is incurred as part of travel abroad to seek care but is not directly related to the patient's health. This may include additional travel and accommodation costs of the patient plus the expenses of accompanying persons such as relatives.

151. On a national level, it may also be desirable to produce tables according to the mode of supply, specific trading partners or regions (*e.g.* in the case of EU countries – separating intra-EU and extra-EU trade) or sub-national regions.

Table 6.1 Expenditure on health care imports by function and financing scheme

Functions	Financing schemes	HF.1 Governmental schemes and compulsory contributory health financing schemes	HF.1.1 Governmental schemes	HF.1.2 Compulsory contributory health insurance schemes	HF.1.3 Compulsory Medical Saving Accounts (CMSA)	HF.2 Voluntary health care payment schemes	HF.3 Household out-of-pocket payment	HF.4 Rest of the world financing schemes (non resident)	TOTAL
	Million of national currency								
HC.M.1-4	**Curative/rehabilitative/long-term care (health) and ancillary services**								
	Of which:								
HC.M.1.1/2.1/3.1	Inpatient care								
HC.M.1.3/2.3/3.3	Outpatient care								
	Of which:								
HC.M.1.3.2	Dental care								
HC.M.5	**Medical goods (non specified by function)**								
HC.M.6	**Preventive care**								
HC.M.7	**Governance, management and health system administration**								
HC.M.9	**Other health care services not elsewhere classified (n.e.c.)**								
	TOTAL								
Memorandum items:									
HC.RI.M.2	Traditional, Complementary and Alternative Medicines (TCAM)								

Table 6.2 Expenditure on health care exports by function and provider

Functions	Providers	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.8 Secondary health care providers, rest of economy	TOTAL
	Million of national currency									
HC.X.1-4	**Curative/rehabilitative/long-term care (health) and ancillary services**									
	Of which:									
HC.X.1.1/2	Inpatient care									
HC.X.1.3/2	Outpatient care									
	Of which:									
HC.X.1.3.2	Dental care									
HC.X.5	**Medical goods (not specified by function)**									
HC.X.6	**Preventive care**									
HC.X.7	**Governance, management and health system administration**									
HC.X.9	**Other health care services not elsewhere classified (n.e.c.)**									
	TOTAL									
Memorandum items:										
HC.RI.X.2	Traditional, Complementary and Alternative Medicines (TCAM)									

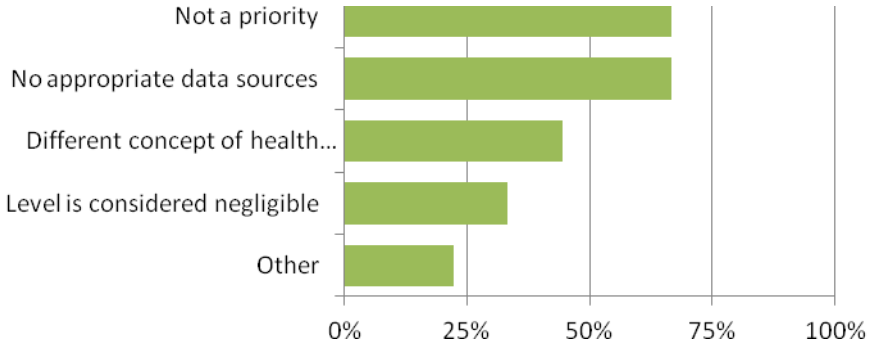
7. CURRENT STATE OF DATA REPORTING ON IMPORTS AND EXPORTS

152. As part of the final phase of the project a questionnaire was sent to all OECD and EU participating countries in order to ascertain the current and future levels of reporting and gauge their responses to the proposed supplementary data tables on imports and exports.

153. From the 22 countries that answered the questionnaire, just over half (12) are already providing some estimates of the value of goods and services provided by non-domestic providers (i.e. imports). The detail and coverage of imports can vary between countries. Of the countries that do not currently report any data on imports there remains a high degree of uncertainty as to whether they will be in a position to deliver such data in the short term, that is, in the next 1 to 2 years. Three out of the 10 countries do not expect to data any such data in this period.

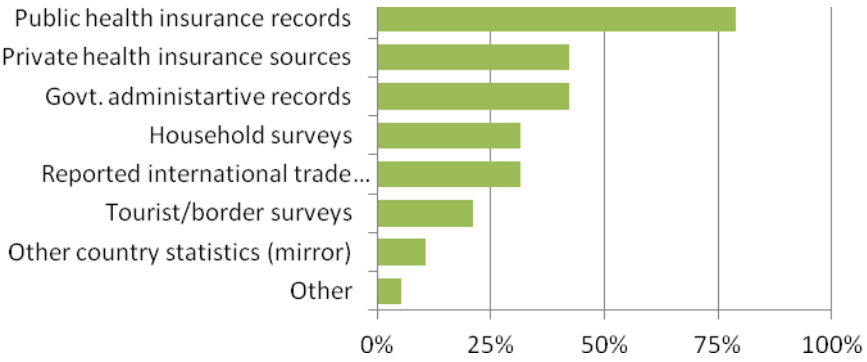
154. Regarding the reasons for non-submission, two-thirds of the respondents cited either the lack of appropriate data sources and/or the low priority in their country as the main barriers to data reporting (Figure 7.1). The next most common reason was the use of a different concept in what was reported – that is, countries excluding imports (and including exports) from their estimates of total health spending. Finally, around a third of non-reporting countries expressed the opinion that the levels were considered too negligible at present to justify the resources needed for accurate estimation.

Figure 7.1 Reasons for current non-reporting of expenditure on imported health care goods and services



155. The main sources of information currently used for reporting favours those countries with public health insurance systems, where the administrative records of the public insurance funds provide a rich source of information for the reimbursement of services or goods consumed from abroad (almost 80% of respondents quoted this as a data source) (Figure 7.2). The next most common sources are government administrative sources (e.g. in the case of international liaison offices linked to social security regulations in the EU) and data coming from private insurance corporations also. For the difficult task of tracking or calculating private household expenditures, only 30% and 20% of respondents cited household surveys or border surveys as used sources of information. Interestingly only around a third of countries used reported trade statistics (e.g. from the Balance of Payments) as a source of information.

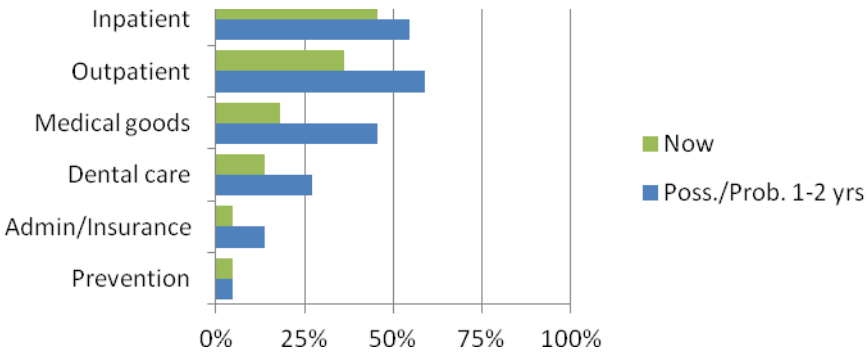
Figure 7.2 Main sources of information used in current reporting of imports



156. One of the conceptual issues highlighted in the study has been the adherence of reported data to the definition of residency, that is the reporting of persons still covered by their health insurance of their country of origin but residing abroad, and thus in effect outside the boundary of their country's health expenditure. Of those countries currently reporting imports, two-thirds adhere to the residency definition of the System of Health Accounts, with a further country partially conforms with regards to certain health services or providers. This leaves 25% of countries in a position where the concept of residency differs from that of SHA.

