An Phríomh-Oifig Staidrimh Central Statistics Office

An Roinn Sláinte DEPARTMENT OF HEALTH

Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

Memorandum of Understanding

Between the Health Service Executive, Department of Health, and Central Statistics Office regarding the System of Health Accounts

Version 31st March 2020

Contents

Appendices

List of Abbreviations

CSO	Central Statistics Office
HSE	Health Service Executive
WHO	World Health Organisation
OECD	Organisation of Economic Co-Operation and Development
EU	European Union
DOH	Department of Health
SHA	System of Health Accounts
MOU	Memorandum of Understanding
SHALG	System of Health Accounts Liaison Group
HATG	Health Accounts Technical Group
HATSG	Health Accounts Technical Sub Group

1. Background and Context

The Central Statistics Office (CSO) is required to report health expenditure data in accordance with the classifications and standards of the System of Health Accounts (SHA) to OECD/WHO/EU SHA under Regulation (EU) 2015/359[1].

European statistics such as SHA data required under the regulation are produced in the context of the European Statistical System (ESS), which is a partnership between Eurostat (the EU Statistical Office), the National Statistical Institutes (NSIs) of the member states, and other national authorities (ONAs) responsible for the development, production and dissemination of European statistics.

Article 5a of Regulation (EC) No 223/2009 on European statistics, as amended by Regulation (EU) 2015/759[2] provides for the independence of the heads of NSIs and assigns to them "*the sole responsibility for deciding on processes, statistical methods, standards and procedures, and on the content and timing of statistical releases and publications for European statistics developed, produced and disseminated by the NSI.*". The regulation further assigns the responsibility for the co-ordination of "*the statistical activities of all national authorities that are responsible for the development, production and dissemination of European statistics*" to the head of the NSI. In the case of Ireland this refers to the Director General of the Central Statistics Office, who is the ultimate authority for all European statistics produced by the State.

The Statistics Act 1993 provides for the collection, compilation, extraction and dissemination of Official Statistics and Section 11 (1) of the Act allows the Central Statistics Office to make arrangements with public authorities in this regard.

The SHA is an international standard facilitating analysis of health expenditure (public and private) cross-classified by type of care, providers of care, and sources of funding. The CSO and the Department of Health (DOH) co-sponsored a project from 2013 to mid-2016, the objectives of which were:

- To meet the legal requirements implementing Regulation (EC) No 1338/2008 (see Appendix 1); and
- To institutionalise the production of health expenditure data to meet international reporting requirements thereafter.

Regulation (EU) 2015/359 requires data to be reported for the years 2014 to 2020 (see Article 4, paragraphs 4 and 5). It is assumed that this regulation will be superseded by another regulation. This new regulation and any changes to the data collection that it may involve will be discussed

[1] EU Regulation 2015/359.
[2] EU Regulation 2015/759 .

and agreed at the Eurostat Working Group on Public Health. The development, discussions and decisions around any such new regulation will be communicated to all parties to this MOU in recognition of any impact it may have on the data collection process and associated resources required.

In relation to the on-going production of statistics for the current legal requirement, the Health Service Executive (HSE), as the statutory provider of public health services, has a key role in the collection and compilation of data on public health expenditure. It also has a key role in ensuring that Irish health services are accurately mapped to the international classification.

This Memorandum of Understanding (MOU) sets out the arrangements that have been agreed between the CSO, the HSE and the DOH for compilation and submission of data by the HSE and the DOH to the CSO in order to meet the reporting requirements set out in Regulation (EU) 2015/359. It also sets out arrangements for quality assurance of the data supplied by the HSE and the DOH to the CSO. Lastly, this MOU also sets out the collaborative working approach between the HSE and the DOH.

2. Agreed Arrangements

The following arrangements have been agreed:

- The HSE will take primary responsibility for supplying data in relation to services and agencies which it funds, in so far as the data is available. Where the data is unavailable, the issues pertaining to this will be outlined and reasonable action taken to make this data available for future reporting periods. The HSE will report data to the CSO in accordance with the Data Exchange Schedule (See Appendix 7), which has been designed to meet the legal reporting requirements of Regulation (EU) 2015/359.

