

Input Document Cutting across Units

Discussion note on Concepts and Definitions of Trade in health services and goods under the SHA framework

Summary

‘Total expenditure on health measures the final use of resident units of health goods and services...’ It should, by definition, not include exports of health care goods and services i.e. provided by domestic providers to non-residents, but include imports of health care goods and services, for example, health spending by residents while abroad.

The development of a framework necessitates an evaluation of the concepts and boundaries of trade in health goods and services, covering areas such as the definitions of entitlement and residency, an assessment of modes of service in application to health service transactions, etc. The full range of transactions taking place between the domestic health sector and the rest of the world (i.e. between residents and non-residents) needs be assessed.

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DISCUSSION NOTE ON CONCEPTS AND DEFINITIONS OF TRADE IN HEALTH SERVICES AND GOODS UNDER THE SHA FRAMEWORK

Introduction

1. As defined under the proposed Global Boundaries of Health Care¹, the central accounting framework of the SHA focuses primarily on the domestic consumption of health care goods and services i.e. the consumption of health care goods and services by resident units for final use. Therefore, health expenditure should include all final consumption by resident units irrespective of whether this takes place in the economic territory or abroad. Moreover, it should also be irrespective of who is paying for the goods or services. This means the explicit inclusion of imports (services and goods provided by non-resident units) and the exclusion of exports (goods and services provided to non-residents by resident providers) in order to correctly determine total health spending.

2. Although traditionally seen as non-tradable services or negligible in value, a growing number of health services are now being delivered internationally, either through the movement of patients or health personnel between countries, or via the cross-border delivery of health services and goods direct to patients or other providers. Technological advances, market openings, high domestic prices of treatment or health insurance, and other obstacles to accessing health care treatment at home (*e.g.* waiting times, quality of treatment, or legal/ethical obstacles), have become some of the driving forces behind the movement of patients and trade in health.

3. There is a growing body of evidence that the part related to patient mobility or ‘medical tourism’, *i.e.* the movement of patients across international borders, is becoming increasingly important in many countries, *e.g.* Thailand reported to have treated over one million foreign patients in 2006 (Thai Board of Investment, 2008). In addition to the requirements of health accounts, the risks and benefits for national health systems generated by such trends, means that timely and comprehensive data collection in the area is crucial. There is also a wider trade 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)² - the health sector is particularly interesting since trade in health services is delivered in several GATS sectors and in all four modes of supply (see Table A1.1). An interest from a number of countries in developing health exports as a currency earner has resulted in a necessity to assess the impact on public health provision in the exporting country. Finally, there is a growing awareness in some countries that parts of domestic health service demand is being met by foreign providers of health care, and it is this perspective of consumption of health goods and services that concerns the international measurement of health expenditure under the System of Health Accounts (SHA). The different points of view lead to a slightly different definition of trade under, on the one hand, the core

¹ See <http://www.oecd.org/dataoecd/45/3/43891377.pdf>

² Although the supply of health services by governmental organisations such as national health services are included in the SHA and SNA views of trade in health services, it should be noted that GATS does not cover these.

framework of the SHA and, on the other, trade in health care products in a wider economic sense which will be examined later in this note.

4. As a first step, the SHA manual needs to establish a conceptual basis for the reporting of imports and exports of health goods and services in line with the boundaries of health expenditure. To this end, clear definitions of the concepts of economic territory and residence are required. Therefore, and to ensure that SHA statistics are compiled on a uniform basis with other macroeconomic statistics, it is reasonable for the SHA to take its lead from the standard definitions and concepts already 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.

5. In addition, reference should also be made to the concepts and definitions outlined in Tourism Satellite Accounts (TSA) (Box A1) with an assessment of the existing survey instruments and methodologies employed in developing estimates of tourist consumption of health services and goods.

Box A1. Tourism Satellite Accounts

A distinction should be made between the concept of a 'visitor' according to the methodological framework of Tourism Satellite Accounts and that of 'non-resident' in the Balance of Payments. A visitor is defined as someone outside of their 'usual environment' – that is, the 'area ... within which an individual conducts his/her regular life routines'. 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, in the case given above, border workers living in Belgium and regularly crossing into France would be excluded from visitors and any expenditure on health services and goods in France would not be included in tourist consumption figures.

While non-resident visitors can be considered a subset of non-residents, or travellers, then tourism can be considered as a subset of the travel item of BPM. For example, if the purpose of a trip is to employment and to earn an income, then the trip cannot be considered as a tourist trip and the individual cannot be considered as a visitor. Therefore, in the case of seasonal workers, any expenditure on health would again be excluded from the Tourist Satellite Account.

