ACCOUNTING AND MAPPING OF LONG-TERM CARE EXPENDITURE UNDER SHA 2011

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Purpose of the Guidelines

1. This document provides additional advice on how to account for long-term care expenditure under SHA 2011 and is intended to serve as guidance to health accounts experts for the reporting of long-term care under the JHAQ data collection. The SHA 2011 manual is clear about which activities of long-term care need to be distinguished but less clear when it comes to defining the different groups of beneficiaries for which these services are provided. This document is an update of the guidelines published in December 2012. It is hoped that the document will further limit differing interpretations and contribute to a more comparable data collection in the area of long-term care expenditure. Please note that the recommendations given in this document deviate in some few instances from the SHA 2011 manual to make accounting more consistent.

Long-term care activities in SHA 2011

2. **Total long-term care (HC.3+HCR.1)** consists of a range of medical/nursing care services, personal care services and assistance services that are consumed with the primary goal of alleviating pain and suffering or reducing or managing the deterioration in health status in patients with a degree of long-term dependency.

3. In general, **long-term care (health) (HC.3)** is composed of

- Medical or nursing care (e.g. wound dressing, administering medication, health counselling, palliative care, pain relief and medical diagnosis with relation to a long-term care condition). This can include preventive activities to avoid deterioration in long-term health conditions or rehabilitative activities to improve functionality (e.g., physical exercise to improve the sense of balance and avoid falls); and
- Personal care services which provide help with activities of daily living (ADL) such as eating (support with food intake), bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence.

4. **Long-term care (social) (HCR.1)** consists of

- Assistance services that enable a person to live independently. They relate to help with instrumental activities of daily living (IADL) such as shopping, laundry, cooking, performing housework, managing finances and using the telephone.

5. There are also a number of expenditure items around medical/nursing care, personal care and assistance services that should be considered under HC.3 and HCR.1 respectively. The most common ones are listed in Table 2 at the end of this document.

6. However, the nature of the activity alone is not sufficient to be considered as long-term care! Additionally, for an activity to be classified as long-term care (HC.3+HCR.1) in SHA 2011 the following three properties must hold:

- the service must be aimed at **dependent people** such as the elderly or physically or mentally disabled people suffering from chronic conditions with functional or

cognitive limitations **over an extended period of time**; dependent people require long-term care (LTC) services on a continued and recurrent basis;

- the service must be **related to the LTC dependency status** (medical treatment of a common cold will most likely not be related to LTC dependency and would be classified as curative care);
- there exists a **transaction**, this means that LTC provision without financial remuneration of the care giver (own-account household production) is excluded. However, care allowances to beneficiaries or care givers are included as these payments are taken as a proxy for a paid transaction.

Conditions and limitations that result in LTC dependency

7. For an activity to be classified under LTC it must be aimed at a **dependent person** (but not all services to dependent persons have to be classified as LTC!). SHA 2011 (A System of Health Accounts 2011, p.90)[1] defines dependency as an impairment, activity limitation and/or participation restriction on a continued or recurrent basis over an extended period of time. Dependency can be due to a chronic physical, psychiatric, or cognitive condition such as functional and physical disability, behavioural and mental health (including other neurological disorders and substance abuse issues).

8. The generic definition of dependency as "impairment, activity limitation and/or participation restriction" requires further elaboration as it has proven to be too vague leaving too much room for interpretation. This has affected international comparability of long-term care expenditure figures. For the purpose of future data collections it is suggested to define the dependent population as those people that require help with ADL services. Consequently, this means that persons

- requiring medical/nursing care (but no help with ADL) **are not LTC dependent**. Hence, for this group of people, wound dressing, administering medication and other medical/nursing care activities would be classified as curative or rehabilitative (HC.1/HC.2) but not as long-term care (health) (HC.3);
- requiring help with IADL services (but no help with ADL) **are not LTC dependent**. Hence, for this groups of people, help with shopping, laundry and housework would not be considered as long-term care services (neither as HC.3 nor as HCR.1);
- requiring help both with ADL and IADL services **are LTC dependent**. Hence, the services they receive, i.e. medical/nursing care (if related to dependency) and help with ADL and IADL, should be recorded as long-term care services;
- requiring help with ADL services (but no help with IADL)[2] **are LTC dependent.** Hence, the services they receive, i.e. medical/nursing care (if related to dependency) and help with ADL, should be recorded as long-term care services.

9. Table 1 gives an overview about the accounting consequences of whether a person is considered as LTC dependent or not.

[1] OECD, Eurostat and WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264270985-en

[2] This case will be quite rare as the vast majority of patients requiring help with ADL will also require help with IADL.

