Revision of the System of Health Accounts

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Conceptual framework and definition of long-term care expenditure

Summary
Clear definitions and the international harmonisation of the boundaries of health care are major requirements for producing comprehensive and internationally comparable data on total expenditure on health. Experience with data on long-term care expenditure, however indicates that in the System of Health Accounts (SHA) Manual 1.0 (OECD, 2000) the definition of long-term nursing care (HC.3) is not adequately clarified. Additional guidance and clearer definitions have been provided since the preparation of the manual but outstanding issues remain. As a result, variations in the treatment of long-term health care has an effect on the comparability of key indicators such as health expenditure to GDP ratio and the public-private share of financing with different estimation methods affecting total health expenditure by up to 10%.

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CONCEPTUAL FRAMEWORK AND DEFINITION OF LONG-TERM CARE EXPENDITURE

INTRODUCTION

1. Clear definitions and the international harmonisation of the boundaries of health care are major requirements for producing comprehensive and internationally comparable data on total expenditure on health. Experience with data on long-term care expenditure, however indicates that in the System of Health Accounts (SHA) Manual 1.0 (OECD, 2000) the definition of long-term nursing care (HC.3) is not adequately clarified. Additional guidance and clearer definitions have been provided since the preparation of the manual but outstanding issues remain. As a result, variations in the treatment of long-term health care has an effect on the comparability of key indicators such as health expenditure to GDP ratio and the public-private share of financing with different estimation methods affecting total health expenditure by up to 10%.

2. The general objective of this project on long-term care (LTC) is to refine the definition and the methodology for the collection of long-term care data with an overall aim of contributing to the amendment of the current Guidelines and to improve and enhance the availability and comparability of LTC data. This amendment will contribute to the definition of long-term care expenditure and will feed into the revision process for the SHA manual. The revision of the SHA manual is a joint collaborate activity of the OECD, Eurostat and WHO.

3. In addition, specific objectives of the project are to produce an inventory of country sources of LTC data and report on both cross country and trend analysis of the data.

Definition of Long-term care

4. The term 'long-term care services" refers to the organisation and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time. There are two complementary components of this definition: the care continues over a long time period, and second the care is usually provided as an integrated programme across service components. The services may be provided in a variety of settings including institutional, residential[1] or home care.

5. Long-term care needs are most prevalent for the oldest age groups who are most at risk of long-standing chronic conditions causing physical or mental disability. The term 'disability' is used as an umbrella term covering any or all of the following components: impairment, activity limitation and participation restriction This usage was endorsed in the International Classification of Functioning, Disability and Health

1 In this report, residential care refers to services of care and social support, other than nursing homes, provided in supported living arrangements.

(ICF)by the World Health Assembly in 2001[2].

6. Assessment of an individual's need for a type of long-term care has traditionally been based on the measurement of dependency. One of the most common categorisations of dependency, but not the only one, is the degree of difficulty performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The degree of difficulty people experience in carrying out ADLs and IADLs denotes their level of dependency. ADLs is a core set of self-care or personal care activities which includes bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management. In the above definition of disability, ADL restrictions are activity limitations which imply that an individual has difficulty in executing daily activities. IADLs relate to domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs. IADL restrictions may otherwise be considered as participation restrictions or problems an individual may experience in involvement in life situations. Assistance with ADL denotes a higher degree of dependency than assistance with IADLs and thus is associated with more intensive care.

Background

7. The effect of ageing on public spending (including health and social budgets) is a key policy issue. Among the main purposes of public policies are to ensure adequate income (through the pension system and social assistance) and to provide services to people who are limited in their ability to function independently on a daily basis. From the point of view of public budgets, it is desirable to provide information concerning the total spending on services provided to dependent people.

8. To ensure comparability across countries, a major criterion of the SHA is "comprehensiveness". In accordance with the functional approach, all programmes designed for promoting health and preventing disease, curing illness, caring for persons with health-related impairment, disability, etc. through the application of medical, paramedical and nursing knowledge and technology should be included in total health expenditure, regardless of whether it is labelled "health care" or not in national statistics. The current LTC Guidelines used for the collection of the SHA data under the Joint Health Accounts Questionnaire (JHAQ) apply the same functional and comprehensive approach for long-term care[3]. All programmes designed to provide LTC services should be counted, regardless how they are labelled in national statistics. In a conceptual sense, this approach ensures comparability across countries and over time.

9. In essence there are two issues here. One is that government and policy makers would like to know the total costs of providing long-term care to dependent people. The second is that from the perspective of health expenditures, it is desirable to know the proportion of LTC which is health care (in this report called long-term health care or LTHC). If carefully measured, the difference between the LTC and LTHC is long-term social care (LTSC). In practice, the division of LTC into its health and social components is challenging as many services provided to LTC recipients have both a health and social component.

10. As the guidelines for collecting data on LTC under consideration in this report are an integral part of the collection of consistent and comparable health expenditure data under the SHA framework, the definition of the health care provided in the SHA manual (2000) is applicable. The definition provided

2. WHO (2001), *International Classification of Functioning, Disability and Health*, Geneva.

3. The *Guidelines for Estimating Long-Term Care Expenditure in the Joint 2006 SHA Data Questionnaire* are available at http://www.oecd.org/dataoecd/1/23/37808391.pdf.

is that it comprises the sum of activities performed either by institutions or individuals pursuing through the application of medical, paramedical and nursing knowledge and technology with the goals (*inter alia*) of caring for persons affected by chronic illness, with health-related impairments, disabilities and handicaps and assisting who require nursing care and end-of-life care[4].

11. Over the last four years, the OECD has conducted three projects with the aim of improving the conceptual framework, Guidelines and the availability of data on LTHC and LTC. These are: *Long-term care for older people* under the *OECD Health Project*; the "Complementary data collection on expenditure on health and social care for the elderly and people with physical and mental impairments"; and the subsequent work on LTC Guidelines which was applied in the 2006 Joint OECD, Eurostat and WHO Health Accounts data collection.