- The DOH will take primary responsibility for supplying data in relation to its expenditure and that of agencies which it funds (with the exception of the HSE and its agencies), in so far as the data is available. Where the data is unavailable, the issues pertaining to this will be outlined and reasonable action taken to make this data available for future reporting periods. The DOH will report data to the CSO in accordance with the Data Exchange Schedule (See Appendix 7) which has been designed to meet the legal reporting requirements of Regulation (EU) 2015/359.

- The CSO will take primary responsibility for investigating data sources in relation to all other public health expenditure and privately funded health expenditure.

- The HSE will ensure that SHA concepts and classifications are taken into account when developing public health information systems in order to meet statutory reporting

requirements. Where possible, the HSE will facilitate embedding of SHA requirements within the functional specification of the new national financial system for the HSE as a requirement for sustainable improvement in developing SHA over time.

- The CSO will transmit the data tables to Eurostat before the required deadline and publish appropriate statistical information nationally.

- It is agreed by all parties that an appreciation, knowledge and understanding of the SHA 2011 manual (revised 2017)[3] is a key requirement to the output of robust data. This appreciation is also acknowledged as being a vital component in the generation and interpretation of results.

- It is agreed by all parties that they will work together to agree the correct implementation of the SHA concepts and methods to the Irish health care system and associated expenditure data. The structures for this collaborative process are detailed in Section 3 below and the process for collecting and classifying the data is detailed in Appendix 6.

- It is acknowledged by all parties that clear communications around the classification of data is essential to ensuring the correct implementation of the SHA 2011 in the Irish context.

3. Working Structures

System of Health Accounts Liaison Group (SHALG)

The System of Health Accounts Liaison (SHALG) shall be the formal, high-level mechanism for consultation and communication between the CSO, HSE, DOH, and experts appointed by the SHALG. The Chair of the SHALG will be the Assistant Director General in the CSO. The Liaison Group shall appoint, as required, ad hoc working groups to investigate issues arising who shall report to the SHALG, see draft Terms of Reference for the SHALG in Appendix 2.

Health Accounts Technical Group (HATG)

The Chair of the Health Accounts Technical Group (HATG) will be the relevant Head of Division from the CSO. The Group will consist of a Statistician from the CSO, and the relevant resource from the relevant divisions within the HSE and the DOH. The HSE resources will include a representative from the Planning and Performance division. The DOH resources will include a representative from the Statistics & Analytics unit to lead the Departmental data compilation, processing and reporting. Administrative support will be supplied to the group by the CSO. Other

[3] SHA 2011 Manual, Revised 2017 edition

staff from the three organisations may be asked to attend meetings to provide expertise and technical advice from time to time.

The objective of the HATG is to maintain sustainable data compilation, processing and reporting systems on health care expenditure in line with SHA classifications for reference year N and to identify improvements and advise on their implementation, see draft Terms of Reference for the HATG in Appendix 3.

The members of the HATG will be appointed Officer of Statistics under Section 20 (b) of the Statistics Act, 1993 see Appendix 4.

Health Accounts Technical Sub Groups (HATSG)

For the purposes of providing best estimates of a service delivery area's expenditure in terms of the SHA, sub group comprised of the relevant resources from the HSE the DOH and the CSO will be set up as required. For example one sub group could examine long term care and it's spilt between social and health care expenditure. The DOH resources will include a representative from the Statistics & Analytics unit to lead the co-ordination of theSub group . These sub groups will work in a collaborative way to ensure that the expenditure data submitted by the HSE for SHA is a valid representation of that service delivery area expenditure for the given time period, see Terms of Reference for the Sub Groups in Appendix 5.

4. Co-operation between CSO and HSE and the Department of Health

(a) Data Exchange Schedule

The HSE and the DOH will provide the CSO with SHA data for year N (i.e. required reporting year) no later than T+13m, (i.e. no later than 13 months after year end). This exchange will be in accordance with the Data Exchange Schedule in Appendix 7, which has been designed to meet the legal reporting requirements of Regulation (EU) 2015/359.

Should the legal reporting requirements be amended by Eurostat, the CSO and/or the DOH will inform other parties to this MOU in writing of such changes in a timely manner. The affected data suppliers will endeavour to meet these legal reporting requirements.