Table 1. Activity - Dependency matrix

activity/cost	Dependency status; patient requires.....		no ADL or IADL help	help with IADL only	help with ADL and IADL	help with ADL only*
	Medical/nursing care	Administering medication	HC1	HC1	HC1/HC3[a]	HC1/HC3[a]
	Medical/nursing care	Performing medical diagnosis	HC1	HC1	HC1/HC3[a]	HC1/HC3[a]
	Medical/nursing care	Dressing wounds	HC1	HC1	HC1/HC3[a]	HC1/HC3[a]
	Medical/nursing care	Health counselling	HC1	HC1	HC1/HC3[a]	HC1/HC3[a]
	ADL	Help with eating	n.a	n.a.	HC3	HC3
	ADL	Help with washing	n.a	n.a.	HC3	HC3
	ADL	Help with mobility	n.a	n.a.	HC3	HC3
	ADL	Help with managing incontinence	n.a	n.a.	HC3	HC3
	IADL	Help with shopping	n.a		HCR1	n.a
	IADL	Help with housework	n.a		HCR1	n.a
	IADL	Meals on wheels	n.a		HCR1	n.a
	Community day care activities	singing, playing etc.			HCR1	HCR1
	Community day care activities	physical exercise			HCR1	HCR1
	Community day care activities	day trips (zoo)			HCR1	HCR1
	Expenditure for accommodation	Residential LTC facility	n.a.		HC3	HC3
	Expenditure for accommodation	Assisted LF with caretaker on-site	n.a		HCR1	HCR1
	Expenditure for accommodation	Assisted LF with caretaker not on-site	n.a		[b]	[b]
	other	Special schooling	n.a	n.a.		
	other	Sheltered employment	n.a	n.a.		

n.a. patients in category do not require these services outside SHA

* this will be a rare case as the vast majority of patients requiring help with ADL will also require help with IADL

[a] included under HC3 if service is related to LTC condition, under HC1 otherwise

[b] in that case Assisted LF is considered the home of the patient.

LTC dependent population groups

10. Based on this definition of dependency the following list contains the *main* population groups that could be *potentially* considered as LTC dependents:

- Elderly with physical and/or mental impairment
- Patients with dementia and/or Alzheimer's disease (typically elderly)
- Physically handicapped adults
- Mentally handicapped adults
- Physically handicapped children
- Mentally handicapped children
- Substance abuse patients
- Mental health patients
- Terminally ill patients
- Patients with other chronic conditions

11. For all these potential beneficiaries, the requirement for help with ADL as a criterion for dependency still holds. Thus, some patients among the above mentioned patient groups may not require any LTC services at all. For example, many chronic diabetes type 2 patients should not be considered as LTC dependent as they typically do not require help with ADL. Hence, medical care provided to them (e.g. regular check-

ups) should be considered as HC.1 rather than HC.3 (although the services will not be "curative" in a stricter sense). In the case that an elderly and frail diabetic patient needs help with insulin injections this could, however, be considered as HC.3 as the limitation to inject insulin himself will be due to a functional limitation. The situation can be similar with patients with HIV. In many countries, people with HIV infection who have access to treatment options can lead a fairly normal life if they comply with their medication plan. Their only health interventions consist of a daily intake of various pharmaceuticals and occasional routine examinations by their doctors. Although HIV infection is a chronic condition which can eventually see deterioration in the functional ability of the individual, the patients described above can hardly be regarded as LTC dependent. Their medical consultations should therefore rather be classified as HC.1 than HC.3. Yet, patients with advanced AIDS may experience increased dependency such that the medical and nursing care service as well as personal care services (and possibly palliative care) should be classified as HC.3.

Duration of services

12. A second important condition for a service to be classified as LTC is that the service is required on a continued or recurrent basis for an extended period of time. This means that all services provided for people who are dependent for only a temporary period of time, for example for a patient who has broken both arms in an accident and requires help with ADL and IADL for 2 months, should not be considered as HC.3 but as HC.1. The same is true for a number of substance abuse patients that are institutionalised in a rehabilitation centre for 4-6 weeks but discharged after detoxication. Here, too, the services should be considered rather HC.1/HC.2 than HC.3. As a rule of thumb it is suggested to consider patients as LTC dependent when their impairment is expected to last at least 6 month or for their rest of their lives without expectation of a full recovery (some terminally ill patients requiring care may have less than 6 month to live).

How to distinguish LTC from other activities

When should medical/nursing care services for LTC dependent people be considered as HC.3?