12. *Long-term care for older people* focused only on long-term care as a component of total health expenditure. There was a realisation however that a better understanding of differences across countries required going beyond the boundaries of the health system. Therefore, the OECD Health Data 2005 complementary data collection compiled basic information regarding the availability of expenditure data on health and social care for the elderly and people with physical and mental impairments, regardless of whether a particular item is recorded in the current health or social statistics in member countries.

13. Based on the results of the two projects mentioned, together with experience from SHA implementations between 2000 and 2005 and knowledge from the international literature, more detailed Guidelines for estimating LTC expenditure were developed [HA2005(3)].

14. The LTC Guidelines were further amended based on the feedback from the 2005 Meeting of Health Accounts Experts, and included in the Guidelines ("Explanatory Note") of the 2006 Joint OECD, Eurostat and WHO Health Accounts questionnaire (JHAQ)[5]. At the 2005 Meeting of Health Accounts Experts, there was agreement that health accounts should report both health and social components of LTC and total expenditure on LTC should also be reported among the key aggregate figures. Total health expenditure would include only the health component of LTC, however.

15. An interim report from this project was produced in December 2006. It provided a description of the available data sources for long-term care expenditure and clarified four options for drawing the boundaries between health and social components of LTC. Health accounts experts were asked to comment on these options in early 2007 and again at the 2007 Meeting of Health Accounts Experts with the presentation of a LTC report [DELSA/HEA/HA(2007)/6].

16. Feedback from countries involved in the Joint Health Accounts Data Collection has been taken into account in preparing the final report of this project. This project will also contribute to the revision of the System of Health Accounts manual which like the JHAQ is a joint cooperative activity between the three international organisations of the OECD, Eurostat and WHO.

Contributions for the project on long-term care expenditure

17. This document on LTC submitted as an input for Unit 2 of the SHA revision is based

4 *A System of Health Accounts*, OECD, 2000, p. 42.

5. By 2005, nearly all EU Member States and OECD countries had at least commenced pilot implementation of the SHA framework. OECD, Eurostat and WHO, who had been increasingly co-operating in health accounting activities, decided to extend the cooperation to the launch the first joint health accounts questionnaire (JHAQ) in December 2005. The second JHAQ in December 2006 was thus a natural progression emanating from the success of the first JHAQ.

on Part 1 of the LTC report (*Conceptual framework and methods for analysis of data sources for long-term care expenditure*) which was prepared by the Health Division of the OECD in 2006 and 2007. The project on long-term care was funded during 2006 and 2007 by regular contributions from member countries of the OECD. The long-term care expenditure project was also supported during 2006 and 2007 by a grant provided by the Directorate General for Public Health and Consumer Affairs of the European Commission.

CONCEPTUAL FRAMEWORK AND DEFINITION OF LONG-TERM CARE EXPENDITURE

Long-term care in a wider context

18. Figure 1 illustrates the major components of spending on services provided for aged persons and people with physical and mental disabilities. Some public spending on the aged and disabled persons both in the form of benefits in-kind and in-cash are not due to health-related impairments but are universally available. Examples are various types of pensions and free use of public transport for pensioners.

19. Figure 1 also illustrates that LTC is positioned between the health and social sectors as LTC has both health and social components. The challenge in dealing with data on LTC expenditure, and one considered in this report, is to define the boundary in a practical and comprehensive way between LTHC and LTSC.

20. Under the SHA framework, the reporting of only long-term health care (HC.3), social services of LTC (HC.R.6.1) and cash benefits related to sickness and disability (HC.R.7) are requested.

Definition and interpretation of LTC expenditure in the System of Health Accounts[6]

21. The functional classification of SHA (ICHA-HC) includes three categories related to care provided due to chronic impairments and a reduced degree of independence for aged and disabled persons:

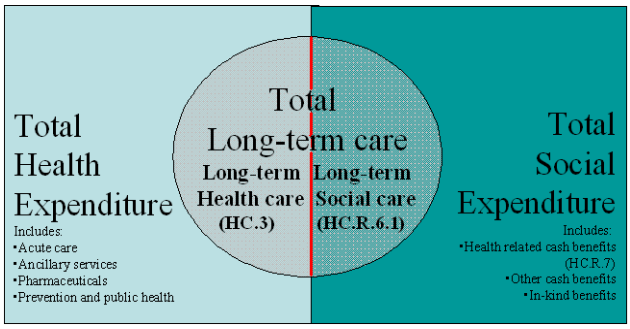
HC.3 Services of long-term nursing care as a component of total expenditure on health

HC.R.6 Administration and provision of social services in kind to assist living with disease and impairment. This category is wider than help with IADL limitations; it also includes, for example, special schooling for the handicapped, vocational rehabilitation and sheltered employment.

HC.R.7 Administration and provision of health related cash-benefits. This category is wider than cash benefits provided to persons with ADL or IADL limitations: it also includes, for example, sick pay.

22. By definition, health-related expenditure (HC.R.6 and HC.R.7) are not included in total expenditure on health.

Figure 1 The wider context of Long-term care expenditure



Definitions in the SHA Manual

23. The definition of Services of long-term nursing care (HC.3) provided in the SHA Manual is: "Long-term health care comprises ongoing health and nursing care given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long-term care is provided in institutions or community facilities. Long-term care is typically a mix of medical (including nursing care) and social services. Only the former is

6. Annex II provides details of the linkage of the SHA classifications to the System of National Accounts (SNA) Classifications.

recorded in the SHA under health expenditure."

24. Services of long-term nursing care (HC.3) consists of three subcategories: In-patient long-term nursing care (HC.3.1); Day cases of long-term nursing care (HC.3.2); and Long-term nursing care: home care (HC.3.3).