(b) Data Revision Policy

All new requests for revisions of published data (i.e. those arising due to methodological changes rather than routine data updates) shall be raised within, or brought to the attention of, the HATG and/or the SHALG. This will include a detailed explanation of the rationale for the methodological change, such as a change in the standard, or the discovery of incorrect classification of data. The

objective of the group(s) is to ensure that the statistical data meets the international classification standards. All methodological changes will be explained in the metadata to Eurostat/OECD and Background notes in the national SHA publication. It is imperative that the statistical requirements are clearly explained to ensure that users and stakeholders are aware of differences that may arise with other say financial classifications/presentations. The CSO will therefore ensure that any changes which may be required in order to maintain statistical quality are clearly communicated. Previous years can be revised at any subsequent transmission and will also be explained in the metadata for Eurostat and Background notes of the National publication.

(c) Data Confidentiality

The CSO undertakes that all data received from the HSE and the DOH shall be treated as strictly confidential and shall be used for statistical purposes only, in accordance with national and EU statistical law, and also in conformity with the relevant data protection legislation. The CSO shall maintain the appropriate infrastructure to ensure the secure storage of data and controlled access to data. Non-CSO representatives on the SHALG and HATG will be Officers of Statistics under Section 20 of the Statistics Act for the duration of their participation on the Technical Group.

(d) Statistical Quality

As previously referenced, the SHA data are compiled according to international standardised statistical rules. The CSO will accompany all statistical data files with the relevant metadata to meet international reporting and other user requirements. The CSO SHA national publication will contain Background notes detailing statistical requirements and other relevant information, such as that described under Section 4(b) above.

As with all CSO statistical outputs, quality of data is paramount. The CSO will set out the SHA statistical quality requirements of the data to the HSE and the DOH. The CSO will work with the SHALG to ensure that these legal statistical requirements are met.

(e) Review

The MOU will be reviewed biennially by the DOH, the HSE and the CSO, but may be reviewed at any time at the request of any party. It will also be reviewed on the cessation of Regulation (EU) 2015/359. Any changes to the MOU shall be effected only with the mutual agreement of the DOH, the HSE and the CSO.

(f) Communication

The approval of this MOU and its content and procedures shall be communicated within the DOH, the CSO and the HSE; such communication shall include publication on the respective websites.

5 .Signatures

Signed:

Paul Reid	Robert Watt	
Paul Reid, **Chief Executive Officer** **Health Service Executive**	**Robert Watt** **Secretary General** **Department of Health**	**Pádraig Dalton** **Director General** **Central Statistics Office**
Date: 26/11/2021	**Date:** 16/12/2021	**Date:** 21/12/2021

Appendix 1

COMMISSION REGULATION (EU) 2015/359

of 4 March 2015

implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council as regards statistics on healthcare expenditure and financing

(Text with EEA relevance)

THE EUROPEAN COMMISSION,

Having regard to the Treaty on the Functioning of the European Union,

Having regard to Regulation (EC) No 1338/2008 of the European Parliament and of the Council of 16 December 2008 on Community statistics on public health and health and safety at work [1], and in particular Article 9(1) and Annex II, point (d), thereof,

Whereas:

(1)Regulation (EC) No 1338/2008 establishes a common framework for the systematic production of European statistics on public health and health and safety at work.

(2)Implementing measures determine the data and metadata to be supplied on healthcare expenditure and financing and the reference periods, intervals and time limits for the data provision.

(3)In accordance with Article 6(2) of Regulation (EC) No 1338/2008, a cost-benefit analysis, taking into account the benefits of the availability of data on healthcare expenditure and financing in relation to the cost of the data collections, which Member States have been conducting on a voluntary basis since 2005 according to the principles set out by the System of Health Accounts, and the burden on Member States, has been carried out. Pursuant to Article 6(1) of Regulation (EC) No 1338/2008, in 2013 and 2014, the Commission instituted pilot studies that were completed on a voluntary basis by the Member States. The Commission has discussed user needs with Member States at various meetings. The availability of EU-wide data is likely to be of great benefit for decisions relating to health and social policy.

(4)In order to ensure relevance and comparability of data, the System of Health Accounts 2011 manual [2], which was produced jointly by the Commission (Eurostat), the Organisation for Economic Cooperation and Development (OECD) and the World Health Organisation (WHO) and sets out the concepts, the definitions and the methods for data processing relating to healthcare expenditure and financing, should form the basis for the detailed questionnaire and the accompanying guidelines used in the joint annual data collection exercise carried out by these three bodies.

(5)The measures provided for in this Regulation are in accordance with the opinion of the European Statistical System Committee,

HAS ADOPTED THIS REGULATION:

Article 1

This Regulation lays down rules for the development and production of European statistics in the area of healthcare expenditure and financing, one of the subjects for statistics on healthcare listed in Annex II to Regulation (EC) No 1338/2008.