13. Medical and nursing care services should only be considered as HC.3 when the treatment is related to the LTC dependency. This refers for example to palliative treatment (e.g. pain relief) for terminally ill patients or medical examinations of patients diagnosed with dementia. This should also include, for example, daily insulin-injections for older and frail diabetes type 2 patients (the reasoning being that the patients are no longer able to perform the injections themselves due to a severe activity limitation).

14. Many medical and nursing care interventions, however, are unrelated to the LTC condition. This is true for all sorts of injuries and accidents but also for unrelated medical conditions, for example, in case a LTC patient in a residential inpatient facility is transferred to a hospital due to pneumonia or stroke. In these cases the hospital treatment should be considered as HC.1 as treatment aim will be to cure the disease or restore full physical functionality of all parts of the body. It is accepted that the distinction of whether medical treatment is related to LTC dependency or not is sometimes difficult to establish in practice. This is true in particular for care services provided by GPs and geriatricians.

When should preventive or rehabilitative activities be considered as HC.3?

15. SHA 2011 states (A System of Health Accounts 2011, p. 91) that the medical/nursing care component of HC.3 may also include a range of preventive activities to avoid a deterioration of the health condition and rehabilitative activities to recover or maintain functionality and retard impairment. If these preventive or rehabilitative activities are targeted at the LTC condition they should be considered as HC.3 (e.g. physical exercise to improve mobility), if not they should be considered as HC.6 and HC.2 (for example, an influenza vaccination for people over 65 should be considered as HC.6). It is recognised that in an inpatient LTC setting, preventive and rehabilitative services may be frequently provided in a package together with ADL and IADL services.

How to treat activities of supervision and oversight for people with dementia/Alzheimer's disease?

16. A number of potential LTC cases do not require physical help with ADL activities but do need to be supervised, supported or assisted when performing these activities on their own. This is for example true for patients with dementia or other severe mental disorders (including Alzheimer's). In general, these patients can be characterised by loss of everyday cognitive competence requiring constant support and supervision because they lack orientation or are at risk of encountering or experiencing psychologically distressful events and potentially dangerous situations (e.g. wandering off or forgetting to switch off household appliances). They should therefore be considered as LTC dependent. For SHA purposes it is recommended that physical help in performing ADL and general supervision of people with dementia and Alzheimer's disease for everyday activities are considered under HC.3. Help with IADL and activities more focused on the social integration of patients (e.g., activities in organised day care groups such as singing, reading or playing games) should be recorded under HCR.1. It is again recognised that in practice splitting the different activities may be difficult and activities may need to be allocated based on the dominant character.

What type of day care should be considered under long-term care?

17. Day care activities as well as day care settings can look different for the various LTC dependent populations. For the elderly and physically impaired, day care activities can have an important ADL component and should hence be classified as HC.3.2. This may refer to ADL activities such as washing and feeding for LTC dependents that live in their family homes but are treated in day care facilities throughout the day to allow family members to pursue a professional career.

18. Frequently, these services will be provided in day-time wards of LTC nursing homes. Some day care activities, for example, for people with dementia, focus more on social integration and can include singing, reading and playing in a day care facility. These activities should be considered as HCR.1. Day care facilities for the mentally and physically handicapped providing special schooling or targeted at professional integration (e.g. sheltered work places) are considered outside of the scope of SHA -unless they provide ADL or nursing care services. This is also true for the activities of social integration (e.g. bingo nights) for the elderly without LTC dependency.

Location of services provided

19. The nature of the LTC services as well as the location where these services are provided will differ between the different patient groups. This is also true for the intensity of care and the composition of LTC; care for the elderly with physical impairment is typically more nursing care and ADL-intense than for paraplegic young adults who might require only limited help will ADL and IADL.

Types of institutions for care for the elderly

20. There are different types of care institutions for the elderly which correspond to different needs associated with the severity to the LTC condition. In most countries, LTC will first be provided at the homes of the patients. If independent living in the home environment is no longer possible, LTC dependents may move into assisted living facilities where the level of ADL services provided will be incidental. If the health status continues to deteriorate, LTC patients may be treated in institutions with permanent nursing staff providing predominantly nursing care or ADL services such as LTC nursing homes or geriatric wards in hospitals.

Residential LTC facilities (HP.2)

21. Characteristics: Permanent nursing or LTC staff (or even medical staff) available around the clock. LTC dependents are in a single room or sharing a room with other LTC dependents. Provision of nursing care or help with ADL is the dominant activity in these settings. Hence, all or at least the majority of residents in this type of facility are typically LTC dependent. Some of these facilities may also have day care wards offering LTC day care.

22. Accounting recommendation: All expenditure (including help with IADL and room and board) should be considered as HC.3.1. Any costs for non-LTC dependents that may also live in the facilities should not be included. Costs associated with the delivery of day care services in day care wards should be accounted for as HC.3.2.