Tourism is defined by the demand side, with the consumption of goods and services cutting across many different industries, including health services and goods. The demand-side tables of TSA show tourist expenditure and consumption by product. Tourist expenditure is defined as the amount paid for the acquisition of consumption goods ... during tourist trips' by visitors themselves as well as expenses that are paid for or reimbursed by others'. Tourism consumption goes beyond this to include, among others, transfers in kind (including social transfers in kind) for e.g. health services.

Consumption products are divided into tourism characteristics products and other consumption productions, using internationally approved classifications of products (CPC, Ver. 2.). Although not listed specifically as an internationally comparable tourism characteristic product, countries may choose to include health services and goods as country-specific where they consider them to be of importance. This may be the case in 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.

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

Concepts and definitions

Economic territory

6. In its broadest sense, an economic territory can refer 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 refer to 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 under the estimate of health expenditure or not.

Residence

7. The concept of residence is subsequently determined by the delimitation of the economic territory. According to the definition of BPM6, a unit is said to be resident in a country when its “*centre of economic interest*” is situated within that country’s economic territory.

8. “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

9. Regarding a household’s centre of economic interest, BPM6 states that this is “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 who belong to the same household must be residents of the same economy. At this point, it is perhaps important to make the distinction between the concept of residence in economic terms rather than any based on nationality or legal criteria. Therefore an individual considered to be a resident of a particular economy may not necessarily be a citizen of that country. Of particular relevance to health care, a differentiation should also be made between the resident population and the covered or insured population. Public health care insurance coverage may not cover the whole population or 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 Box A2).

ISSUE: This is an important issue to consider, particularly but not exclusively in the EU, regarding the portability of health insurance (public or private) by nationals retiring or residing abroad.

10. BPM6 (which conforms to the definitions of SNA 2008) sets out a criterion for residence 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. Non-residents are consequently classified as residents of their own home economies. 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.

11. 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 be regarded as residents of Belgium rather than residents of France.

Box A2. Current 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.

The Draft EU Directive of Patients' Rights in Cross-border Healthcare

In July 2008, the European Commission published a draft Directive on the application of patients' rights in cross-border healthcare. This draft legislation set out to codify existing European Court of Justice case law on patients' rights in accessing cross-border healthcare and clarify its application.

The draft Directive set out a legal framework for patients seeking access to healthcare in another EEA Member State. The broad outline of the Commission's proposal is 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 does not alter the right of Member States to define the benefits that they choose to provide.

The detail of the draft Directive has been under negotiation with the European Parliament and Council of the European Union but has been subject to revision and compromise by the current Swedish Presidency of the Council. There remain some hurdles to overcome regarding the scope of the directive and a number of EU delegations are not satisfied with the current draft directive and the immediate adoption of the directive is unclear.

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

12. Refugees are considered residents if they stay, or *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.

ISSUE: Consideration should be made 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.

13. As stated, an exception to the one-year rule is made in determining the resident status of students because application of the one-year rule could lead to problems with interpretation and availability of data. Students are generally expected to return to their home economies upon completion of their studies. Consequently, their centres of interest may not be closely related to the length of stay abroad. Therefore, 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 is 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 programs; and whether he or she plans to return to the country of origin on completion of his or her studies.

ISSUE: One issue to consider is the reporting of imports and exports of some of the health-related items currently under SHA 1.0, such as education and training. The training of medical professionals abroad is of particular relevance to some countries.

14. Medical patients abroad are dealt with in the same manner as students. 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. In reality, this is of significance only to a very small minority of medical patients.

ISSUE: Further consideration should be made however to the residential status of Long-term care patients in nursing care homes abroad given the boundaries of health under the System of Health Accounts. 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.

15. BPM6 provides further detail on other categories of persons such as diplomats, employees of international organisations, military personnel, etc.

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

17. 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 on the territory by health care professionals or as part of foreign government or international aid efforts may be less straightforward. Similarly, the use of commercial agents and foreign-owned institutions requires some consideration.

Enterprises

18. The Balance of Payments Manual states that an enterprise has a centre of economic interest and 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 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. Though, in practice, these additional conditions are generally satisfied for enterprises engaged in longer-term activity.

19. The term enterprise includes (1) corporations, which are entities engaged in production for profit and recognized 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, such is the case for many self-employed doctors and dentists.

Commercial agencies

20. How should the resident status of commercial agencies be determined? Agencies transacting business on behalf of non-resident principals should be treated as resident producers in the economies in which the agencies are located. Services rendered by an agent to the enterprise that the agent represents should be attributed to the economy in which the agent is a resident. Transactions conducted by an agent on behalf of a non-resident principal should, without exception, be attributed to the economy of the principal. For example, one of the new

burgeoning areas is in the area of health tourism facilitators or the setting up of commercial offices abroad to representing medical institutions.