Article 2

The definitions to be used in applying this Regulation are set out in Annex I.

Article 3

Member States shall provide data on the areas specified in Annex II.

Article 4

1. Member States shall provide the required data and the associated standard reference metadata on an annual basis. The reference period shall be the calendar year.

2. Data and reference metadata for the reference year N shall be transmitted by 30 April N+2.

3. Data and reference metadata shall be provided to the Commission (Eurostat) using the single entry point services or should be made available for retrieval by the Commission (Eurostat) by electronic means on an annual basis.

4. The first reference year shall be 2014.

5. The last reference year shall be 2020.

6. By way of derogation from paragraph 2, Member States shall provide the data and reference metadata for the reference year 2014 by 31 May 2016.

Article 5

1. Member States shall provide data at the level of aggregation specified in Annex II.

2. Member States shall provide the necessary reference metadata, in particular concerning the data sources, their coverage and the compilation methods used, information on features of national healthcare expenditure and financing specific to the Member States that deviate from definitions provided in Annex I, references to national legislation where this forms the basis for healthcare expenditure and financing, as well as information on any changes to the statistical concepts mentioned hereto.

Article 6

This Regulation shall enter into force on the twentieth day following that of its publication in *the Official Journal of the European Union.*

This Regulation shall be binding in its entirety and directly applicable in all Member States.

Done at Brussels, 4 March 2015.

For the Commission

The President

Jean-Claude JUNCKER

(1) OJ L 354, 31.12.2008, p. 70.

(2) OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing, doi: 10.1787/9789264116016-en

ANNEX I

Definitions

1. 'Healthcare' means all activities with the primary purpose of improving, maintaining and preventing the deterioration of the health status of persons and mitigating the consequences of ill-health through the application of qualified health knowledge;
2. 'Current expenditure on healthcare' means the final consumption expenditure of resident units on healthcare goods and services, including the healthcare goods and services provided directly to individual persons as well as collective healthcare services;
3. 'Healthcare functions' relate to the type of need that current expenditure on healthcare aims to satisfy or the kind of objective pursued;
4. 'Curative care' means the healthcare services during which the principal intent is to relieve symptoms or to reduce the severity of an illness or injury, or to protect against its exacerbation or complication that could threaten life or normal function;
5. 'Rehabilitative care' means the services to stabilise, improve or restore impaired body functions and structures, compensate for the absence or loss of body functions and structures, improve activities and participation and prevent impairments, medical complications and risks;
6. 'Inpatient care' means the treatment and/or care provided in a healthcare facility to patients formally admitted and requiring an overnight stay;
7. 'Outpatient care' means the medical and ancillary services delivered in a healthcare facility to a patient who is not formally admitted and does not stay overnight;
8. 'Day care' means the planned medical and paramedical services delivered in a healthcare facility to patients who have been formally admitted for diagnosis, treatment or other types of healthcare and are discharged on the same day;
9. 'Long-term care (health)' means a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency;
10. 'Home-based care' means the medical, ancillary and nursing services that are consumed by patients at their home and involve the providers' physical presence;
11. 'Ancillary services' (non-specified by function) means the healthcare or long-term care related services non-specified by function and non-specified by mode of provision, which the patient consumes directly, in particular during an independent contact with the health system and that are not integral part of a care service package, such as laboratory or imaging services or patient transportation and emergency rescue;
12. 'Pharmaceuticals and other medical non-durable goods' (non-specified by function) means pharmaceutical products and non-durable medical goods intended for use in the diagnosis, cure, mitigation or treatment of disease, including prescribed medicines and over-the-counter drugs, where the function and mode of provision are not specified;
13. 'Therapeutic appliances and other medical goods' (non-specified by function) means medical durable goods including orthotic devices that support or correct deformities and/or abnormalities of the human body, orthopaedic appliances, prostheses or artificial extensions that replace a missing body part, and other prosthetic devices including implants which replace or supplement the functionality of a missing biological structure and medico-technical devices, where the function and the mode of provision are not specified;
14. 'Preventive care' means any measure that aims to avoid or reduce the number or the severity of injuries and diseases, their sequelae and complications;
15. 'Governance, and health system and financing administration' means services that focus on the health system rather than direct healthcare, direct and support health system functioning, and are considered to be collective, as they are not allocated to specific individuals but benefit all health system users;