25. With respect to providers of home care, the SHA Manual includes not only providers with health qualifications, but also households: "Private households as providers of home care" (HP.7.2). The Manual emphasises: "The production of health care services not only takes place in establishments …but also in private households, where care for the sick, infirm or old people is provided by family members. … SHA includes, however, personal services provided within households by family members, in cases where they correspond to social transfer payments granted for this purpose." (p. 59, SHA Manual)

26. Definition of Administration and provision of social services in kind to assist living with disease and impairment (HC.R.6): "This item comprises (non-medical) social services in kind provided to persons with health problems and functional limitations or impairments where the primary goal is the social and vocational rehabilitation or integration. Includes: education of bed-bound children and special schooling for the handicapped (ICD-9-CM, 93.82); occupational therapy (ICD-9-CM, 93.83); vocational rehabilitation and sheltered employment (ICD-9-CM, 93.85)."

27. Definition of Administration and provision of health related cash-benefits (HC.R.7): "This item comprises the administration and provision of health-related cash benefits by social protection programmes in the form of transfers provided to individual persons and households. Included are collective services such as the administration and regulation of these programmes.

Main problems with the definitions in the SHA Manual

28. The content of HC.3 defined as "ongoing health and nursing care" is not specified in detail[7]. In particular, the content of "ongoing health care", the difference between "health" and "nursing" care and the content of "nursing" care are not explained. As a consequence, "Long-term nursing care" can be (and has been) interpreted in two ways: (a) as a type of care regardless who provides it, and (b) as services provided by health personnel. The general functional approach of the SHA and the fact that the SHA includes households as providers of "LTC: home care" suggest that "nursing care" refers to the character of the activity and not to the qualification of the provider. However, paragraph 3.3 of the SHA says (p. 42): "The prerequisite of a basic level of medical and nursing knowledge refers in most cases to national standards of accreditation or licensing for health care personnel." If this requirement is applied in a strict sense, LTC provided by personnel without medical or health qualifications and home care provided by private households should not be included in HC.3.3 long-term nursing care: home care.

29. Furthermore, the phrasing of the definition of HC.3 is inadequate. It refers only to in-patients (p.118), while it is obvious that HC.3 is a wider category including home care.

30. Total LTC expenditure cannot be calculated based on the current SHA Manual, as health related categories (HC.R.6 and HC.R.7) contain a wider group of services: for example, vocational rehabilitation, sheltered employment and payment for maternity leave, etc.

[7] It excludes preventive, curative and rehabilitative care, because these are reported under other categories of ICHA-HC.

Definition of long-term care in Long-term care for Older Persons

31. Long-term care for older people project covered 19 countries, with a focus on the description of characteristics of service provision and financing (e.g., continuum of care, consumer protection, etc.). The data collection under *Long-term care for older people* resulted in only limited new information on LTHC expenditure[8]. Additionally, the issue of whether the differences in the data were due to real differences in financing and provision of LTHC or were due to differences in the interpretation of LTHC data and its availability were not addressed.

32. In the project, LTC was defined as help with ADL restrictions. No distinction was made between health and social components of LTC and consequently, total LTC is included under total expenditure on health. This concept of LTC deviates in some respects from the SHA Manual as according to the Manual, LTC is a mix of health and social services.

33. Thus, the main problem with the definition of LTC in this project was that the boundary between health and social care was not defined. As a result the content of LTC was ambiguous. For example, it was not clear whether help with help with IADL provided to persons whose primary need is help with ADL was included in LTC or not.

Long-term care Guidelines under the Joint OECD, Eurostat and WHO Health Accounts data collection (the current definition)

34. The *Guidelines for estimating Long-Term Care expenditure* (LTC Guidelines) applied in the Joint Health Accounts Questionnaire (JHAQ) for collection of 2006 and 2007 SHA data report the following categories separately:

- Long-term health care, to be included in total health expenditure under the SHA framework (HC.3).
- Social services of Long-term care (LTC other than HC.3)– that is, HC.R.6.1
- Total long-term care (LTC), including the "social" and "health" components of long-term care (HC.3 plus HC.R.6.1).

35. Table 1 shows the place of the aggregates (HC.3 and HC R.6.1) among the categories of ICHA-HC. It also shows the breakdown of HC.3 into its 3 components. In practice, few countries report Day cases of LTHC (HC3.2) and the category is usually combined with HC 3.1.

Total long-term care (HC.3 + HC.R.6.1)

36. One of the key improvements in the LTC Guidelines, compared to the SHA Manual, is that it specifies the components and content of services provided under LTC by providing a detailed description of components of LTC expenditure and assigning them to HC.3 or HC.R.6.1.

37. The delineation between health and social care is based on whether care is provided for help with functional dependencies associated with ADLs or IADLs. ADL functions are essential for an individual's self-care (e.g. washing or dressing oneself), whereas IADL functions are more concerned with self-reliant functioning in a social or community environment (e.g. shopping, housekeeping). From the perspective of the patient, both limitations associated with ADL and IADL functions are restricting. However, in many countries, the delivery of care with respect to these two groups of activities is provided by different professions or agencies (sometimes combined with different types of financing); therefore, these two groups of activities may be distinguished and measured separately.