Assisted living facilities (HP.8.2)

23. Characteristics: Nursing or LTC staff available on-site or on-call. Help with IADL available on-site. People in assisted living facilities may have their own room or own apartment and are able to live a fairly independent life. The composition of people living in assisted living facilities may be diverse; some may require help with ADL (LTC dependent) others may only require help with IADL or no help at all (not LTC dependent).

24. Accounting recommendation: Expenditure for LTC dependents should be split between ADL and IADL. Help with ADL should be considered as HC.3.1, help with IADL as HCR.1. Expenditure on accommodation should be included in HCR.1. Expenditure for non-LTC dependents is outside of the scope of SHA and should be excluded.

Homes for the elderly or social care (ex-HP.8.9)

25. Please note that as a consequence of the proposed precision in the definition of LTC dependents (people requiring help with ADL), facilities that provide exclusively help with IADL (directed at people requiring only help with IADL – non-LTC dependents) would no longer be considered as part of the SHA universe! This is a

departure from the stipulations in the SHA 2011 manual. For countries currently reporting HCR.1 under HP.8.9 this would mean either a shift of activities to HP.8.2 or an exclusion of these activities from SHA based on the question whether the people receiving these services are LTC dependent or not.

26. If LTC dependent people live in any other facility than LTC facilities (HP.2) or assisted living facilities (HP.8.2) without any nursing care services on-site or on-call then these facilities should be considered as the home of the patient and accounted for accordingly (e.g. ADL as HC.3.4 provided by, for example HP.3.5; costs for accommodation should not be included in LTC expenditure). The provision of IADL services for people requiring help with IADL only should be outside of the scope of SHA.

27. In all residential LTC facilities (HP.2) and assisted living facilities (HP.8.2), costs for accommodation should only be considered for LTC dependent persons (requiring help with ADL and IADL) and not for persons who require milder levels of care or no care at all and live in these facilities for other reasons, such as to avoid social isolation. For facilities characterised as HP.2, accommodation costs would be recorded under HC.3.1, for facilities characterised as HP.8.2, accommodation costs would be recorded under HCR.1.

LTC for mental health and substance abuse patients

28. There is also a huge variety in mental health disorders and intellectual disabilities affecting different age groups. They stretch across dementia and Alzheimer's, schizophrenia, mood disorders such as depression, eating disorders as well as mental and behavioural disorder due to substance abuse such as alcohol and drugs as well as to forms of mental retardation and disorders of the psychological development such as autism. Some genetic disorders such as Down's syndrome could also be subsumed under this category. Depending on the nature of the condition, patients with mental disorders or intellectual disabilities can receive a wide range of health care and social care services including curative care (HC.1), rehabilitative care (HC.2), LTC (health) (HC.3), LTC (social) (HCR.1) as well as social services outside of the scope of SHA.

29. It is important to reiterate that for care directed at mental health and substance-abuse patients to be considered as LTC services, patients need to be considered as LTC dependent (i.e. they require help with ADL including supervision) for an extended period of time.

30. While this may be the case for patients with dementia, Alzheimer's, severe depression and mental retardation, patients with mild to moderate depression, eating disorders or mild forms of autism will rarely require help with ADL. In many cases of substance abuse, patient care episodes will be limited to several weeks in a 'rehab clinic' for detoxication with recommended follow-up visits to GPs or specialists and counselling from self-help groups or other organisations after discharge. This treatment path should not be considered as LTC although there may be help with ADL provided for a limited amount of time in early treatment. However, for severe cases of substance abuse with intensive treatment lasting for a longer time period, a classification as LTC dependent may be appropriate. This also depends on country-specific treatment guidelines for these conditions.

31. LTC dependent mental health and substance abuse patients may be treated in a variety of settings. For inpatient care they may be treated in the same long-term care facilities as other LTC dependents (such as the elderly). This would most likely be the

case for dementia patients. Other mental health and substance abuse LTC dependent patients may be living in dedicated long-term care facilities (HP.2.2). The costs for room and board should be included in LTC expenditure in these cases. Please note that mental health and substance abuse facilities (HP.2.2) can also provide care to patients that cannot be considered as LTC dependent, classified as curative (HC.1) or rehabilitative (HC.2). Like other LTC dependents, mental health and substance abuse patients may also live in assisted living facilities (HP.8.2). But as in the case of elderly LTC dependents nursing or LTC staff would need to be available on-site for facilities to be classified as HP.8.2. Group homes with exclusively social counselling should be outside the SHA framework as its residents could not be considered as LTC dependent.