16. 'Healthcare financing schemes' means types of financing arrangements through which people obtain health services, including both direct payments by households for services and goods and third-party financing arrangements;
17. 'Government schemes' means healthcare financing schemes whose characteristics are determined by law or by the government and where a separate budget is set for the programme and a government unit that has an overall responsibility for it;
18. 'Compulsory contributory health insurance scheme' means a financing arrangement to ensure access to healthcare for specific population groups through mandatory participation determined by law or by the government and eligibility based on the payment of health insurance contributions by or on behalf of the individuals concerned;
19. 'Compulsory medical savings accounts (MSA)' means savings accounts that are legally compulsory, whereby the basic method for fund-raising and some issues concerning the use of the account to pay for health services are regulated by government, and where there is no pooling across individuals, except for family members;
20. 'Voluntary health insurance schemes' means schemes based upon the purchase of a health insurance policy, which is not made compulsory by government and where insurance premiums may be directly or indirectly subsidised by the government;
21. 'Non-profit institutions financing schemes' means non-compulsory financing arrangements and programmes with non-contributory benefit entitlement that are based on donations from the general public, the government or corporations;
22. 'Enterprise financing schemes' means primarily arrangements where enterprises directly provide or finance health services for their employees without the involvement of an insurance-type scheme;
23. 'Household out-of-pocket payment' means a direct payment for healthcare goods and services from the household primary income or savings, where the payment is made by the user at the time of the purchase of goods or the use of the services;
24. 'Rest of the world financing schemes' means financial arrangements involving or managed by institutional units that are resident abroad, but who collect, pool resources and purchase healthcare goods and services on behalf of residents, without transiting their funds through a resident scheme;
25. 'Healthcare providers' means the organisations and actors that deliver healthcare goods and services as their primary activity, as well as those for which healthcare provision is only one among a number of activities;
26. 'Hospitals' means the licensed establishments that are primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialised accommodation services required by inpatients and which may also provide day care, outpatient and home healthcare services;
27. 'Residential long-term care facilities' means establishments that are primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents, where a significant part of the production process and the care provided is a mix of health and social services with the health services being largely at the level of nursing care in combination with personal care services;
28. 'Providers of ambulatory healthcare' means establishments that are primarily engaged in providing healthcare services directly to outpatients who do not require inpatient services, including both offices of general medical practitioners and medical specialists and establishments specialising in the treatment of day-cases and in the delivery of home care services;
29. 'Providers of ancillary services' means establishments that provide specific ancillary type of services directly to outpatients under the supervision of health professionals and not covered within the episode of treatment by hospitals, nursing care facilities, ambulatory care providers or other providers;
30. 'Retailers and other providers of medical goods' means establishments whose primary activity is the retail sale of medical goods to the general public for individual or household consumption or utilisation, including fitting and repair done in combination with sale;
31. 'Providers of preventive care' means organisations that primarily provide collective preventive programmes and campaigns/public health programmes for specific groups of individuals or the population-at-large, such as health promotion and protection agencies or public health institutes as well as specialised establishments providing primary preventive care as their principal activity;
32. 'Providers of healthcare system administration and financing' means establishments that are primarily engaged in the regulation of the activities of agencies that provide healthcare and in the overall administration of the healthcare sector, including the administration of health financing;
33. 'Rest of the economy' means other resident healthcare providers not elsewhere classified, including households as providers of personal home health services to family members, in cases where they correspond to social

transfer payments granted for this purpose as well as all other industries that offer healthcare as a secondary activity;

34. 'Rest of the world providers' means all non-resident units providing healthcare goods and services as well as those involved in health-related activities.