[8] The *Long-term care for older people* project collected data from 8 of the 19 countries covered by the project. Data for another 4 countries were only rough estimations, and for the remainder of the countries, the data was taken from OECD Health Data. (See Table 1.2. in OECD, 2005 p.26)

Table 1. Aggregate in ICHA-HC

HC1 & HC2	Services of curative and rehabilitative care
HC3 *HC3.1* *HC3.2* *HC3.3*	Services of Long-term nursing care *Inpatient long-term nursing care* *Day case of long-term nursing care* *Long-term nursing care: home care*
HC4	Ancillary services
HC5	Medical goods
HC 6	Prevention and public health
HC7	Health administration and health insurance
HC1-2, HC4-7	EXP. ON PREVENTIVE, CURATIVE and rehabilitative HEALTH CARE
HC 1-7	TOTAL CURRENT HEALTH EXPENDITURE
HC 1-7; HC.R.1	TOTAL HEALTH EXPENDITURE
Memorandum items	
HC.R.6	Social services of Long-term care (LTC other than HC3)
HC3 + HC.R.6	Total LTC EXPENDITURE
HC 1-7, HC.R.6	TOTAL CURRENT HEALTH AND LONG-TERM CARE EXPENDITURE

38. To assist with measuring total LTC as well as defining the boundary between health and social long-term care services, all services of long-term care are included. These are as follows in decreasing order of medical or health intensity:

- Palliative care (end-of-life care)
  - According to the SHA Manual long-term nursing care (HC.3.3) includes hospice or palliative care. The original text (page 118) continues to apply: "This includes hospice or palliative care (medical, paramedical and nursing care services to the terminally ill, including the counselling for their families). Hospice care is usually provided in nursing homes or similar specialised institutions."

- Long-term nursing care (intensive, high level care and assistance with ADL restrictions), including accommodation in (high-level care) nursing homes
  - Long-term nursing care generally is care provided by a skilled nurse, according to national professional standards that govern registration or licensing of nurses. In the context of long-term care, this often refers to skilled nursing care that is provided to clients on a daily/ongoing basis. Sometimes this refers to care by less qualified personnel but provided under the supervision of a (higher) qualified health professional. provided in a number of specialised institutional service settings, such as nursing homes or mental hospitals, or homes for individuals who are developmentally challenged. The term can also be used for nursing home care by qualified professionals provided for chronically ill or disabled persons.

- Personal care services (assistance with ADL restrictions)
  - Personal care services refer to intermediate care, mainly of assistance with one or more ADLs either through physical support or supervision for a person who is disabled or is otherwise unable to care for themselves in this respect. Personal care services are in many instances provided by care assistants, or aides who are not medical professionals (such as qualified nurses, other medical or paramedical personnel) but often are trained to help with these tasks.

- Home help and care assistance (help with IADL restrictions, including housekeeping, meals on wheels)
  - Home help refers to a variety of home care arrangements of all (most) levels of care need and care intensity. Generally care received in the home would be of a lower level than that received in an institution. The service arrangements, and service availability, however for lower level care differ widely between countries.
- Services and financing in support of informal (family) care
  - Social services in support of informal or family care givers includes care allowances, social protection of informal carers, training and counselling.
- Residential care services other than nursing homes:
  - Residential care services covers a variety of long-term care services which exist in the between "living at home" and "living in an institution". It includes a range of housing arrangements adjusted to the needs of older persons, or persons with disabilities such as independent living and supported or assisted living arrangements. Generally, these residential care services offer individual combinations of housing, personalised supportive services (help with IADL restrictions) and personal care, but usually do not provide the highly skilled and/or more intense care provided in a nursing homes. There are considerable differences between countries in the types of services available.
- Other social services provided in a long-term care context
  - Other social services include social services of day care, case management and coordination, special types of transportation and social activities for dependent older persons.

Services of long-term health care (HC.3)

39. This item is included in total expenditure on health. In the current Guidelines, the following are included under HC3:

- palliative care,
- long-term nursing care,
- personal care services, and
- services in support of informal (family) care.

40. Long-term nursing care comprises a range of services required by persons with a reduced degree of functional capacity, either physical or cognitive, who are consequently dependent on help with basic activities of daily living (ADL). This physical or mental disability can be the consequence of chronic illness, frailty in old age, mental retardation or other limitations of mental functioning and/or cognitive capacity. In addition, help with monitoring status of patients in order to avoid further worsening of ADL status.

41. Long-term nursing and personal care services may be provided and remunerated as integrated services with lower-level care of home help or help with instrumental activities of daily living (IADL) more generally, such as help with activities of home making, meals etc., transport and social activities.

42. In principle, expenditure on IADL services should be reported under HC.R.6.1. When disaggregation of these spending items into ADL and IADL services is not possible or problematic, country experts should decide, based on the dominant character of the particular programs, whether these cases are reported under HC.3 or HC.R.6.1. When it is not possible to judge the dominant character of the programmes concerned, the

current guidelines proposed to report this expenditure under HC.R.6.1, unless a country already has an established practice of reporting this expenditure under HC.3

Social services of Long-term care (HC.R.6.1.)

43. This item is excluded from total expenditure on health, but included in total LTC expenditure. In the current Guidelines, the following are included under HC.R 6.1:

- home help and care assistance,
- residential care services, and
- other social services.

44. These services are aimed predominantly at providing help with IADL restrictions to persons with functional limitations and a limited ability to perform these tasks on their own without substantial assistance. An effort should be made to estimate expenditure on these items separately. For example, where home help is provided together with long-term nursing (for ADL restrictions) and home help (for IADL restrictions), the services should be separately counted under Long-term nursing care: home care (HC.3.3) and HC.R.6.1 (home help). When the separation is not possible, all expenditure should be reported under HC.R.6.1.

Possible approaches to define long-term care and long-term health care

45. A key purpose of the current project is to clarify and discuss possible options for the treatment of LTC expenditure under the revised SHA manual.