Specific Accounting issues

Accounting for LTC in SHA follows a functional approach

32. Conforming to the functional approach set out in SHA 2011, the classification of a service or good into the category of long-term care is irrespective of:

- the provider (among others, LTC services can be provided by hospitals, nursing homes, doctors' offices, households and other types of provider where the provision of LTC is a secondary activity);
- countries' labelling of the financing schemes (LTC services could be financed by central or local government, voluntary private health insurance, accident insurance schemes, social welfare programmes, etc…);
- the qualification of the caregiver. SHA 2011 acknowledges on page 56 that qualified medical or health care knowledge and skills are needed for health care activities to be included in the SHA-boundary or that these services are provided under supervision. In the area of long-term care the latter includes informal care services provided by family members (in case of care allowances) on the assumption that they have some basic introductory training and occasional visits by qualified care professionals to ensure the services are provided appropriately. Hence, depending on the LTC arrangements existing in countries, different LTC services could be provided by doctors, nurses, care givers or even family members.

Accounting for LTC services when provided in a package

33. Services of LTC (health or social) are frequently provided in a package. In general, an effort should be made to analyse all components of a LTC service package. If personal care services (ADL) and assistance services (IADL) are provided together (in a home care setting) but can be identified separately, they should be accounted for as follows:

- Personal care services ➔ HC.3
- Assistance services ➔ HCR.1

34. If they cannot be identified separately they should be accounted for based on the dominant character of the service package:

- If personal care services are dominating the service, the package should be accounted for as HC.3;

- If assistance services are dominating, the whole package should be accounted for as HCR.1.

In the absence of hard data, the amount of time spent on the provision on each of the service components might be a good indictor to evaluate the dominant character of a package.

35. In the case of inpatient settings, the total LTC package (nursing care, ADL and IADL) should be allocated to HC.3 in case that nursing care and ADL are the dominant activity in the package even if assistance services could be separately identified. In case IADL is the dominant activity within the package, the nursing care and ADL component should be separately accounted for as HC.3, if possible. If a separation is not possible, the whole package should be accounted for as HCR.1.

Recommended long-term care accounting

Table 2 provides some examples of services from the LTC orbit together with the recommended accounting practice. This aims to complement the paragraphs on LTC in SHA 2011.

Table 2. Classification of typical LTC activities

Nature of the service	HC	Reasoning
Medical treatment, examinations and diagnosis (typically done by doctors) related to the underlying condition of the patient causing dependency with LTC services in hospitals/nursing homes/hospices/out-patient practices/arranged living facilities/homes of the patients.	HC.3	These services should be part of LTC (health) as they are related to the condition causing the dependency.
Medical treatment, examinations and diagnosis (typically done by doctors) for another disease or condition unrelated to the condition of the patient causing dependency with LTC services in hospitals/nursing homes/out-patient practices/arranged living facilities/homes of the patient.	HC.1 or HC.2	These services do not pertain to the LTC dependency of the patient and should be accounted for separately as curative or rehabilitative care.
Nursing care (wound dressing, monitoring of medication, giving injections etc.) typically provided by qualified nurses related to or as a consequence of the condition of the patient causing dependency with LTC services in hospitals/nursing homes/hospices/out-patient practices/arranged living facilities/homes of the patients.	HC.3	These services should be part of LTC (health) as they are related to the condition causing the dependency.
Nursing care (wound dressing, monitoring of medication, giving injections etc.) typically provided by qualified nurses for another disease unrelated to the condition of the patient causing dependency with LTC services in hospitals/ nursing homes/ hospices/ out-patient practices/ arranged living facilities/ homes of the patients.	HC.1 or HC.2	These services do not pertain to the LTC-dependency of the patient and should be accounted for separately as curative or rehabilitative (e.g. could be related to a surgical procedure).
Personal care services (washing, bathing, helping out of bed etc.) that provide help with activities of daily living (ADL) by qualified nurses and relate to the condition of the patient causing dependency in hospitals/nursing homes/hospices/out-patient practices/arranged living facilities/homes of the patients.	HC.3	These services should be part of LTC (health) as they are related to the condition causing the dependency.
Personal care services (washing, bathing, helping out of bed etc.) that provide help with activities of daily living (ADL) by lesser-qualified caregivers (e.g. family members) and relate to the condition of the patient causing dependency in the home of the patient, under the condition they receive some kind of payment or allowance.	HC.3.4	These services should be part of LTC (health) as they are related to the condition causing the dependency. The nursing allowance is treated as a proxy for the payment of the service, though it might be well below the typical country-specific wage for nurses.
Personal care services (washing, bathing, helping out of bed etc.) that provide help with activities of daily living (ADL) by lesser-qualified caregivers (e.g. family members) and relate to the condition of the patient causing dependency in the home of the patient, under the condition that it is unpaid.	Not included	As there is no transaction, it is unpaid household production. As such it should go unaccounted for in SHA.
Assistance services (meal preparation, shopping, housework etc.) that provide help with instrumental activities of daily living (IADL) by qualified nurses or lesser-qualified caregivers (if there exists an allowance for the provision of these services) at the home of the patient in case the person receiving the care is LTC dependent (requiring help with ADL).	HCR.1	If these assistance services are provided separately they should be reported as HCR.1. If the assistance services by lesser-qualified care takers (e.g. family members) are not remunerated via an allowance they should be considered as unpaid household production.
Personal care services (washing, bathing, helping out of bed etc.) that provide help with activities of daily living (ADL) **in combination with assistance services** (shopping, housework etc.) by qualified nurses or lesser-qualified caregivers (e.g. family members) at the home of the patient.	HC.3 if ADL dominant HCR.1 if IADL dominant	An effort should be made to identify the components of the services package and account for them separately. If a separation is not feasible and the health part (ADL) in this integrated service package is dominating the whole package should be recorded as HC.3. If the social part (IADL) is dominating the whole package should be recorded as HCR.1
Nursing care, personal care and assistance services provided by caregivers (that may or may not be qualified) that are employed informally (illegally) by the LTC dependent.	HC.3 if ADL dominant HCR.1 if IADL dominant	The same accounting rules should apply as for legal or formal employment. It is one aim of SHA 2011 to also include activities of the non-observed economy.
Pharmaceuticals provided to patients requiring LTC services when they are a component of a service package (most common in an in-patient or home-care setting).	HC.3	Follows the same logic as pharmaceuticals dispensed in hospitals where they are part of curative care (HC.1). Pharmaceuticals are additionally considered as a factor of health care provision in the ICHA-FP classification.