ANNEX II

Subjects to be covered and their characteristics, cross-classification data and breakdowns

1. Cross-classification current expenditure on healthcare by healthcare functions (HC) and financing schemes (HF) (1)

	Financing schemes	HF.1.1	HF.1.2; HF.1.3	HF.2.1	HF.2.2	HF2.3	HF.3	HF.4	
Healthcare functions		**Government schemes**	**Compulsory contributory health insurance schemes and Compulsory medical saving accounts (2)**	**Voluntary health insurance schemes**	**Non-profit institutions financing schemes**	**Enterprises financing schemes**	**Household out-of-pocket payment**	**Rest of the world financing schemes**	**Current expenditure on healthcare** **HF.1-HF.4**
HC.1.1; HC.2.1	Inpatient curative and rehabilitative care								
HC.1.2; HC.2.2	Day curative and rehabilitative care								
HC.1.3; HC.2.3	Outpatient curative and rehabilitative care								
HC.1.4; HC.2.4	Home-based curative and rehabilitative care								
HC.3.1	Inpatient long-term care (health)								
HC.3.2	Day long-term care (health)								
HC.3.3	Outpatient long-term care (health)								
HC.3.4	Home-based long-term care (health)								
HC.4	Ancillary services (non-specified by function)								
HC.5.1	Pharmaceuticals and other medical non-durable goods (non-specified by function)								
HC.5.2	Therapeutic appliances and other medical goods (non-specified by function)								
HC.6	Preventive care (3)								
HC.7	Governance and health system and financing administration								
HC.9	Other healthcare services not elsewhere classified (n.e.c.)								
	Current expenditure on healthcare HC.1-HC.9								

2. Cross-classification current expenditure on healthcare by healthcare functions (HC) and healthcare providers (HP) (4)

	Healthcare providers	HP.1	HP.2	HP.3	HP.4	HP.5	HP.6	HP.7	HP.8	HP.9	
Healthcare functions		**Hospitals**	**Residential long-term care facilities**	**Providers of ambulatory healthcare**	**Providers of ancillary services**	**Retailers and other providers of medical goods**	**Providers of preventive care**	**Providers of healthcare system administration and financing**	**Rest of the economy**	**Rest of the world**	**Current expenditure on healthcare HP.1-HP.9**
HC.1.1; HC.2.1	Inpatient curative and rehabilitative care										
HC.1.2; HC.2.2	Day cases of curative and rehabilitative care										
HC.1.3; HC.2.3	Outpatient curative and rehabilitative care										
HC.1.4; HC.2.4	Home-based curative and rehabilitative care										
HC.3.1	Inpatient long-term care (health)										
HC.3.2	Day long-term care (health)										
HC.3.3	Outpatient long-term care (health)										
HC.3.4	Home-based long-term care (health)										
HC.4	Ancillary services (non-specified by function)										
HC.5.1	Pharmaceuticals and other medical non-durable goods (non-specified by function)										
HC.5.2	Therapeutic appliances and other medical goods (non-specified by function)										
HC.6	Preventive care (5)										
HC.7	Governance and health system and financing administration										
HC.9	Other healthcare services not elsewhere classified (n.e.c.)										
	Current expenditure on healthcare HC.1-HC.9										

3. Cross-classification current expenditure on healthcare by healthcare providers (HP) and financing schemes (HF) (6)

	Financing schemes	**HF.1.1**	**HF.1.2; HF.1.3**	**HF.2.1**	**HF.2.2**	**HF.2.3**	**HF.3**	**HF.4**	
Healthcare providers		**Government schemes**	**Compulsory contributory health insurance schemes and Compulsory medical saving accounts** (7)	**Voluntary health insurance schemes**	**Non-profit institutions financing schemes**	**Enterprises financing schemes**	**Household out-of-pocket payment**	**Rest of the world financing schemes (non-resident)**	**Current expenditure on healthcare** **HF.1-HF.4**
HP.1	Hospitals								
HP.2	Residential long-term care facilities								
HP.3	Providers of ambulatory healthcare								
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 healthcare system administration and financing								
HP.8	Rest of the economy								
HP.9	Rest of the world								
	Current expenditure on healthcare HP.1-HP.9								

(1) Data shall be transmitted in millions of national currency.

(2) Expenditure on HF.1.3 shall be reported in the metadata.

(3) Preventive care is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. Interventions are included when their primary purpose is health promotion and if they occur before the diagnosis has been made. Preventive care includes interventions for both individual and collective consumption.

(4) Data shall be transmitted in millions of national currency

(5) Preventive care is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. Interventions are included when their primary purpose is health promotion and if they occur before the diagnosis has been made. Preventive care includes interventions for both individual and collective consumption.

(6) Data shall be transmitted in millions of national currency.

(7) Expenditure on HF.1.3 shall be reported in the metadata.

Appendix 2

Terms of Reference forthe System of Health Accounts Liaison Group (SHALG)

Objective of SHALG

The objective of the SHALG is to oversee and support the production of the System of Health Accounts (SHA) for Ireland. It is envisaged that the SHALG will meet as required but not less than once a year. The SHALG provides a formal quality assurance mechanism in relation to Ireland's SHA statistics.