46. Three broad alternative approaches (or a combination of them) could be taken to define the boundaries of long-term care and distinguish between health and social LTC expenditure:

- A functional approach based on the type of services (help with ADL vs. IADL; or using other categories of services) as currently used under the JHAQ;
- An approach based on the type or characteristics of providers or financers. Within this approach, three further possibilities can be discerned:
  - (i) health vs. non-health qualification of personnel (that is only services provided by personnel with medical or nursing qualification are classified as LTHC);
  - (ii) health vs. social institutions (that is only services provided by institutions or personnel reported under health sector in national statistics are classified as LTHC);
  - (iii) financing from heath vs. social budgets (that is only services financed by health or LTC insurance or health budget are classified as LTHC).
- An approach based on the health status of recipients (LTC health and social services provided for persons with ADL restriction vs. social services of LTC provided for persons with IADL restriction only).

47. The functional approach defines health components of LTC as help with ADL and social components of LTC as help with IADL. This approach requires separate accounting of expenditure on the different types of services. This approach is the closest to the functional approach of the SHA.

48. The second approach is based on the type or characteristics of providers or financiers and defines the health component of LTC as nursing care services provided by personnel with medical or paramedical qualifications or in institutions classified as health care in national statistics (hospitals or nursing homes). Similarly, the health component of LTC may be defined as services financed by health insurance or

government's health budget. However, there is considerable variation in how (by what personnel and in what institution) the same types of services are provided or financed across countries. Thus, the comparability of data based on this approach is limited.

49. The third approach makes a distinction between health and social components of LTC based on the severity of a person's restrictions with activities of daily living. All services provided to persons with ADL restrictions are categorised under long-term health care, including help with IADL (provided to persons whose basic need is the help with ADL).

Arguments for a functional approach

50. The SHA Manual should provide a framework that is able to better serve the policy needs. In particular, it is desirable to provide comparable data on total LTC and its health and social care components, taking into account the diversity of national practices and changes in national institutional arrangements.

51. As institutional arrangements differ across countries, and help with ADL restriction may be provided by personnel with differing qualifications across countries, it seems that an approach based on the type of institutions or professional qualifications cannot provide comparable data on the consumption of personal care services (consequently on LTC expenditure). On the other hand, the functional approach, by disentangling the main components of LTC and defining whether each should be reported as health or social care, has a better potential for internationally comparable data.

52. The LTC Guidelines require further clarification of definitions, even if the basic characteristics of the current definition (used under the JHAQ) are maintained. One area where the current definitions (under the JHAQ) could be easily and quickly amended is the classification of Personal care services (assistance with ADL restrictions). These services are classified as health under the LTC Guidelines, whereas home help or care assistance (help with IADL) is classified as social services of LTC. These services are positioned at the centre of the debate on the divide between health and social care as in practice it can be very difficult to distinguish the two types of services.

53. Help with ADL (personal care services) which is currently classified as a health service may be provided under different institutional circumstances and by caregivers with different professional qualifications. In several countries help with ADL and IADL for persons living in their home is provided together by the same provider and, hence, expenditure data cannot be disentangled (e.g., Germany and Switzerland). These countries report spending on these combined home care and home help services under health expenditure. This however, does lead to an inconsistency: home help is classified as health expenditure in these countries, while in other countries, where separate data are available, as social expenditure. A question for further debate is how to handle this inconsistency.

54. A functional approach, in classifying personal care services (assistance with ADL), can be applied in two ways:

- keep the current method with personal care services classified as health services, or
- classify personal care services as social services.

Arguments for an approach based on characteristics of providers

55. In several countries, policy-making is still focused on the budget of different government services and less interest is placed in total spending on meeting the needs of the elderly or handicapped. In this circumstance, there is considerable focus on the statistics on spending by institutions and thus this information is readily obtained.

56. Alternatively, a key means for distinguishing health and social services is the professional qualification of personnel. In this case, only services provided by health professionals (medical practitioners, nurses and other health practitioners) would be classified as LTHC. With this approach, expenditure on services provided by health professionals employed in social care institutions should be separated and reported as health care. This approach, however, also means that home care provided by households would be excluded from health care expenditure.

57. An approach based on characteristics of providers, either who finances the services or the qualifications of those providing the services, may be more readily available from national statistics. Thus, data collection and reporting may be easier than under a functional approach that may require considerable work with mapping of national categories to ICHA-HC.

58. Implementation of the functional approach for estimating LTC expenditure requires co-operation between experts working with health and social statistics. It may be easier where statistical offices are responsible for compiling Health Accounts. Countries where a health information institute is responsible for estimating national health expenditure may find it difficult to establish co-operation between different institutions. Such kinds of problems do not arise in the case of the approach based on characteristics of providers.

Possible approaches for modifying the LTC Guidelines

59. The revised SHA Manual is expected to provide definitions of, and Guidelines for estimating LTC expenditure which fulfil the criteria of policy relevance, comparability of LTC data, and feasibility of the estimation methods. In addition, consensus on the definitions and Guidelines is considered important. Therefore, the second phase of this project has re-examined the major options. With this purpose, all OECD and EU countries were sent a request in April 2007 to provide their view on two interrelated issues:

- their preference regarding the three alternative approaches mentioned previously to define the boundaries of long-term care and distinguish between health and social LTC expenditure;

- their preference regarding four possible ways of modifying the LTC Guidelines currently applied in the OECD, Eurostat and WHO Joint data collection.

60. The options for modifying the LTC Guidelines, on which countries were asked to express their preferences, are as follows:

Option A: the status quo

This option would entail maintaining the basic characteristics of the current definition (under the JHAQ). In particular, the recommendations on defining the boundary between health and social components of LTC require further detail. The current Guidelines contain a set of recommendations, but further advice on data compilation should be developed and further guidance provided on estimation and data compilation issues.

Option B: use different approaches to define the boundary between health and social components of LTC. Four different approaches are outlines below.

Option B.1 entails using a functional approach based on types of services (ADL and IADL) as in option A but modifying the current definition in only one respect. Personal care (help with ADL) which is currently categorised as health would be categorised as social care[9].

Option B.2 involves applying an approach based on the professional qualification of

9. The reasons for this change are discussed in paragraphs 52-54 above.

providers. In this case, only services provided by personnel with medical or nursing qualification are classified as LTHC[10].