Pharmaceuticals provided to patients requiring LTC services when they are not a component of a service package (e.g. patient has to acquire medication from pharmacy on his own or has it delivered to him or his nursing care facility).	HC.5	The acquisition of medication as a separate transaction should be reported as such. It follows the same logic as in the case of pharmaceuticals used for curative purposes in in-patient (HC.1) or out-patient settings (HC.5).
LTC services provided in day care (or night care) **centres**. These facilities can be dedicated to the elderly or to the physically or mentally disabled of all ages. Day (night care) means that the patient is being take care of in these facilities for some hours during day time (night time). The rest of the time they usually spend in their home, possibly under the care of family members. Patients need to be classified as LTC dependent for the services to be considered as LTC.	HC.3.2	If the dominant character of these institutions is the provision of nursing care and ADL services they should be recorded as HC.3. If their focus is more of a social nature they should be recorded as HCR.1 (except for the ADL part that should be reported – if possible – as HC.3).
Respite care for families with dependent person requiring LTC services. Some schemes in countries allow family members to take a break from care obligations for the elderly or physically or mentally disabled relatives. During this time (either once a year for a longer period or shorter periods every quarter or month) the LTC dependent will typically be cared for full-time in an in-patient setting, e.g. a nursing home specialised in short-term stays.	HC.3.1	Respite care is typically provided in an in-patient setting and in this case should be considered as HC.3.1. For shorter respite episodes (an afternoon) these services can also be classified as HC.3.2.
Summer camp for disabled people and/or for whole families with disabled children (considered as LTC dependents).	HCR.1 (or HC.3.2)	Included in HC.3 if the whole "package" has a significant nursing and/or personal care component. If the social component is the main purpose, should be considered as HCR.1, with the exception of any health services which should be – if possible – be reported as HC.3.
Home adjustment measures are construction works in the home of the LTC patient. The aim of these works is to enable the patient to stay in his familiar surrounding as long as possible and to avoid a move into a usually much more expensive nursing home. The works typically include disability-adapted construction works of the house, like the widening of door thresholds or the installation of technical devices like stair case lifts.	Capital account	These transactions should be considered as an investment rather than final consumption; it should therefore be included in gross fixed capital formation in the capital account.
Support services for informal carers (e.g. family members) that provide ADL services (paid or unpaid). The support services could include counselling and basic training lessons in LTC provision. Note that the cost of social protection of carers (e.g. insurance and pension payments) may also be included – see also care allowance below).	HC.3.4 or HCR.1	Support services should be considered as HC.3 if they support informal carers that provide help with ADL. Following the logic of this document, eventual support services for informal carers providing solely help with IADL should be recorded as HCR.1 (but only if the help is directed at LTC dependent persons).
Telematic services are becoming increasingly popular in the whole health care sector. The idea behind them is to use modern ICT equipment to enable patients to stay in their familiar surroundings and avoid costly institutionalisation. In connection with LTC services these telecare services could include emergency call infrastructure within their homes, remote monitoring systems of medication intake and vital parameters.	HC.3.3	If the telematic services are part of a LTC-service package (usually provided by a scheme) it should be reported as HC.3. The own-account acquisition of telematic equipment itself should be recorded under HC.5.2.9.
Care allowance are funds provided by financing schemes to dependent people with LTC needs and oblige them to organise their nursing and/or personal care themselves (typically by informal carers like family members).	HC.3.4	Care allowances paid out for the organisation of nursing care or personal care services should be recorded as HC.3.
LTC (social) cash-benefits are allowances to LTC dependents or family members to cover informal care service of a social nature (or help with IADL).	HCR.1	LTC (social) cash-benefits for the organisation of help with IADL services or to cover the cost of other social services should be recorded as HCR.1. If these services have a nursing or personal care component, this part should be – if possible – reported separately under HC.3. If patients are not LTC dependent transaction is outside of the scope of SHA.
Cash benefits can be granted to people with sickness, disability or dependency. The main purpose is income protection. There is no direct relationship to nursing care, personal care or IADL services.	Not included	Cash benefits are not considered as a substitute for LTC services if there is no obligation to organise the care with this money.
Special schooling programmes for children suffering from a mental or physical handicap and who are thus requiring some elements of LTC services are provided in most countries.	Not included	The primary purpose of special schooling lies in social integration and has no health care purpose. If there are components of ADL or IADL services that can be identified separately, they should be accounted for as HC.3 or HCR.1,