ISSUE: In this above case, should the service charge part be included under administration of the economy where the agent is resident, but the healthcare fees would be reported under imports?

Non-profit institutions

21. Like enterprises, non-profit bodies are resident entities of the economic territories in which the non-profit bodies are located or conduct their affairs. Non-profit bodies are generally engaged in furnishing educational, health, cultural, recreational, and other social and community services free of charge or at sales prices that do not fully cover the costs of production. Examples of non-profit bodies are such entities as private hospitals, churches, cultural societies, foundations, universities, colleges, and the Red Cross.

22. In practice, the residence of the vast majority of non-profit institutions may 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 may be classified as being provided by non-resident units.

Government

23. 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.

24. 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 it 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.

Rest of the world

25. 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 country under review. The rest of the world therefore comprises all non-resident units that provide health services and goods to resident units (these sales being imports) and the non-resident units that consume health services and goods provided by resident units (these purchases being exports).

Valuation

26. 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.

ISSUE: How should the valuation of externally funded and provided services/goods be made when there is a large differential between the importing and exporting country's valuation? For example, consultancy services provided in a developing country. The BPM appears clear that the valuation can only be made in terms of the donor country currency but some further consideration may be given to this.

27. In the national accounts, detailed figures for imports and exports of goods are valued at "fob" prices, a maritime term that stands for "free on board", signifying that the prices of the goods include transport and insurance costs when they arrive at the exporting country's frontier but not the transport and insurance costs further to that frontier. However, detailed goods trade data are valued at 'cif' (cost, insurance, freight) for imports and 'fob' for exports, meaning an adjustment will need to be estimated.

Timing

28. In the case of exports and imports, these are recorded at the time when a service is delivered or, in the case of medical goods, when the change in ownership of real assets occurs.

Imports and exports under the System of Health Accounts

29. At this stage it is perhaps worth making the clear distinction between the core information requirements for imports and exports under the core framework of the SHA, and trade in health care products in a wider economic sense as referred to in the Balance of Payments and National Accounts. As stated the SHA concerns itself foremost with the **final consumption** of health goods and services by resident units.

Box A3. Examples of trade in health services and goods under SHA

Imports and exports cover the range of health services and goods for final consumption (not for the purposes of intermediate consumption) defined under the functional classification. It may be useful to consider the following examples:

Cross-border supply: In its simplest case, this could be the provision of health goods direct from a non-resident provider by e.g. mail order or via the internet. In another example, this could be health counseling provided over the phone by a doctor in the UK directly to a patient in Germany. This would be an entry in the German, not UK, Health Accounts and is classed as an export for the UK and an import for Germany.

However, health counselling provided over the phone by a doctor in one country to a doctor in another is considered as intermediate consumption and therefore not included.

In another example, the provision of health insurance to residents by non-resident insurance companies and vice-versa can be considered as foreign trade. However, this only includes the service charge element of the premium paid by households, in line with the general SHA treatment of health administration and insurance. 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 provided by non-resident health-care providers. For example, if a US resident takes out health insurance with a Mexican-based health insurance company and receives dental care from a Mexican based dentist, then both the insurance service charge and dental care are reported as imports.

Consumption abroad: In the simplest example, this could be an Italian tourist receiving medical treatment in a hospital in France. This would be an entry in the Italian, not French, health account, and is an export for France and an import for Italy.

In this latter example, it is useful to distinguish between those who travel abroad for the purpose of receiving medical treatment (for example, some UK residents are sent abroad by the National Health Service for certain operations), and travel where medical treatment is incidental (for example, where the medical treatment is related to an unforeseen accident abroad). In the first case, the cost of travel and other related expenses should be included as an integral part of the cost of the medical treatment if the primary reason for travel is health care. In the latter case, they should not.

ISSUE: This may induce a possible definitional difference between 1) treatment of patient transport in SHA and 2) treatment under SHA and BPM? If, in the above example, the UK patient is sent abroad by NHS, should the travel be included in the 'package' and included under HP.9, even though the international travel may be provided by a resident carrier. Is it feasible for it to be separated with Patient transport reported apart?

Both the cross-border and consumption abroad examples have focused on health services but the treatment of health goods is similar. The transaction is either a movement of goods from one country to another, or it is the consumption of a good by a resident of one country in another country.

A further example of foreign trade relevant to SHA is the provision of services by non-resident providers on the resident territory. This could be a team of doctors or specialists working for a health care provider fulfilling a short-term contract to delivery services in another country.