Option B.3 involves applying an approach based on the types of institutions or financing arrangements. In this case, only services provided by institutions or personnel reported under health sector in national statistics are classified as LTHC or only services financed by health or LTC insurance, or from the health budget are classified as LTHC.

Option B.4 entails applying an approach based on health status of recipients as the preferred criteria to define the borderline between health and social components of LTC.

Option C: report total LTC only

In this case, no distinction is made between health and social components of LTC. LTHC is excluded from total health expenditure Thus the definition and estimation of total expenditure on health would be narrower than the current one, since health care would include only prevention, curative and rehabilitative care. (Only such nursing services that are integral part of a curative or rehabilitative episode of care would then be included.)

Option D: report LTHC only

Only services provided for LTHC would be reported. The advantage of this approach is that although it would be necessary to define the boundary between health and social care, it would not be necessary to count and report social services of LTC in the JHAQ data collection[11]. The boundary between LTHC and social services of LTC could be defined according to one of the four approaches as outlined in paragraph 48 (i.e. ADL vs. IADL, professional qualifications of providers, types of institutions, types of financing arrangements or health status of recipients). This option would entail a narrower definition for total long-term care than the current one. Social components of LTC (e.g. home help) would be labelled as social care, and would not be included in the definition of total LTC. In this case, obtaining the total expenditure on services provided for people with functional limitations would require summing up LTHC expenditure and expenditure on certain types of social care.

61. Health accounts experts were asked to comment and express their preferences on the options for modifying the LTC Guidelines in early 2007. Answers received from 29 countries (22 OECD and 7 non-OECD EU countries) concerning the options for modifying the LTC Guidelines are provided in Table 2 and summarised below. Note that 10 countries did not respond to the request for information.

Option A: the status quo was supported by 15 countries. In their response, 5 out of 15 countries said that they also use data on recipients (option B4) to assist with the separation of the expenditure into health and social components.

Option B.1: classifying personal care as social care was supported by 2 countries, and an additional 2 countries in combination with another approach.

Option B.2: approach based on professional qualifications was supported by 3 countries with another 2 countries opting for either professional qualifications or another approach to define the boundary.

[10] Of all the options, this is the one closest to the definition of HC.3 Services of long-term nursing Care provided in the SHA Manual 2000. The SHA Manual definition, however also includes home care provided by households, that is by carers without medical or health qualifications.

[11] Two social expenditure statistics data collections, SOCX and ESSPROS, collect and publish data on social expenditure in long-term care.

Option B3: approach based on institutions (either financing or providers) was supported by 2 countries with another 4 countries opting for either institutions or another approach to define the boundary.

Option B.4: approach based on recipients was supported by 3 countries in combination with another approach. Recipients data was mentioned by an additional 7 countries as useful for helping to determine the boundary between health and social care.

Option C: report LTC only was supported outright by two countries and as a possible option by another 3.

Option D: report LTHC only was supported by 3 countries but in all cases in conjunction with another option.

Table 2. Country responses to options

Country	Option on reporting LTC	Option	Supplementary Information used
Austria	Current JHAQ guidelines	A	
Bulgaria	Current JHAQ guidelines	A	
Denmark	Current JHAQ guidelines	A	
Finland	Current JHAQ guidelines	A	
France	Current JHAQ guidelines	A	
Germany	Current JHAQ guidelines	A	*recipients data B4*
Luxembourg	Current JHAQ guidelines	A	
Norway	Current JHAQ guidelines	A	*recipients data B4*
Slovenia	Current JHAQ guidelines	A	*recipients data B4*
Switzerland	Current JHAQ guidelines	A	
Canada	Current JHAQ guidelines or just LTHC	A or D	
Czech Republic	Current JHAQ guidelines or just LTHC	A or D	
Ireland	Current JHAQ guidelines or report TLTC	A or C	
Romania	Current JHAQ guidelines or report TLTC	A or C	
Iceland	Current JHAQ guidelines or change boundaries	A or B4	
Cyprus	Change JHAQ guidelines	B3 (Providers) or B4	
Estonia	Change JHAQ guidelines	B1 or B3 (Providers)	
Hungary	Change JHAQ guidelines	B2	
Japan	Change JHAQ guidelines	B2	
Korea	Change JHAQ guidelines	B2, B3 (Financing)or B4	
Latvia	Change JHAQ guidelines	B1 or B3 (Providers & financing)	
Lithuania	Change JHAQ guidelines	B2 or B4	
Netherlands	Change JHAQ guidelines	B1	
Sweden	Change JHAQ guidelines	B1	
United States	Change JHAQ guidelines	B3 (Providers)	
Turkey	Change JHAQ guidelines & report only LTHC	B3 (Providers & financing)& D	
Australia	Report TLTC	C	
Belgium	Report TLTC	C	
Spain	Report TLTC or change JHAQ guidelines	C or B4	
Croatia	No comment		
Greece	No comment		
Italy	No comment		
Malta	No comment		

Mexico	No comment		
New Zealand	No comment		
Poland	No comment		
Portugal	No comment		
Slovak Republic	No comment		
United Kingdom	No comment		

Recommendations

62. On the basis of the responses in Table 2, the majority of countries support the collection and reporting of LTC as an important indicator to understand the expenditure on all levels of LTC, not just on health. In addition, there appears to be acceptance of the overall boundaries and components of LTC. Thus, use could be made in the reporting of and comparisons using SHA data of this aggregate. In the same manner, the aggregate for curative-preventive care (HC1-2, HC4-7) could similarly be better reported and used more frequently for comparisons. Therefore as a first recommendation LTC should be collected and be reported as an aggregate.