157. Considering the detail of imports in terms of the type of goods and services, not surprisingly in-patient followed by out-patient care are most commonly reported (35-45% of countries) with this to climb possibly towards 6 out of 10 countries in the next 1-2 years (Figure 7.3). Interestingly, one of the areas often quoted as being one of the growth areas of patients travelling abroad for care - dental care – suffers from a lack of information and is only separately reported by 3 countries, and only potentially doubling in the short term. Again, the purchase of pharmaceuticals (either via delivery from foreign providers or while abroad) is another area where there is little information – only 4 countries are currently able to provide information in this area. With regard to some of the possible supplementary areas related to medical travel, e.g. spa and well-being services and cosmetic surgery (with a non-health purpose) the prospects for reporting in the near future are bleak.

Figure 7.3 Current and future reporting of imports of health care goods and services

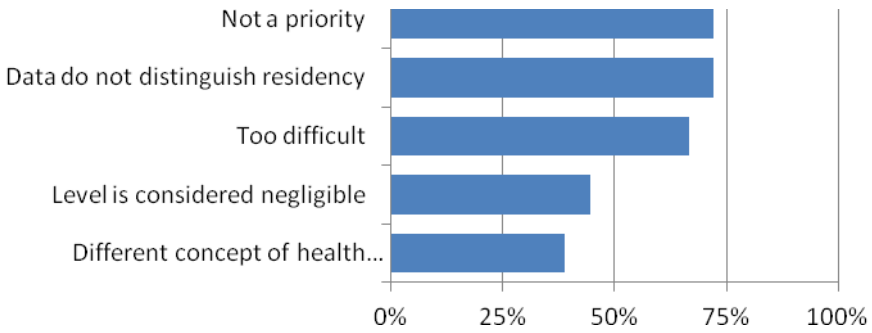


158. Finally, the questionnaire on imports asked whether information to allow the reporting of trade according to regions or partners (e.g. within the EU) might be possible, a little of a third of respondents were positive.

159. Health expenditure according to the System of Health accounts should be restricted to spending on health care goods and services by the resident population, that is, it should exclude spending by non-residents on health services provided by domestic health care providers (i.e. exports). The second part of the questionnaire asked countries to report their current practices regarding exports.

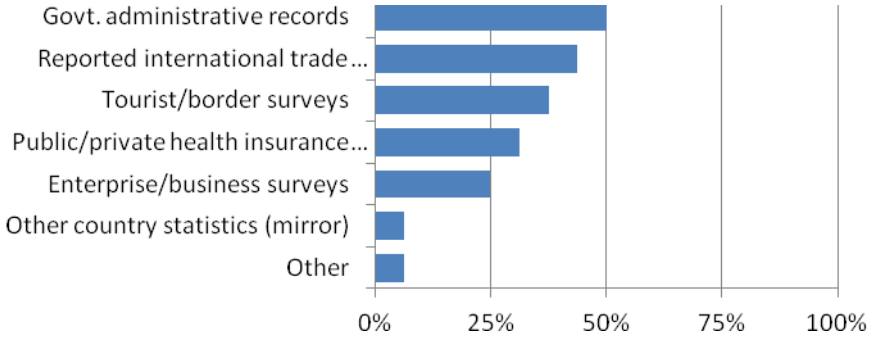
160. Of the 22 respondents only 6 were currently able to, or partially able to exclude exports from their estimates of health spending. However, half the respondents indicated that they intend to exclude such exports in the short term from their health accounts with less than a third expressing no intention of removing exports from estimates in the next two years. Around two-thirds cited the reason(s) for non-exclusion as too difficult and/or the data not allowing a distinction based on residency and/or it is not considered a priority. Seven countries also responded that they report health spending according to a health care provider income accounting basis (Figure 7.4).

Figure 7.4 Reasons for current non-reporting of expenditure on exported health care goods and services



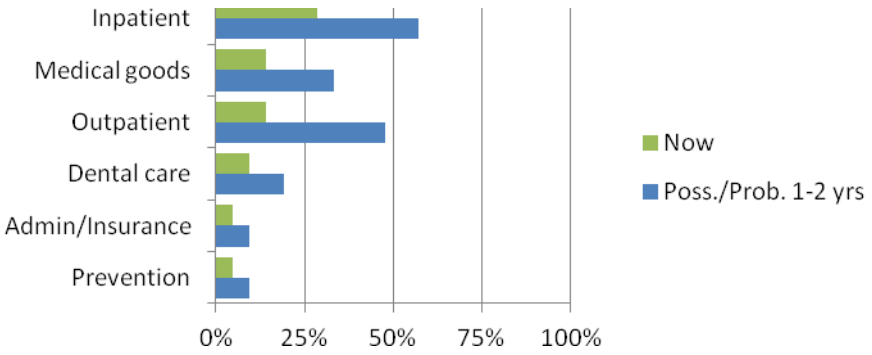
161. In terms of sources of information, there are a variety of data sources used, including government administrative sources, published international trade statistics and tourist or border surveys (Figure 7.5).

Figure 7.5 Main sources of information used in current reporting of exports



162. Similar to reporting on imports, much of the information refers to in-patient or hospital services, with very little reporting in areas such as dental care or pharmaceuticals, although a third of countries report that it should be probable or possible to report the latter in one or two years time (Figure 7.6).

Figure 7.6 Current and future reporting of exports of health care goods and services



163. Based on the limited data provided to the questionnaire and on the latest health accounts submissions, the levels of imports as a share of total health spending remain at very low levels for most OECD and EU countries that report figures. Imports of health goods and services accounts for only around 0.1-0.5% of total health spending for most countries, rising closer to 1% for some European countries such as Germany, Netherlands and Portugal. For some of the smaller European states such as Cyprus and Iceland, the need to access services abroad becomes more important and the share typically rises above 1% of total spending. Luxembourg is a case apart with a different conceptual approach for its health accounts and many of its covered population being non-resident and accessing services outsid of Luxembourg. Here imports can typically rise to 5% of health spending. As discussed above, the responses to the questionnaire indicate that most of the data reported relates only to in-patient and out-patient care and to that which is reimbursed by health insurance (public and private). Therefore, we can argue that levels of imports are likely to be underestimates of the true extent, albeit likely to remain marginal for most countries.

164. Annex 3 presents data on imports and exports taken from available published sources in addition to health accounts to show the overall and growth in international trade for European countries. In overall terms, Germany is by far the greatest importer of health goods and services, although, as discussed above, this represents a relatively low share of overall spending. Of the overall imports of 3 billion euros, a lot of this trade also takes place in Netherlands, France, Luxembourg and Belgium where much patient movement tends to occur in the border regions. Growth over the last five years has averaged more than 15% year on year, with much higher growth rates among some of the newer members of the European Union.