		respectively, if children are LTC dependent.
Vocational programmes in sheltered workshops specifically dedicated to mentally or physically disabled exist in many countries. The aim of these programmes is to integrate the disabled people into regular work life to the greatest extent possible. The challenges of their tasks vary depending on the degree of their disabilities. The sheltered workshops are usually subsidised by the government.	Not included	The primary purpose of vocational programmes lies in social integration and has no health care purpose. If there are components of ADL or IADL services that can be identified separately, they should be accounted for as HC.3 or HCR.1 respectively if disabled are LTC dependent.
Social day centres for the physically and mentally disabled are typically for those who are not fit to work. The purpose is more the delivery of social and leisure activities.	HCR.1 (HC.3.2)	If the primary purpose lies on social activities it should be recorded as HCR.1. If there are also LTC services provided that can be identified as such, those should be recorded as HC.3.2. If not targeted at LTC dependents transactions is outside of the scope of SHA.
Social day care centres for the elderly can provide a vast range of predominantly social activities. They are usually different from those of physically and mentally disabled. However, they have in common that their focus is typically not that of health care.	HCR.1 (HC.3.2)	As most of the services provided focus on social activities they should be recorded as HCR.1 or even outside of SHA. Incidental provision of ADL services should of course be recorded as HC.3.2. If not targeted at LTC dependents transactions is outside of the scope of SHA.
Case management is provided by government agencies or health insurance schemes in various countries. For dependent people, case managers usually help with the administrative paperwork, provide for counselling of family members, coordinate nursing and personal service which can be provided from different organisations or contact nursing homes or health professionals. Depending on the country the organisational setting of case managers or their tasks can differ.	HC.3.1 or HC.3.4	Though the services provided by the case manager are more of an administrative nature, they should be recorded as HC.3 as there is a very close relationship to the dependent people and these services are usually provided outside of the typical administrative bodies of the financing schemes.
Medical assessment of applicants for LTC benefits is required in most countries. These assessments are based on medical criteria to evaluate the functional limitations and the overall condition of the patient. As a result the dependent will be grouped into a dependency class that qualifies for the delivery of services or the application is disapproved if the functional limitations are not severe enough. The medical assessments are conducted by professional staff (nurses or doctors).	HC.3.1 or HC.3.4	This administrative procedure is the assessment of the health status of potentially dependent people and should therefore be accounted for as HC.3.
Supported living arrangements for the elderly are barrier-free apartments used by patients who can no longer live in their own houses but who are still too independent to live in nursing homes. Typically the residents require some sort of nursing or personal care provided by qualified nurses having an office on the premises. Meals are usually available on-site but residents can also choose to cook if their condition allows them to do so. Cleaning services and additional services are usually also available.	Depends HCR.1 or HC.3.4 or outside of SHA	The nursing care and personal care component of the services provided in supported living arrangements should be accounted for as HC.3.1. The residential services like cleaning, meals etc. should be accounted for as HCR.1. Also, subsidies to the residential services and the costs of accommodation should be accounted for as HCR.1. A broad range of supported living facilities exists in many countries that differ in level of dependency of the residents. If the above mentioned services are provided together and cannot be separated they should be classified as HCR.1 or HC.3 based on the dominant character of the facilities. If patients are not LTC dependent, services are outside the scope of SHA.
Supported living arrangements for the physically or mentally handicapped are typically different from those for the elderly as they are generally aimed at a younger population with other limitations. These residences can vary according to the need of their residents. Some might focus on the provision of nursing and ADL services, some of them will only provide lower level of care and have basically a social focus.	Depends HCR.1 or HC.3.4 or outside of SHA	The nursing care and personal care component of the services provided in supported living arrangements should be accounted for as HC.3.1 The residential services like cleaning, meals etc. should be accounted for as HCR.1. Also, subsidies to the residential services and the costs of accommodation should be accounted for as HCR.1. A broad range of supported living facilities exists in many countries that differ in the level of dependency of the residents. If the above mentioned services are provided together and cannot be separated they should be classified as HCR.1 or HC.3 based on the dominant character of the facilities. If patients are not LTC dependent services are outside the scope of SHA.
Homecare companies are supplying patients with a variety of medical products at their homes. These products can include, for	HC.5 (HC.3.4 or	Medical products in an out-patient setting should be classified as HC.5. If these products are provided as an integral part of a