63. 2 countries (plus 1 country partially) express the view of restricting the reporting just to the aggregate total of long-term care (LTC). The above recommendation will satisfy this. The majority of countries (26) expressed a preference for some kind of boundary between the health and social components of LTC. Most of these favour retention of the current JHAQ Guidelines. Thus based on the responses from OECD and EU countries, we recommend that the definition of the boundary between LTHC and LTSC should be based on types of services received (ADL/IADL distinction).

64. However, even those countries that purport to follow the current JHAQ Guidelines in their national reporting cannot make a clear separation of health and social components using the ADL/IADL approach. Many countries express the importance of relying on other available information such as that of beneficiary status to assist in the delineation of the data between health and social care. This practice is acknowledged and encouraged as recognition that there is a grey area between health and social care where division is problematic.

65. Country experience in dealing with problematic cases suggests that the data may be separated in the following way:

1. Survey methods or expert opinion may be used to ascertain the proportion of services provided in either in institutions or home services which are ADL vs. IADL. The Ministry of Health France uses surveys to separate health and social care.

2. In cases where it is difficult to separate LTHC and LTSC based on ADL/IADL restrictions, a second best approach is to define the boundary using health status of recipients (requiring ADL vs. IADL care)

66. Those countries opting for a change in the approach to the definition of the boundaries (options B.2, B.3, B.4) obviously prefer other methods of delineation. Therefore, although the functional approach is often been promoted as being theoretically correct and in keeping with the functional approach of the SHA, from a practical point of view the Guidelines for Long-term care should be improved to enable countries to make better use of available national data to make the necessary allocation of expenditure. In this regard, publication of more country approaches of methods for delineating health and social care expenditure would be beneficial (5 examples of country best practice are provided below in Annex I).

67. There was little response from the countries to option B1 of shifting personal

services (help with ADL) into social services.

68. In several countries home care (help with ADL) and home help services (help with IADL) are provided together at the home of the beneficiaries with ADL restrictions. If methods for separating health and social care are not available, we recommend that the services should be assigned to LTHC rather than LTSC, because the main reason for help is the restriction with ADL.

69. Any proposed changes to the measurement of Long-term care expenditure need to accommodate both current challenges in measurement and those which arise with policy developments in LTC. Several such countries have Long-term care insurance systems[12]. Amongst the motivations for introducing the system is a desire to reconstruct the present vertically-divided system between health, medical and welfare services, and to establish a system by which service recipients can receive comprehensive services from a variety of institutions of their choice. In these countries, access to insurance benefits is based on the assessment of an individual's functioning capabilities. The questionnaires for evaluation of the appropriate care level of aged and disabled persons provide a rich source of data which should be used as much as possible when delineating long-term care into health and social components. The data on health status of recipients does not necessarily align perfectly with the services, ADL and/or IADL received but of the 3 alternative options (under B2, B3 and B4), it is the closest to the current guidelines. Thus, data on health status and service requirements of recipients may be used pragmatically to separate health and social expenditure.

70. Guidelines for defining the boundary between LTHC and LTSC should be flexible in order to accommodate the considerable differences between countries in long-term care organisation and also changes in the organisation over time. Separation of expenditure into health or social components is relatively straightforward for the largest portion of LTC expenditure in most countries. For the grey areas where services provided straddle the health and social sectors, countries can learn from each other. In order to formalise this process, we propose to integrate more country information into the Guidelines.

[12]. Germany, Japan and Luxembourg have long-term care insurance. Long-term care insurance will be introduced in Korea in 2008.

Annex I

Country Experiences in Defining the Boundary between Health and Social Care

Australia

71. Until recently, the Australian Institute of Health and Welfare (AIHW) had been splitting residential aged care expenditure into health and welfare based on the Resident Classification Scale (RCS) categories. There are 8 Resident Classification Scale categories from RCS 1 to RCS 8. These are ranked progressively in terms of intensity of need. RCS 1 to 4 are described as high-level care, and RCS 5 to 8 are low-level care. Funding for residents assessed in category 1 was the highest. Residents classified in category 8 do not attract any funding. Expenditure for residents classified as RCS 1 to 4 (high level care needs) was allocated to health expenditure and expenditure for those classified as RCS 5 to 8 (low level care) was allocated to welfare services expenditure.

72. For funding purposes, each resident is classified according to the answers given to the RCS questionnaire. The questionnaire has 20 questions ranging from communication and mobility to technical and complex nursing procedures. It is the view of the AIHW that the majority of these activities (excluding 17 to 19) fall under the category of personal care assistance rather than health care. The following three areas (17 to 19) could be considered health services: medication; technical and complex nursing procedures; and therapy. The other 17 areas, which mostly involve assistance with activities of daily living, could be considered welfare services. These activities can be performed by people without health qualifications, and this is an indication that the activities do not primarily have a health purpose. On that basis, the three areas allocated to health accounted for 28% of the total government basic subsidy for residential aged care. The other 17 areas accounted for 72% of the government basic subsidy.

73. Given that over two-thirds of the expenditure for residential care facilities is of a welfare services nature rather than a health nature, the AIHW considers that it is no longer appropriate to continue to use the high level care/low level care split whereby 78% of residential aged care expenditure was allocated to health and 22% to welfare services. In the reporting of health and welfare expenditure from 2005-06 onwards, all expenditure on residential aged care facilities is classified to welfare services in accordance with the classification practices of many other Australian government departments.

74. In addition, the AIHW comments that higher level care categories should not necessarily be associated with higher needs for health services. For many in aged care, illness is the cause of the need for care this does not mean that the provided type of care has a health purpose. A service has a health purpose if the service is actively aiming to improve a person's health or to prevent illness or injury. Most residential aged care services have a care focus rather than a cure focus. Most of the services are to cater for needs for personal care that have developed because of declines in health status in the past, but are not directly attempting to reverse that health status decline.