165. Export figures come primarily from international trade statistics and totalled around EUR 2.5 billion for Europe in 2008, although again this is likely to be an underestimate. The Czech Republic, France and Poland all reported relatively high levels of exports in 2008. As reported in the introduction, some central and eastern European countries have become popular destinations for services such as dental surgery. A more detailed analysis of the figures is presented in the annex.

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ANNEX 1. INTERNATIONAL STANDARDS AND CLASSIFICATIONS OF TRADE AND TOURISM

International trade in services by mode of supply

166. Trade statistics play an important information role in analysing the strengths and weaknesses of economies and in assessing the impacts of different policies and identifying opportunities offered by partners' markets. The World Trade Organisation, recognising the increasing role of the service sector, concluded the General Agreement of Trade in Services (GATS) in 1995, bringing services more into the spotlight of considerations about international trade. In addition to the general obligations that apply across all service sectors of all WTO Members, countries can choose which service sector and mode they wish to open up to trade. GATS has been an important driving force for the development of statistics on the international supply of services,[30] and has influenced the establishment of a classification of four different modes of trade in services. The supply of health care services can take place in all four of these GATS modes, although not all are relevant to the measurement of trade under the System of Health Accounts.

167. To date, WTO Members have only made relatively limited commitments in health services (Mattoo, A. *et al.*, 2007). However, services are an important part of ongoing multilateral trade negotiations, and further liberalisation is expected in the future.

168. The following paragraphs describe the GATS four modes of supply, with particular reference to health services. GATS also sets out a classification that identifies relevant sectors and sub-sectors for the purposes of trade negotiating purposes, rather than for statistical purposes. The classification known as GNS/W/120 comprises 12 major categories, including "Health-related and social services".

Mode 1: Cross-border supply

169. Mode 1, cross-border supply, takes place when a service is supplied "from the territory of one Member into the territory of any other Member". This is comparable to trade in goods where the product is delivered across borders and the consumer and the supplier remain in their respective territories.

170. In the domain of health services, Mode 1 can take different forms: tele-health services[31] are the most prominent method, such as a physician providing a medical diagnosis to a patient via email, internet or telephone. A variety of services includes tele-diagnosis, tele-pathology, tele-radiology and tele-psychiatry and can cover preventive and curative care. The service can be delivered in real time (for example, through video conferences) or by store-and-forward, which means that the analysis is done at a different moment in time. For example, hospitals in the United States may send X-ray images electronically to India, where they are analysed by radiologists (Pollack, 2003). Another area relevant to the SHA is the provision of health insurance by non-resident entities.

30. Although the supply of health services by governmental organisations such as national health services is included in the SHA and SNA views of trade in health services, it should be noted that GATS does not cover these.

31. There are currently a number of alternative terms in use: tele-medicine, e-medicine and e-health.

171. In addition to electronic delivery of health services, this also includes the shipment of laboratory samples, diagnosis and clinical consultations via traditional mail channels.

Mode 2: Consumption abroad

172. Mode 2, consumption abroad, takes place when the service is supplied "in the territory of one Member to the service consumer of any other Member", *i.e.* either the consumer or his property is abroad.

173. In theory, all health services could be purchased abroad; however, there exist practical constraints, such as the non-portability of health insurance or the capacity of the providing country. To date, the most prominent and most easily identifiable part of trade in health services is when patients travel abroad to receive medical treatment. This phenomenon is often called "medical or health tourism", hinting at a mix of health, well-being and leisure activities. In some instances this may be the objective, and the marketing of services may play upon opportunities to visit and experience a country at the same time as receiving quality care, but more often this concerns travel specifically and often exclusively for health care purposes and thus may more correctly be termed "health (or medical) travel" or "patient mobility". In other cases, tourists or persons on business travel may become sick or suffer an accident and need to seek medical care in the destination country.

174. The medical treatment of non-resident persons, *i.e.* person travelling abroad to the home country of the provider, can often be categorised into those seeking:

i. Specialised or advanced treatment not available in the home country, generally sought by affluent patients from developing countries travelling to hospitals in industrialised countries or in neighbouring developing countries with superior health care standards;

ii. Or a price or quality advantage over the home country, generally sought by patients from industrialised countries who purchase affordable, high-quality treatment or alternative medicines and treatments in less developed countries.

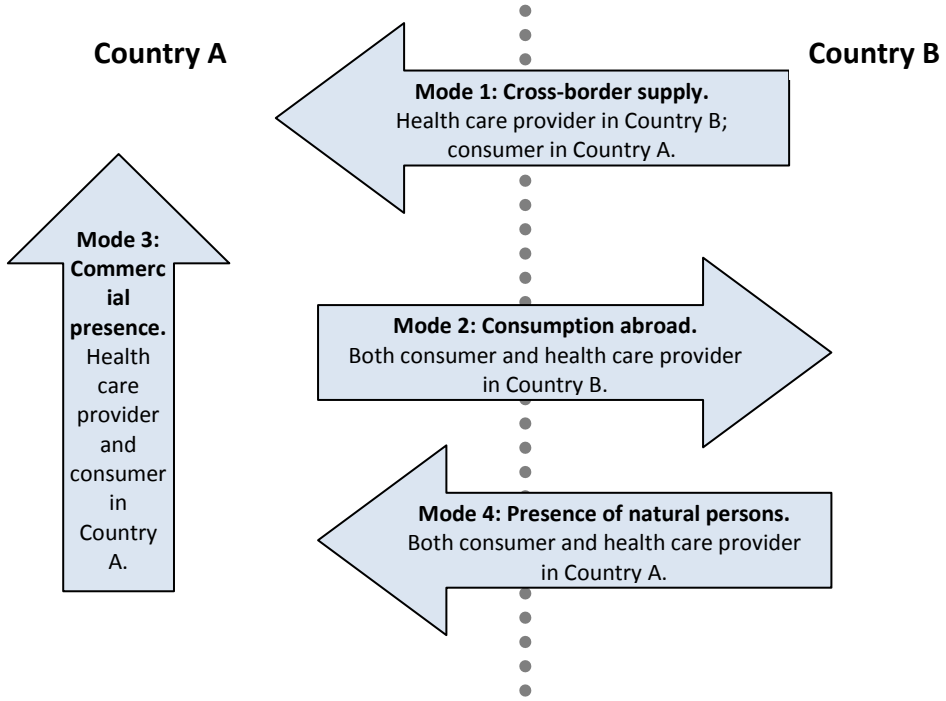
Mode 3: Commercial presence

175. Mode 3, commercial presence, takes place through "the supply of a service by a service supplier of one Member, through commercial presence in the territory of any other Member". GATS recognises that it is often necessary for service suppliers to establish a commercial presence abroad to ensure closer contact with the consumer at various stages of production, distribution, marketing, sale and delivery as well as after-sales service. Commercial presence in a market abroad covers not only juridical persons in the strict legal sense, but also legal entities that share some of the same characteristics, such as representative offices and branches, *e.g.* medical services provided by a foreign-owned hospital.

176. The commercial presence of a foreign health care provider through, for example, capital investment, branches or affiliates, falls under mode 3. Commercial presence is mainly represented by the activities of foreign-controlled affiliates' trade. Health care companies in industrialised and some developing countries are increasingly engaging in joint ventures and alliances, resulting in several regional health care networks and chains.