Responsibilities of SHALG

In order to meet this objective the SHALG will:

- Meet once a year, and more if required;
- The CSO will update on any revisions or changes in classification of data;
- Advise on strategies for accessing and using existing data systems appropriately in order to provide statistical data;
- Advise on developments required for health information systems;
- Contribute their expertise and experience relating to the healthcare system in Ireland;
- Facilitate access to appropriate personnel and data sources in their respective agencies as appropriate;
- Contribute to quality assurance of project outputs;
- Raise awareness of and promote use of SHA concepts in healthcare information systems having regard to the general information requirements of the HSE; and
- Communicate the importance and relevance of the SHA to the Irish healthcare sector within their own organisations and across the health care sector in general;
- Will discuss developments arising from EU Commission / OECD and WHO.

Composition of the SHALG

The SHALG shall be the formal, high-level mechanism for consultation and communication between the CSO, HSE, DOH, and experts appointed by the SHALG. The Liaison Group shall appoint, as required, ad hoc working groups to investigate issues arising; such working groups shall report to the SHALG. Administrative support will be supplied to the group by the CSO.

Chair of the SHALG

The Chair of the SHALG will be the relevant Assistant Director General from the CSO.

Working Procedures

The Chair of the SHALG has the authority to convene meetings either at his/her initiative or in response to requests from the chairperson of the Health Accounts Technical Group (HATG).

Appendix 3

Terms of Reference for Health Accounts Technical Group (HATG)

Objective of Health Accounts Technical Group (HATG)

The objective of the HATG is to maintain sustainable annual data compilation, processing and reporting systems on health care expenditure in line with SHAclassifications for reference year N and to identify improvements and advise on their implementation.

Responsibilities of HATG

In order to meet this objective the HATG will:

- Meet as required but not less than 2 times a year;
- Ensure access, where available, to required data sources with the support of the members of the System of Health Accounts Liaison Group (SHALG);
- Ensure adherence to statistical reporting and data protection requirements in the data collection and compilation process;
- Be aware of and review potential new data sources;
- Improve the data quality;
- Work to increase the granularity of the data;
- Ensure that any changes to the Irish health care system are reflected in the reported data;
- Review and respond to requests for clarification or metadata arising from user queries, including the verification processes of the international organisations collecting SHA data;
- Be aware of recommendations arising from the work of the Bilateral Health Accounts Technical Groups (BHATG);

Composition of the HATG

The Group will consist of a Statistician from the CSO, and the relevant resource from the relevant divisions within the HSE and DOH. The DOH resources will include a representative from the Statistics & Analytics unit to lead the Departmental data compilation, processing and reporting. Administrative support will be supplied to the group by the CSO. Other staff from the three organisations may be asked to attend meetings to provide expertise and technical advice from time to time.

Chair of the HATG

The Chair of the Health Accounts Technical Group (HATG) will be the relevant Head of Division from the CSO.

Working Procedures The Chair of the HATG has the authority to convene meetings either at his/her initiative or in response to requests from the SHALG.

Appendix 4

Statistics Act, 1993 – Sections 20 and 11

Officer of Statistics

20.—Each of the following persons—

(*a*) every member of the staff of the Office and any other person directly engaged by the Office in the collection or extraction of information under this Act,

(*b*) every other person who, consequent on arrangements made under *subsection (1)* of *section 11* of this Act, is for the time being engaged in and about the collection, extraction, compilation or dissemination of information under this Act, and

(*c*) any other person authorised in writing by the Director General to perform for a specified period particular statistical analysis which may necessitate access to data collected under this Act, shall, for the purposes of this Act, be and is in this Act referred to as an officer of statistics.

Co-operation and liaison with other public authorities and persons

11.- (1) The Office may make arrangements with other public authorities and persons for the collection, compilation, extraction or dissemination of information for statistical purposes.

(2) The Office shall maintain close and regular contact with the principal users and suppliers of statistics.

Appendix 5

Health Accounts Technical Sub Groups

Objective of each HATSG

A Health Account Technical Sub Group (HATSG) will be set up as required if a specific area of the health accounts needs further review. Each of the main service delivery areas of the HSE will be represented by an individual Sub Group. The objective of each Sub Group is to review expenditure data submitted by the HSE for SHA purposes to ensure that the data is a valid representation of that service delivery area's expenditure for a given time period.