ISSUE: This gives rise to some grey areas where non-resident health professionals are providing services on a short term basis as self-employed or under contract to a resident provider. This may be particularly the case for non-medical professionals providing long-term care for example. How should this be treated?

30. The main classification used for the functions (services and goods) of health care - ICHA-HC - is described as a classification according to purpose. The classification of functions distinguishes between the different services of care (*e.g.* curative, rehabilitative and long-term care), medical goods dispensed to outpatients as well as services delivered collectively to the population, such as public health and administration of the health system. The main reconciliation of this defining 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 – ICHA-HP - is based on the International Standard Industrial Classification (ISIC, Rev. 4). In terms of source data this is important since ISIC provides the basis for business, survey, employment and census statistics. Statistics of international trade are more aligned with the analysis of production and as such classifications are based on the standard classification of products.

31. Second, there are fairly large differences between countries in the balance between intermediate and final use concerning trade in health services and, more particularly, medical

goods. Even in the case of medical services, a lot of the recent growth in cross-border trade is from provider to provider e.g. the provision of diagnostic services from foreign laboratories to domestic hospitals. Therefore, the majority of, say, the UK's trade in medical goods and services is likely destined for intermediate consumption or production whereas for Luxembourg, perhaps, imports and exports of health goods and services for final use may well be relatively high.

32. In the System of Health Accounts, a category related to non-resident units exists in both the provider and financing schemes classifications. In both classifications they refer to "rest of the world". However, with respect to imports and exports of health goods and services, it is important to clarify that it is the provision rather than the financing by non-resident units that is of interest here. 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 be provided by domestic provider and therefore not an import. If, however, a service is provided for by a foreign government to a resident (irrespective who pays for it), then this is indeed accounted for as an import.

33. In the SHA tables therefore, imports of goods and services from non-resident units are to be recorded under the provider category 'Rest of the world' and to be cross-classified by the various functions under the core framework – since the same boundary and functions of health care prevails for services and goods consumed by residents abroad (Figure A1.1).

34. Within the consumption boundary, exports are not included since 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 for reconciliation with the production of resident health providers, exports should also be reported. Therefore, services and goods consumed by non-residents can be cross-classified with health providers (and health financing) as a single line memorandum entry or a separate full cross-classified table (broken down by HC categories) for exports.

Possible reporting of trade in health services and goods under the SHA framework

35. How should the categories of exports be developed? What is currently being proposed is that exports should be a part of the functional classification. This may cause conceptual problems as it is not in itself a functional category – *i.e.* services and goods provided to non-residents (for final consumption) are the same as those provided to residents. The functional classification is therefore a classification of health services and goods not of resident health services and goods.

36. Note that the current proposal for the functional classification³ also makes a distinction for exports between direct purchases by non-residents on the territory and cross-border exports of health services and goods, whether for intermediate or final consumption. Is this the correct approach?

37. Should there be a distinction made in the reporting of exports (and imports) by mode of supply? (and should this be extended to include memorandum reporting of Mode 3 (and Mode 4) trade?)

³ See <http://www.oecd.org/dataoecd/45/17/43891914.pdf>

38. Foreign trade in for ‘intermediate consumption of health care providers’ as additional reporting items would require additional classifications covering such goods.

Figure A1.1. Simplified reporting of trade in health services and goods under the SHA 2.0 framework

HCxHP		Providers of Health care (ICHA-HP)			
		Resident providers		Non-resident providers	
		HP.1.0	...	HP.7.0	HP.9.0
Functions of Health care (ICHA-HC)	HC.1.0				Health services and goods (HC.1.0 to HC.x.0) to residents by non-resident providers (imports)
	..				
	HC.x.0				
	X.(HC)	Health services and goods (HC.1.0 to HC.x.0) to non-residents by resident providers (exports)			
	...				

39. For imports, should there be a further (voluntary) breakdown and reporting of imports by provider *i.e.* should HP.9 be subdivided into HP.9.1 Hospitals, HP.9.2 Nursing homes, etc?

40. How should the previously reported health-related items such as R&D and education and training be treated with regards to non-resident providers?

41. A further item that was listed as relevant for reporting under SHA manual 1.0 was ‘foreign trade in capital formation in health care industries...’. This may raise some specific issues which are dealt with under DELSA/HEA/HA(2009)8.

Statistics of International Trade in Services

42. Faced with the requirements for relevant, comparable and reliable statistics on trade in all services, not only in health, the international agencies have been active in developing the concepts and data reporting requirements.

43. This work on international trade in services has taken on added importance since the WTO General Agreement on Trade in Services (GATS) in 1995, which defined four modes of supply of services (Table A1.1).