177. It should be noted that commercial presence is *not* defined as trade under the SHA (or balance of payments) framework.[32] However, it may be of policy interest for some countries to monitor separately the extent of services delivered by foreign health care providers on the territory.

Figure A1.1: The four modes of supply for trade in health services as defined by GATS



Mode 4: Temporary presence of natural persons

178. Mode 4, presence of natural persons, takes place when an individual is temporarily present in the territory of an economy other than their own to provide a commercial service. GATS defines Mode 4 as the supply of a service by "a service supplier of one Member, through the presence of natural persons of a Member in the territory of any other Member". Mode 4 is generally understood as covering:

- Contractual service suppliers, whether employees are of a foreign service supplier or self-employed;
- Intra-corporate transferees and foreign employees directly recruited by foreign established companies;
- Service sellers who enter the host country to establish contractual relationships for a service contract, or persons responsible for setting up a commercial presence.

179. It might sometimes be difficult to distinguish between those service providers that fulfil Mode 4 criteria and those that do not. However, it needs to be emphasised that from a public health perspective, it

32. Foreign ownership is not a criterion applied in determining the resident status of health care providers under the SHA. Thus, foreign-owned resident health care providers are classified under the appropriate domestic provider category, and the health care goods and services consumed are treated accordingly.

is very important to generate information on both the movement of health professionals under Mode 4 as well as outside Mode 4.

180. Examples in the health field include the movement of nurses, physicians, paramedics, midwives and other professionals from one country to another to provide health services. Short-term flows have been driven mainly by conscious strategies to promote the export of health services in order to earn foreign exchange and foster cooperation between governments.

Balance of Payments and National Accounts

181. The Balance of Payments is a statistical statement that provides a record of an economy's economic transactions with the rest of the world. In general terms, transactions in goods, services and incomes come under the current account, while a capital and financial account shows the financial resource flows. Services are arranged according to 12 broad standard services components. The 2008 System of National Accounts and the BPM6 have a common conceptual framework.

Manual on Statistics of International Trade in Services (MSITS)

182. The *Manual on Statistics of International Trade in Services* (UN, 2010) is built not only around the requirements of GATS but also on the key concepts of the System of National Accounts (SNA 2008) and the Balance of Payments (BPM6). The MSITS provides recommendations for the measurement of international trade in services and therefore provides a clear link to the measurement of trade in services under the System of Health Accounts. The MSITS sets out the Extended Balance of Payments Services Classification (EBOPS 2010), which provides a greater level of detail to the BPM6 classification of services and has correspondence tables with standard product and industry classifications.[33] The coverage of the MSITS goes beyond that required by the System of Health Accounts, in that it allows for the separate identification of services delivered through locally established, but foreign controlled enterprises. Such transactions are covered by Foreign Affiliates Statistics (FATS). Although this information may be of importance to governments and policy-makers, this distinction among health care providers is not made in the SHA supplementary trade tables.

183. Within the EBOPS 2010 classification (Table A7.1), health services approximating to personal health care[34] are split between two classes, depending on their mode of supply:

- 4.2.1. Health-related travel (corresponding to Mode 2 of GATS);
- 11.2.1. Health services (either Mode 1 or part of Mode 4).

Health-related travel

184. Of the two categories, the more important for most countries is "health-related travel"; the nature of most health care requires the presence and co-location of patient and healthcare provider, entailing the movement of one or the other. In this case, it is the movement of the patient abroad that is covered under the item Travel (EBOPS 4). Any services provided as a result of a non-resident provider moving (temporarily) across the border would be included under the "Health services" category.

33. The MSITS provides correspondence tables between the EBOPS classification, CPC, Ver.2 and GNS/W/120 (a Services Sectoral Classification drawn up by the GATT Secretariat for trade negotiating purposes rather than statistical classification).

34. Note that medical goods consumed abroad are considered as part of services and reported under the category *Travel* in the MSITS.

185. The concept of Travel as part of services under the MSITS and BPM6 differs from most other traded services in that it does not refer to a specific product. Travel is defined as "goods and services, for own use or to give away, acquired from an economy, by non-residents during visits to that economy". It covers stays of any length, provided there is "no change in residence" (normally taken as less than a year). However, in contrast to tourism statistics (see the next section), this also covers students and patients staying more than a year, as well as the consumption of seasonal, border and other short-term workers. Also important from the SHA perspective is the inclusion of third-party payments, *e.g.* health costs paid or reimbursed by government or insurers and in theory the imputation of social transfers in kind, *e.g.* government consumption expenditure on non-market health services.

186. Travel is broken down into *Business travel* and *Personal travel*. *Business travel* covers all the goods and services acquired by persons whose primary purpose of travel is business. This includes not only employees and self-employed persons travelling on business, but also cross-border, seasonal and short-term workers. Therefore, all expenditure items, including any health goods and services, would be included under *Business travel*. On the other hand, *Personal travel* covers the goods and services acquired by persons going abroad for any purpose other than business. MSITS 2010 recommends a further breakdown of personal travel into three subcomponents, one of which is *Health-related*. This, in effect, measures the consumption of all goods and services (*i.e.* food, transport, accommodation, etc.) – not just the health services acquired – by persons whose primary purpose for travelling is for health or medical reasons.

187. However, an alternative breakdown of *Travel* by product is also recommended, which provides a much closer link to the requirements of health accounts. There is a split into subcategories such as local transport and accommodation, as well as a category of other travel-related services, with health services as a suggestion. This kind of breakdown would gather together the consumption of health services by residents abroad, irrespective of the main purpose of travel. Note, however, that the purchase of any medical goods by travellers would not be included in this category.

Health services

188. *Health services* forms one part of the EBOPS first-level category "Other personal, cultural or recreational services" and equates to CPC Ver. 2 Group 931 (and class 9321 Residential health-care services other than by hospitals) covering human health services provided by hospitals, doctors, nurses and paramedical and similar personnel, as well as laboratory and similar services, whether rendered remotely (through telemedicine or tele-diagnosis) or on-site. Included are diagnostic-imaging services, pharmaceutical, radiology and rehabilitation services. This equates to the cross-border provision of health services (Mode 1), but also includes the presence of a non-resident health-care provider on the territory (Mode 4). It should be noted that in contrast to health services under travel, health services here can include both services provided provider-to-provider (*i.e.* diagnosis services from a laboratory in one country provided to a laboratory or hospital in another country) in addition to services provided directly to a patient. This important distinction is further discussed under the section intermediate and final use.

189. Any health services supplied by and to governments should also be included under health services. In practice it may be that some services will not be able to be separately identified and are included under Government goods and services not included elsewhere (n.i.e). This can be relevant to health services provided to embassy or military staff posted abroad.

190. MSITS 2010 also provides suggestions for the complementary grouping of EBOPS 2010 categories, including *C.8. Total health services*. This aggregates the two components:

- *Health services* (product breakdown of *travel, other services*); and

- *Health services* (under other personal, cultural and recreational services).

191. Reporting of this complementary grouping is a close proxy to what is required under trade in health services under the SHA framework. Some additional items and adjustments related to SHA boundaries would in principle still be required.