Responsibilities of each Sub Group

In order to meet this objective each Sub Group will:

- Meet as necessary to deal with relevant SHA matters specific to that service delivery area as they arise;
- Advise on the representativeness of data submitted by the HSE to the CSO for SHA purposes for that service delivery area;
- Make recommendations to the Health Accounts Technical Group on methodological issues arising which are relevant to SHA data for that service delivery area.

Composition of each Sub Group

Each Sub Group shall have a representative from the relevant service delivery area from the HSE and the DOH and the CSO. The DOH resources will include a representative from the Statistics & Analytics unit to lead the co-ordination of the Sub Group. In addition, at least one representative from the Health Accounts Technical Group from each of the HSE and the DOH shall be members of each Sub Group. Administrative support for each Sub Group will be supplied by the DOH.

Chair of the Sub Group

The CSO will chair each of the sub-groups.

Working Procedures

The Chair of the Sub Group has the authority to convene meetings either at his/her initiative or in response to requests from either the chair of the Health Accounts Technical Group (HATG) or the chair of the System of Health Accounts Liaison Group (SHALG).

Appendix 6

Working Procedures around the SHA Data Collection

Process for the collection, classification and processing of administrative data (HSE and DoH data) supplied for the purposes of meeting (a) legal requirements under Regulation (EU) 2015/359 and (b) national requirements identified by the DoH and the HSE.

Data review process - routine data collection

1. Initial data set agreed and supplied.
2. Quality checking of data by the CSO, to comprise
   a. Checking of coding formats and combination of codes;
   b. Checking of data coding against metadata supplied;
   c. Review of coding of services and providers against SHA manual and guidance notes issued by international organisations (OECD, Eurostat, WHO);
   d. Cross checking of data coding against other data sources being analysed by the CSO.
3. The CSO will revert to the HSE/DOH with queries and engage with the HSE/DOH on reasons for coding decisions. All parties will engage with process to map HSE services/providers to the international classification as laid out in the manual and international guidance.
4. International Organisations (OECD, WHO, Eurostat via International Health Accounts Technical Group (IHAT)) will be consulted where guidance on interpretation of manual is required.

Methodological developments

1. The CSO and the DOH who attend meetings covering SHA at the OECD and Eurostat will inform HSE of possible quality or methodological issues raised in these fora. The agenda and relevant documentation for these meetings will be circulated to all parties to this MOU to allow for input at these meetings from all parties. The HSE may attend any meeting where it is felt appropriate.
2. An appropriate timescale for implementation of any changes arising as a result of discussions at these meetings will be agreed among all parties affected.
3. The CSO and/or the DOH will inform the HSE/DOH in writing of any changes to the data collection effected by EU or other legislation.
4. The CSO, HSE and DOH will utilise opportunities to verify and improve the quality of the data; for example, provide detailed metadata, complete quality questionnaires provided by OECD and Eurostat.

Classification decisions

1. The CSO will confirm classification in consultation with the data provider through:
   a. documented evidence of national situation;
   b. review of SHA standard;
   c. advice of international bodies where required.
2. Any required change to coding of HSE/DOH data arising from this process will be notified to and discussed with the data provider at the SHA Liaison group in advance of publication along with an explanation of the reasons for doing so.
3. The basis for classification decisions will be clearly explained in all outputs.

Appendix 7

Data Exchange Schedule

Exchange of data	Data Name	For which transmission	Format	Transmission method	Deadline	Years
HSE to CSO	Data in relation to HSE health expenditure for reference year 2015 and each year subsequently	Eurostat health care expenditure and financing transmission as detailed in implementing Regulation (EC) No 1338/2008 of the European Parliament (see Appendix 1) on 31st April each year.	Excel	E-mail	T+13m from reference year end. e,g. for 2016 data this would be end Jan 2018.	Reference year 2015 and each year subsequently
DOH to CSO	Data in relation to Department of Health expenditure for reference year 2015 and each year subsequently	Eurostat health care expenditure and financing transmission as detailed in implementing Regulation (EC) No 1338/2008 of the European Parliament (see Appendix 1) on 31st April each year.	Excel	E-mail	T+13m from reference year end. e,g. for 2016 data this would be end Jan 2018.	Reference year 2015 and each year subsequently