example, ostomy care, continence care, wound care or enteral nutrition. They are not exclusively aimed at LTC patients. In addition to the supply, field staff may also provide basic advice in their usage.	HC.1)	LTC service package they should be considered as HC.3.4. If the products are part of a service package aimed at patients with no LTC dependency they should be accounted for as HC.1.
Transportation of LTC dependents to day care nursing facilities can be provided by governmental or insurance programmes in the case of day care or respite care.	HC.3.2 or HC.4.3 or excluded	Transportation services should be accounted as HC.3.2 if part of a LTC-service package funded by a scheme. If costs are borne separately and transportation is based on medical recommendation, they should be reported as HC.4.3. If the households have to provide the transportation service themselves, they should not be accounted for (unpaid household production).
Transportation of LTC dependents to day care facilities with a social focus.	HCR.1 or excluded	Transportation services should be accounted for as HCR.1 if they are part of a package funded by a scheme or borne separately If the households have to provide the transportation service themselves, they should not be accounted for (unpaid household production).
Transportation of mentally or physically disabled children to special schools or adults to sheltered workshops.	Not included	If the services in these institutions are outside the scope of SHA (see above), so should be the transportation service.
Investment surcharges or direct investment payments refer to the situation in some countries where LTC recipients are required to pay for the capital expenses If that LTC provider separately. These capital expenses are borne by the providers to ensure the delivery of LTC services. In most countries capital expenses are an inherent component of the price of the LTC services and are a not accounted for separately.	HC.3 or HCR.1	By convention, private households cannot engage in capital formation. The health care providers are the ones making the decision to acquire or dispose of assets. Those transactions should be captured in the capital account. The investment surcharge payable by LTC recipients should be treated for as an ordinary price component of the service provided, even if billed separately. In the case of an LTC institution with a focus on nursing/personal care these payments should be accounted for as HC.3. In the case of a nursing institution with a focus on residential care or IADL services the payments should be accounted for as HCR.1.
Medical treatment, nursing care and personal care services for dependent persons with mental conditions in **mental health and substance abuse facilities (HP2.2) or mental health hospitals (HP1.2)** where the focus is on room and board and protective supervision.	HC.3.1	These services should be considered as LTC (health) when the focus is on nursing care and personal care services and the patients can be considered as LTC dependent. Depending on countries' organisation of care these services can be delivered in mental health facilities (HP.2.1) or mental health hospitals (HP.1.2).
Medical treatment, with less frequent incidental nursing care and personal care services for patients with mental conditions in **mental health hospitals (HP.1.2)** where the focus is on diagnostic and medical treatment as well as counselling with the principal intent to relieve symptoms of the illness or to reduce its severity.	HC.1.1	These services relate to curative care and not to LTC as they are typically not targeted at people with LTC dependency.
LTC facilities may receive additional revenues from donations to cover part of the current costs of the LTC services.	HC.3.1-HC.3.4	These transactions should be included under HC.3.1 to HC.3.4 depending on the main focus of the LTC facility if they are used to finance the delivery of LTC services (HF.2.2).
LTC facilities may receive additional revenues from donations to cover part of the investment costs or they may receive some investment such as LTC beds, wheelchairs etc.	Capital account	Since the transactions refer to fixed assets these transactions should be recorded in the capital account but in the core framework of SHA.