Table A1.1 Health services under the EBOPS 2010 classification

4	Travel		
	4.1	Business	
		Acquisition of goods and services by border and seasonal workers	
		Other	
	4.2	Personal	
		4.2.1	**Health-related**
		4.2.2	Education-related
		4.2.3	Other
11	*Personal, cultural and recreational services*		
	11.1	*Audiovisual and related services*	
	11.2	*Other personal, cultural and recreational services*	
		11.2.1	***Health services***
		11.2.2	*Education services*
		11.2.3	*Other*
Alternative EBOPS groupings			
8 Health services = health services in travel + health services in personal, cultural and recreational services			

Other relevant EBOPS categories

192. To achieve a full mapping to health care according to the boundaries of the SHA, reference should also be made to other EBOPS categories, such as business services, other personal services and insurance services. It is clear that the EBOPS classification (and data sources) is not sufficiently detailed to provide much information that is relevant to health spending.

193. In the case of insurance, accident and health insurance provided to and by non-residents cannot be separately identified from a broader sub category of *Other direct insurance*. In theory, the service charges for resident policyholders with non-resident insurers (and vice versa) should be taken into account in estimating health spending (as a component of HC.7 Governance, and health system & financing administration).

194. Similarly, despite the increased use of overseas outsourcing in such areas as health system governance, planning and administration (or research and development), this does not warrant any explicit categorisation in *Business services*.

195. Finally, the boundaries of health expenditure under the SHA mean that some areas of personal care related to parts of care services to the elderly and disabled lie outside the boundaries of Health care services under the EBOPS and are included instead under *Other personal, cultural and recreational services n.i.e.*

Tourism statistics and the Tourism Satellite Account (TSA)[35]

196. Definitions of trade in health goods and services under the SHA framework and the concepts adopted for tourism satellite accounting show many similarities that may be useful in identifying relevant data sources. First and foremost, tourism is primarily a demand-side phenomenon that refers to the activities of visitors and their role in the acquisition of goods and services across many different industries, including health goods and services. Tourism, as defined under tourism statistics, goes beyond what may be traditionally perceived to include persons travelling (under certain conditions explained below) for holiday, leisure and recreation purposes and also includes, among others, business, education, and importantly, health. However, if the purpose of a trip is for employment or to earn an income, then the trip is not considered as a tourist trip, and the individual cannot be considered as a visitor. Therefore, in the case of seasonal and border workers, any expenditure on health would be excluded from the Tourist Satellite Account.

197. The concepts of economic territory and residence are defined in the same way as in the Balance of Payments. Tourism statistics make the further distinction between "the country of residence" and citizenship or nationality. Nationality or citizenship is related to the country issuing the passport or identity card; a person may be resident in one country but hold the nationality of another – or indeed hold dual nationality in some cases. This may be an important distinction regarding health services abroad, since much of the cross-border traffic involves nationals returning for treatment to their country of origin, where they still hold nationality. In addition, statistics of travellers collected at borders may often identify only the nationality (as stated in the passport) rather than the country of residence. For the purpose of tourism statistics and indeed for health accounts, persons are classified according to their country of residence.

198. IRTS 2008 makes a clear distinction between "travel" and "travellers" in the BoP sense, and "tourism" and "visitors" – the latter terms being subsets of the former: such a distinction builds on the concept of "usual environment" (one of the key concepts in tourism statistics). The purpose of introducing such a concept is to exclude from visitors those travellers who commute regularly between their place of usual residence and their place of work or study, or who frequently visit places as part of their regular life routine, for instance, for health care.

199. In relation to the country of reference, the following three basic forms of tourism can be distinguished:

- Domestic tourism,[36] which comprises the activities of a resident visitor within the country of reference either as part of a domestic tourism trip or part of an outbound tourism trip;

- Inbound tourism, which comprises the activities of a non-resident visitor within the country of reference on an inbound tourism trip;

35. In order to provide internationally comparable data on the different aspects of tourism, the World Tourism Organisation (UNWTO) has developed a set of basic concepts, definitions and classifications. The International Recommendations for Tourism Statistics 2008 (IRTS 2008) includes an alignment with other economic statistics. The development of a Tourism Satellite Account analyses in detail all the aspects of demand for goods and services associated with tourism. The Tourism Satellite Account: Recommended Methodological Framework 2008 (TSA: RMF 2008) provides the link between tourism statistics and the standard tables of the SNA 2008.

36. It is important to note differences in the use of the word "domestic". In tourism statistics, "domestic" refers to activities of residents *within the country of residence,* whereas in national accounts and the SHA, "domestic" refers to activities of residents *irrespective* of where this takes place. In tourism statistics, the latter corresponds to "national tourism".

- Outbound tourism, which comprises the activities of a resident visitor outside the country of reference, either as part of an outbound tourism trip or as part of a domestic tourism trip.

200. Although visitors are then divided into residents and non-residents for the purposes of domestic and inbound tourism, non-resident visitors are a category distinct from non-residents abroad. For example, border workers living in Belgium and regularly crossing into France would be excluded from visitors, and any expenditure on health goods and services made in France would not be included in the French inbound tourist consumption figures. Some other differences exist between the scope of visitors in tourism statistics and that of non-residents used in the SHA, *e.g.* refugees, long-term students and patients (that is, those staying longer than one year) are also excluded from visitors.

201. The main priority of the TSA is to provide information on internal tourism, *i.e.* to measure the consumption of inbound and domestic visitors in the economy. The consumption of residents abroad is of a lesser priority to TSA compilers, since there is no direct impact in the economy of reference. Therefore, from the SHA point of view, information coming from the TSA on inbound tourism may be most useful in identifying the consumption of health services by non-residents, *i.e.* exports. Visitor flows – in non-monetary terms – can be split between visitors and other travellers with no tourist purpose. The standard classification of a tourism trip according to main purpose includes a category: "health and medical care".

202. In addition to the traditional measurement of the characteristics and activities of visitors by means of non-monetary data, IRTS 2008 also refers to the measurement of tourism expenditure defined as "the amount paid for the acquisition of consumption goods and services, as well as valuables, for own use or to give away, for and during tourism trips. It includes expenditure by visitors themselves as well as expenses that are paid for or reimbursed by others." The wider measure of tourism consumption is a TSA concept that is more inclusive because it also includes "services associated with vacation accommodation on own account, tourism social transfers in kind and other imputed consumption". For the purposes of health, this distinction can be useful, since it includes, in theory, government consumption expenditure on individual non-market services or products including social services and health that can be considered as benefiting visitors (social transfers in kind).