44. The Manual on Statistics of International Trade in Services (MSITS), incorporates the key concepts from System of National Accounts (SNA 2008) and the Balance of Payments manual (BPM6), and provides recommendations for the measurement of international trade in services. It 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 classifications⁴.

45. Within EBOPS (Table A1.2), health services are split primarily between two classes: Health-related travel (corresponding to Mode 2 of GATS) and Health services (either Mode 1 or part of Mode 4). Of the two categories, it is arguable that the more important category is the former; 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. While the provision of services in the territory by foreign providers can be distinguished as health services under 11.2.1, the movement of patients abroad to seek services is covered under Personal Travel (EBOPS 4.2). In better complete the full range of health services and goods, reference should be made to the provision of health and accident insurance services by foreign providers (EBOPS 5.3) and Government services (EBOPS 10).

46. There are several definitional issues regarding Health-related travel that become apparent. First, where travel abroad is specifically health-related, all spending incurred (local transport, food, accommodation, etc - that is, not directly linked to the treatment received and therefore not included under health expenditure according to SHA) is included under Health-related travel. Second, where health services are provided to temporary residents or tourists, who are on the territory primarily for non-health reasons, these are included under Personal travel rather than under Health-related. An alternative grouping, which provides a better approach to the SHA concept of resident consumption of health care goods and services abroad, breaks down travel for both personal and business travel into the expenditure components – including health-related. It is important to achieve proper linkages and synergies between SHA and international trade reporting by ensuring consistent boundaries and definitions of trade in ‘health care’.

47. In developing and sourcing statistics in international trade, it needs to be reiterated that for estimating total health expenditure under the System of Health Accounts, we are concerned primarily with those goods and services destined for final use. For example, tele-diagnosis services from abroad may be purchased by a domestic hospital. In this case, the in-patient care provided by this hospital constitutes the service consumed, and the tele-diagnosis is an import by the hospital sector rather than a direct import of health services by the patient. Such imports of goods and services for intermediate consumption would need to be accounted for separately and as such methodologies and guidelines need to be identified.

⁴ 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).

Table A1.1. Four modes of supply of services in trade defined by the General Agreement on Trade in Services (GATS)

Mode of supply	Territorial presence of transactors	Health related example	Major statistical areas
Mode 1. Cross-border supply	Service only crosses the border. Consumer in his/her territory of residence: Supplier outside the territory of the consumer	Includes shipment of laboratory samples, diagnosis, and clinical consultation via traditional mail channels, as well as electronic delivery of health services, such as diagnosis, second opinions, and consultations. Variety of telemedicine, tele-health (or e-medicine/e-health) services includes tele-health services, including tele-diagnosis, tele-pathology, tele-radiology and tele-psychiatry.	BPM6
Mode 2. Consumption abroad	Consumer outside territory of residence	Medical treatment of non-resident persons i.e. person travelling abroad to the home country of the provider for: 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 developing countries.	BPM6
Mode 3. Commercial presence	Supplier in the territory of the consumer: through commercial presence	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. Medical treatment in a foreign-owned clinic resident in the reporting economy.	FATS and Activities of Multinational Enterprises
Mode 4. Presence of natural persons either self employed or	Supplier in the territory of the consumer: Through the presence of	Movement of health personnel, including physicians, specialists, nurses, paramedics, midwives and other professionals. Short-term flows have mainly been driven by conscious strategies to promote health services exports, in order to earn foreign exchange and	BPM6 & other ¹

employees	natural persons	foster cooperation between governments.	
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1. The "other" statistical areas include migration and employment statistics. BPM6 is the fifth edition of the IMF Balance of Payments Manual. FATS refers to the "Foreign affiliates statistics", definitions for which are mostly derived from 2008 SNA.

Table A1.2. Health services under the proposed EBOPS 2010 classification

4	Travel
4.1	Business
	Acquisition of goods and services by border and seasonal workers
	Other
4.2	Personal
	Health-related
	Education-related
	Other
	<i>Alternative presentation for Travel</i>
	<i>For both business and personal travel</i>
4a.1	Goods
4a.2	Local transport services
4a.3	Accommodation services
4a.4	Food-serving services
4a.5	Other services
	Of which:
	Health services
	Education services
11	<i>Personal, cultural, and recreational services</i>
11.1	<i>Audiovisual and related services</i>
11.2	<i>Other personal, cultural, and recreational services</i>
11.2.1	<i>Health services</i>
11.2.2	<i>Education services</i>
11.2.3	<i>Other</i>
	<i>Alternative EBOPS groupings</i>
	7 Health services = health services in travel + health services in personal cultural and recreational services