203. The Tourism Satellite Account is organised according to products (using the internationally approved classifications of products CPC Ver. 2) – that is, the goods and services consumed by visitors. However, since the product breakdown of tourist expenditure is based primarily on information provided by visitors, the classification for collection of this expenditure is usually based on purpose, in this case the COICOP. Consequently, there is a need to adapt data based on the COICOP – a functional classification – to the CPC – a product classification – which can be linked to products (CPC) and activities (ISIC). Tourism products are classified according first to broad categories: consumption products / non-consumption products. The former category is further divided into tourism characteristic products (characterised by the fact that the tourism expenditure on the product accounts either for a significant share of total tourism expenditure and/or represents a significant share of the supply of the product in the economy) and other consumption products. Tourism characteristic products are then sub-divided into internationally comparable tourism characteristic products, which are a standard list of products defined in terms of CPC Ver.2, such as accommodation services, food and beverages and transport. The other subcategory refers to country-specific tourism characteristic products, and this is where individual countries can include products that may have particular relevance to their countries, but are limited worldwide. This may be the case for countries where the promotion of health or medical tourism is seen as

an important area, and as such the inclusion of specific questions related to health in tourist surveys or the development of specific surveys of health providers can be seen as an important source of information.[37]

204. It should be noted that a specific category "health and medical care" corresponds closely to the main purpose of the trip, and as such the incidental purchase of health care products and occasional health services may be allocated into non-tourism-related consumption products in the first instance.

205. Additional tables of the TSA show both how this tourist demand is met by domestic supply and imports as well as the link with non-monetary information.

37. For example, Switzerland specifically includes "Health care" as a tourism-connected product in their Tourism Satellite Account (Swiss Federal Statistical Office, 2008).

ANNEX 2. OECD QUESTIONNAIRE ON TRADE IN HEALTH GOODS AND SERVICES UNDER SHA

OECD Questionnaire on Trade in Health Goods and Services under SHA

Health expenditure according to the System of Health Accounts should include all final consumption by residents both in the economic territory and abroad. This means the explicit inclusion of imports (health care goods and services provided by non-resident units) and the exclusion of exports (those goods and services provided to non-residents by resident providers) in order to correctly determine total health spending.

Past experience from international health accounts data collections has shown that the consideration of exports and imports of health goods and services in the estimation of overall health spending has been generally weak and is an area which was not covered sufficiently in the first SHA manual.

This questionnaire aims to collect information on the level of international trade in health care goods and services that is currently available in your country within the context of the ongoing OECD project "Improving estimates of exports and imports of health services and goods under the SHA Framework".

This file contains five worksheets: 1 Information; 2 Imports Questionnaire; 3 Imports Data; 4 Exports Questionnaire; 5 Exports Data
IMPORTS QUESTIONNAIRE contains a short questionnaire designed to collect information on current and prospective treatment of health care goods and services provided to residents by non-resident providers. In the worksheet - IMPORTS DATA - countries are invited to report any currently available data according to the proposed cross-classification of healthcare functions, financing schemes and mode of supply.

EXPORTS QUESTIONNAIRE contains a short questionnaire designed to collect information on current and prospective treatment of health care goods and services provided to non-residents by resident providers - noting that under current reporting requirements such exports are not explicitly recorded. In the worksheet - EXPORTS DATA - countries are invited to report any currently available data according to the proposed cross-classification of healthcare functions, providers and mode of supply.

Please also refer to Chapter 12: Trade in Health Goods and Services in the latest SHA 2.0 Draft for guidance on definitions, boundaries and sources of information when completing the questionnaire.

Link to latest SHA 2.0 Draft

Imports of health goods and services questionnaire

Country: _____

1. In your latest submission of health expenditure data to the OECD, did you include any estimation for health goods and services provided by 'Rest of the world' (ROW) providers (i.e HP.9)? Yes/No

2. If NO, what were the reasons why no estimates were included?

- No appropriate data sources have been identified — Yes/No
- The measurement of imports is not a priority — Yes/No
- The level of imports is seen as negligible — Yes/No
- Different concept of health spending (i.e. excludes imports) — Yes/No
- Other reason (please specify) — Yes/No _____

3. Do you have the intention to include the measurement of imports in the near future (1-2 years)? Yes/No

4. If YES, what are the main sources that are used ?

- Reported trade statistics (e.g. Balance of payments statistics) — Yes/No
- Public health insurance records — Yes/No
- Government administrative sources (e.g. liaison offices) — Yes/No
- Private health insurance sources — Yes/No
- Household surveys — Yes/No
- Tourist or border surveys — Yes/No
- Other country statistics (mirror statistics) — Yes/No
- Other (please specify) — Yes/No _____

5. Do the current estimates of imports for your country conform with the SHA concepts of:

		If not please give further details
Residency	Yes/No	
Boundaries	Yes/No	
Other (please specify)	Yes/No	

6. Imports of which functions of health care are currently reported (even partially) and what do you consider the likelihood of reporting in the coming 1-2 years?

	Now	Next 1-2 years
In-patient care	Yes/No	
Out-patient care	Yes/No	
Dental care	Yes/No	
Medical goods (incl. pharmaceuticals)	Yes/No	
Preventive care	Yes/No	
Admin and insurance	Yes/No	
Other (please specify)	Yes/No _____	_____

7. What information on imports is currently available (even partially) by financing scheme (HF), and what do you consider the likelihood of reporting in the coming 1-2 y

	Now	Next 1-2 years
General government	Yes/No	
Social security funds	Yes/No	
Private Insurance	Yes/No	
Households' out of pocket	Yes/No	
ROW	Yes/No	
Other (please specify)	Yes/No _____	_____

8. The supplementary imports table in the revised SHA manual proposes a cross-classification of the main functions (HC) by financing schemes (HF). Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
In-patient care by HF		
Out-patient care by HF		
Dental care by HF		
Medical goods by HF		
Preventive care by HF		
Governance, management etc by HF		
Other by HF (please specify)		

** Where the option "**limited**" would suggest reporting according to a single financing scheme at the second digit level (e.g. HF.1.2), while "**comprehensive**" would suggest at least two financing schemes.*

9. The supplementary imports table also allows for cross-classifying imported health care goods and services by mode of supply (MoS) (see SHA 2.0 draft paras. 902-917)
Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
In-patient care by MoS		
Out-patient care by MoS		
Dental care by MoS		
Medical goods by MoS		
Preventive care by MoS		
Governance, management etc by MoS		
Other by MoS (please specify)		

10. The tables also include a number of memorandum items.
Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
Traditional, Complementary and Alternative medicines (TCAM)		
Spa and well-being services (non-health) (see SHA 2.0 draft Para. 1009)		
Cosmetic surgery (non-health)		
Non-health travel-related services (see SHA 2.0 draft Para. 1010)		

11. Do you think it might be possible to produce tables according to trading partners or regions (e.g. in the case of EU countries, separating intra-EU and extra-EU trade)? Yes/No

12. You are requested to use the IMPORTS DATA worksheet to provide us with the most recent data on imports that you currently have available. Please complete t cells for which you have information. For example if you currently only have information on imported in-patient services financed through governmental cells for wh schemes, please complete just this cell.

13. Do you have any suggestions to improve the imports data table? Yes/No

If YES, please provide details: _____

Expenditure on health by functions of care and financing schemes and mode of supply by residents abroad (imports)

Country: / Year:	Financing schemes / Mode of supply	HF.1	HF.1.1	HF.1.2	HF.1.3	HF.2	HF.3	HF.4		MS.1	MS.2	MS.4	MS.3
Functions	***Million of national currency***	**Governmental schemes and compulsory contributory health financing schemes**	Governmental schemes	Compulsory contributory health insurance schemes	Compulsory Medical Saving Accounts (CMSA)	**Voluntary health care payment schemes**	**Household out-of-pocket payment**	**Rest of the world financing schemes (non resident)**	**TOTAL**	**Cross-border supply (Mode 1)**	**Consumption abroad (Mode 2)**	**Presence of natural persons (Mode 4)**	*Commercial presence (Mode 3)*
HC.I.1-4	**Personal health care services**												
	Of which:												
HC.I.1.1/2.1/3.1	In-patient care												
HC.I.1.3/2.3/3.3	Outpatient care												
	Of which:												
HC.I.1.3.2	Dental care												
HC.I.5	**Medical goods** (not specified by function)												
HC.I.6	**Preventive care**												
HC.I.7	**Governance, management and health system administration**												
	TOTAL												
Memorandum items:													
RI.I.2	Traditional, Complementary and Alternative Medicines (TCAM)												
HC.R.I.3	Spa and well-being services (non-health)												
HC.R.I.4	Cosmetic surgery (non-health)												
HC.R.I.5	Non-health travel-related services												

Exports of health goods and services questionnaire

Country: _____

1. In your latest submission of health expenditure data to the OECD, were you able to exclude estimates of exports for health goods and services (those goods and services provided to non-residents by resident providers)? Yes/No

2. If NO, what are the reasons why estimates were not excluded?

		Comments
Too difficult to exclude exports	Yes/No	
Data sources do not distinguish between residency status	Yes/No	
The level of exports is seen as negligible	Yes/No	
The measurement of exports is not a priority	Yes/No	
Different concept of health spending (i.e. provider based)	Yes/No	
Other reason (please specify)	Yes/No	

3. Do you have the intention to exclude the measurement of exports in the near future (1-2 years)? Yes/No

4. If YES, what are the main sources that you use ?

Reported trade statistics (e.g. Balance of payments statistics)	Yes/No
Enterprise/business surveys	Yes/No
Government administrative sources (e.g. liaison offices)	Yes/No
Tourist or border surveys	Yes/No
Public/Private insurance records	Yes/No
Other country statistics (mirror statistics)	Yes/No
Other (please specify)	Yes/No

5. Which functions of healthcare do you currently have data available (even partially) and what do you consider the likelihood of reporting in the coming 1-2 years?

	Now	Next 1-2 years
In-patient care	Yes/No	
Out-patient care	Yes/No	
Dental care	Yes/No	
Medical goods (incl. pharmaceuticals)	Yes/No	
Preventive care	Yes/No	
Admin and insurance	Yes/No	
Other (please specify)	Yes/No	

6. What information on exports is currently available (even partially) by HP, and what do you consider the likelihood of reporting in the coming 1-2 years?

	Now	Next 1-2 years
Hospitals	Yes/No	
Nursing health care facilities	Yes/No	
Providers of ambulatory health care	Yes/No	
Other (please specify)	Yes/No	

7. The supplementary exports table in the revised SHA manual proposes a cross-classification of main functions (HC) by providers (HP). Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
In-patient care by HP		
Out-patient care by HP		
Dental care by HP		
Medical goods by HP		
Preventive care by HP		
Governance, management etc by HP		
Other by HP (please specify)		

8. The supplementary exports table also allows for cross-classifying exported health care goods and services by mode of supply (MoS) (see SHA 2.0 draft paras. 902-917)
Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
In-patient care by MoS		
Out-patient care by MoS		
Dental care by MoS		
Medical goods by MoS		
Preventive care by MoS		
Governance, management etc by MoS		
Other by MoS (please specify)		

9. The tables also include a number of memorandum items.
Please provide an indication regarding the feasibility of completing the following:

	Feasibility	Comments
Traditional, Complementary and Alternative medicines (TCAM)		
Spa and well-being services (non-health) (see SHA 2.0 draft Para 1009)		
Cosmetic surgery (non-health)		
Non-health travel-related services (see SHA 2.0 draft para 1010)		

10. Do you think it might be possible to produce tables according to trading partners or regions (e.g. in the case of EU countries, separating intra-EU and extra-EU trade)? Yes/No

11. You are requested to use the EXPORTS DATA worksheet to provide us with the most recent data on imports that you currently have available. Please complete the cells for which you have information. For example if you currently only have information on exported in-patient services provided by hospitals, please complete just this cell.

12. Do you have any suggestions to improve the exports data table? Yes/No

If YES, please provide details: _____

Expenditure on health by functions of care and providers of care by non-residents (exports)

Country: / Year:	Providers / Mode of supply	HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3-9	HP.4	HP.5	HP.6	HP.7	HP.8-9		MS.1	MS.2	MS.4	MS.3
Functions	*Million of national currency*	Hospitals	Residential long-term care facilities	Providers of ambulatory health care	Medical practice	Dental practice	All other providers of ambulatory health care	Providers of ancillary services	Retailers and other providers of medical goods	Providers of preventive care	Providers of health care system administration and financing	Secondary health care providers, rest of economy	TOTAL	Cross-border supply (Mode 1)	Consumption abroad (Mode 2)	Presence of natural persons (Mode 4)	*Commercial presence (Mode 3)*
HC.E.1-4	**Personal health care services**																
	Of which:																
HC.E.1.1/2.1/3.1	In-patient care																
HC.E.1.3/2.3/3.3	Outpatient care																
	Of which:																
HC.E.1.3.2	Dental care																
HC.E.5	**Medical goods** (not specified by function)																
HC.E.6	**Preventive care**																
HC.E.7	**Governance, management and health system administration**																
	TOTAL																
Memorandum items:																	
RI.E.2	Traditional, Complementary and Alternative Medicines (TCAM)																
HC.R.E.3	Spa and well-being services (non-health)																
HC.R.E.4	Cosmetic surgery (non-health)																
HC.R.E.5	Non-health travel-related services																

ANNEX 3. HEALTH AT A GLANCE EUROPE 2010

206. The following text and charts are taken from the OECD publication Health at a Glance: Europe 2010, result of collaboration between the OECD and the European Commission. This presented a brief descriptive analysis of the latest data available on imports and exports for the countries of the European Union.

Trade in health services

207. The trend towards globalisation, reinforced by the relaxation of regulatory obstacles in Europe, has fuelled a steady growth in international trade in health services in recent years, albeit from relatively low levels. However, despite much attention from health analysts, the medical professions and health policy makers, discussions on the opportunities and challenges related to such trade have so far been conducted with relatively little data to inform them.

208. The major part of international trade in health services involves the physical movement of patients across borders to receive treatment – otherwise called patient mobility. While for the most part individuals prefer to receive health care in their home country, under certain circumstances it may be more beneficial to receive health care abroad; for example, where the nearest health facility may be across a border, when visiting a country as a tourist or on business, or if the required care can be provided faster, cheaper or of a higher quality. To get a full measure of imports and exports, there is also a need to consider goods and services delivered remotely such as pharmaceuticals ordered from another country or diagnostic services provided from a doctor in one country to a patient in another. The magnitude of such trade remains small, but advances in technology mean that this area also has the potential to grow rapidly.

209. Data on imports of health services and goods are available for the majority of European countries. They show that total reported imports amounted to more than EUR 3 billion in 2008 (Figure A3.1). The vast majority of this trade is between European countries. Germany is by far the greatest importer of health goods and services, partly reflecting a large growth in pharmaceuticals acquired from foreign-based on-line pharmacies in recent years. Other countries with relatively high imports are the Netherlands, France, Luxembourg and Belgium where much patient movement takes place in the border regions. However, in comparison to the size of the health sector as a whole, trade in health goods and services remains marginal for most countries. Even in the case of Germany, reported imports represent only around 0.5% of Germany's current health expenditure. Growth in the value of imports over the last five years has averaged more than 15% year on year, with much higher growth rates among some of the newer members of the European Union (Figure A3.2).

210. A reduced number of countries currently report exports of health services via international trade statistics totalling around EUR 2.5 billion (Figure A3.3). For both imports and exports, the figures are likely to be significant underestimates. The Czech Republic, France and Poland all reported exports in excess of EUR 400 million in 2008. Some central and eastern European countries have become popular destinations for patients from other European countries, particularly for services such as dental surgery. Annual growth has been over 30% in both the Czech Republic and Poland over the past five years (Figure A3.4).

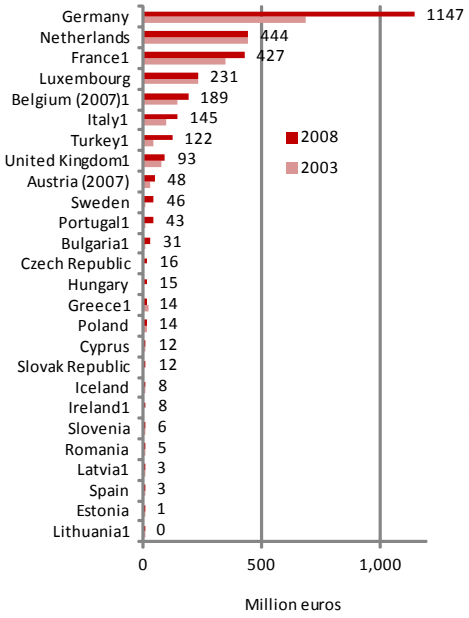
211. Patient mobility in Europe could receive a further boost as the European Commission has sought to clarify patients' rights for treatment coverage in other member states. Many of the proposed changes in European regulations seek to strike a balance between the rights of patients to seek health care and the responsibilities of states to organise the delivery of health services. A Directive has been proposed, seeking to meet three objectives: to guarantee that all patients have care that is safe and of good quality; to support patients in the exercise of their rights to cross border health care; and to promote co-operation between health systems (Council of the European Union, 2010).

Definition and deviations

The *System of Health Accounts* includes imports within current health expenditure, defined as imports of medical goods and services for final consumption. Of these the purchase of medical services and goods, by resident patients while abroad, is currently the most important in value terms.

In the balance of payments, trade refers to goods and services transactions between residents and non-residents of an economy. According to the *Manual on Statistics of International Trade in Services*, "Health-related travel" is defined as "goods and services acquired by travellers going abroad for medical reasons". This category has some limitations in that it covers only those persons travelling for the specific purpose of receiving medical care, and does not include those who happen to require medical services when abroad. The additional item 'Health services" covers those services delivered across borders but can include medical services delivered between providers as well as to patients.

A3.1 **Imports of health services and goods, 2003 and 2008**

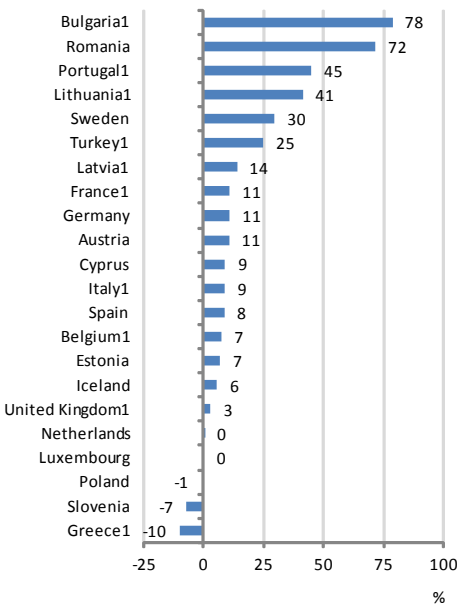


1. Balance of payments concept of imports.

Note: Imports of health services and goods occur when residents receive medical services from foreign providers or when they purchase medical goods abroad.

Source: OECD-Eurostat Trade in services, OECD System of Health Accounts.

A3.2 **Annual average growth rate in imports of health services and goods, 2003-08**

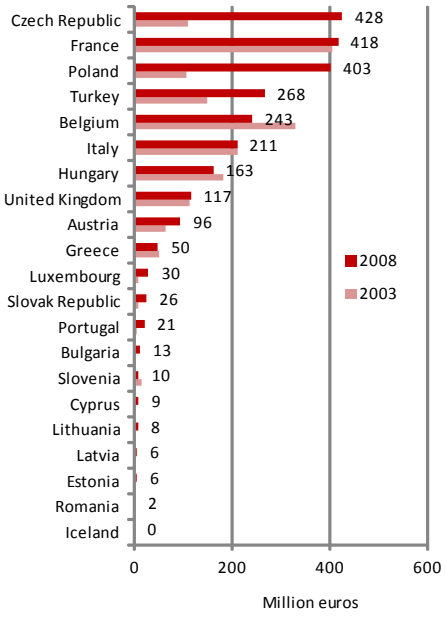


1. Balance of payments concept of imports.

Note: Imports of health services and goods occur when residents receive medical services from foreign providers or when they purchase medical goods abroad.

Source: OECD-Eurostat Trade in services, OECD System of Health Accounts.

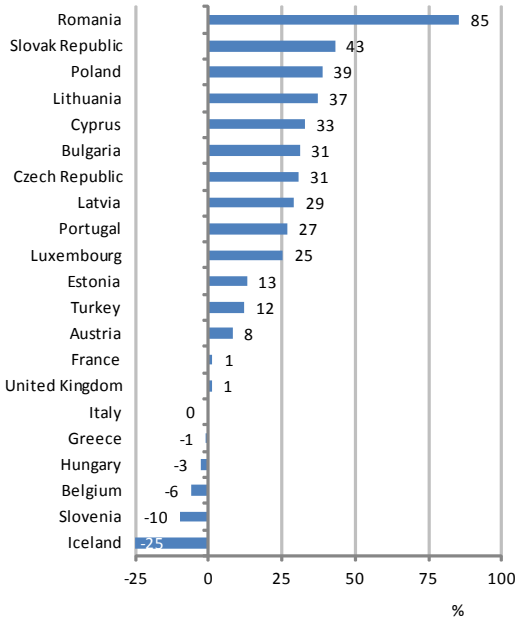
A3.3 **Exports of health services and goods, 2003 and 2008**



Note: Exports of health services and goods occur when domestic providers supply medical services to non-residents or when they sell medical goods to non-residents.

Source: OECD-Eurostat Trade in services, OECD System of Health Accounts.

A3.4 **Annual average growth rate in exports of health services and goods, 2003-08**



Note: Exports of health services and goods occur when domestic providers supply medical services to non-residents or when they sell medical goods to non-residents.

Source: OECD-Eurostat Trade in services, OECD System of Health Accounts.