75. .From 20 March 2008 a new assessment instrument, the Aged Care Funding Instrument, will be introduced. This instrument is a set of 12 questions and will enable categorisation according to 3 levels of care of low, medium and high. The categories are associated with two new supplements, each paid at three levels (low, medium and high) for mental and behavioural conditions, including dementia, and the other for complex health care needs, including palliative care.

76. This summary has been extracted from Health Expenditure Australia 2005-06 Health

and welfare expenditure series no.30, Australian Institute of Health and Welfare 2007 available at http://www.aihw.gov.au/publications/hwe/hea05-06/hea05-06-c06.pdf

Canada

77. The current Canadian Health Accounts contain 42 discrete categories of expenditure grouped into 8 major categories (uses of funds). The classification of uses of funds in the current Canadian Health Accounts may be defined as a mixed classification of providers and functions, but is largely a classification of providers.

78. One of the 8 major categories is "Other Institutions". This category includes residential care types of facilities (for the chronically ill or disabled, who reside at the institution more or less permanently) and which are approved, funded or licensed by provincial or territorial departments of health and/or social services. Residential care facilities include homes for the aged (including nursing homes), facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and facilities for emotionally disturbed children. Facilities solely of a custodial or domiciliary nature and facilities for transients or delinquents are excluded.

79. In the Canadian context, residential institutions are classified based on a considerable share of residents receiving care as classified in the Residential Care Facilities Survey. In the Survey, there are 4 types of care distinguished:

- Type I care is that required by a person who is ambulant but who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living.

- Type II care is that required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who, having reached the apparent limit of his recovery, in not likely to change in the near future, who has relatively little need for diagnostic and therapeutic services of a hospital, but who requires availability of personal care for a total of 1.5 - 2.5 hours in a 24 hours day, with medical and professional nursing supervision and provision for meeting psycho-social needs.

- Type III care is that required by a person who is chronically ill and/or has a functional disability (physical and mental), whose acute phase illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. A minimum of 2.5 hours of individual therapeutic and/or medical care is required in a 24-hour day.

- Higher type care involves more nursing and/or medical care than Type III. Very few residents would receive this type of care. Care above Type III is usually provided in a hospital setting.

80. Only those institutions with a considerable share of residents receiving Type II and higher types of care are classified as long-term health care only three categories of facilities meet this criterion: homes for the aged, institutions for persons with physical disabilities, institutions for persons with psychiatric disabilities.

81. In the correspondence between the Canadian Health Accounts and ICHA-HC, Type I care was excluded. Expenditures for

Type II and Type III care were put under HC.3.1 (In-patient long-term nursing care). Expenditures for care above Type III were put under HC.1.1 (In-patient curative care).

82. There are two departures between the ICHA Categories and those used in national practice. Expenditures by the public sector for home care programs including payments to Victoria Order of Nurses are included under HC3.3. The programs, however, may include some expenditure for curative and rehabilitative care than cannot be distinguished from expenditure on long-term nursing care. Expenses on outreach workers employed by the residential care facilities but providing home care services cannot be distinguished and are included under HC.3.1.

83. This summary has been extracted from Gilles Fortin SHA-Based Health Accounts in Thirteen OECD Countries Country Studies: Canada National Health Accounts 1999 OECD Health Technical Papers No. 2 DELSA/ELSA/WD/HTP(2004)2.

Germany

84. The Guidelines for LTC were introduced for the SHA JHAQ 2006. Germany supplies LTC data consistent with the Guidelines and the data is available since 2000.

85. In Germany entitlement to long-term care was added to the 11th Book of Social Code in 1995 as a separate pillar of the Social Security System. Social LTC Insurance covers the **s**ame persons who are covered under Statutory Health Insurance (approximately 90% of population). The scheme is financed from mandatory social contributions based on 1.7% of gross income with employers paying half of it, although some exceptions do apply.

86. There are 2 sources of public sector data. First, detailed information on the type of LTC-services is derived from financial records of the financing agents. Second, entitlement conditions for recipients of LTC services are legally defined in the respective books of the Social Code. The Social Code states that persons who need help and assistance with daily and recurrent activities due to a physical, psychological or mental illness or disability, for a minimum period of 6 months and require help with ADL and IADL are entitled to benefit from LTC services. The services provided and benefits granted cover help and assistance with ADL and IADL from ambulatory services, public and private, and with basic medical services in licensed nursing care institutions, other services/benefits: respite care, technical appliances, and pension entitlements for informal care givers.

87. The accounting practice for these public services using the JHAQ Guidelines is as follows:

- In-patient long-term nursing care provides basic medical care services and assistance with ADL and IADL and is classified as HC.3.
- Home care / Personal care services (provided by professionals) provide assistance with ADL and IADL and are classified as HC.3.
- Cash benefit / Care allowance given to informal care givers, provides assistance with ADL and IADL and is classified as HC.3.

88. For the private sector, no financial records are available, so estimation methods are required for estimation purposes. For the estimation of private household expenditure in nursing homes, the output of LTC in nursing homes is estimated using the long-term care statistics (number of residents X average daily care rate) and the expenditure of private households is treated as residual value between the output and the payments received from the social LTC Insurance. However, the vast majority of inpatients in nursing homes are entitled to benefits of Social LTC Insurance.

89. Where LTC is provided in the dependent's home, expenditure is estimated using special survey data and overall

expenditure is calculated with all possible reimbursements deducted. Expenditure is broken into long-term health care (HC.3) and social services of long-term care (HC.R.6.1) on the basis of expert estimation.

90. In the case of supported living arrangements, the following accounting practice has been established. If a person in Supported Living Arrangement is not entitled to benefits under Social LTC Insurance, this implies that help with ADL and IADL is not required and thus the expenditure is not considered as LTC. On the other hand, if the person in a Supported Living Arrangement is entitled to benefits under Social LTC Insurance, then assistance with ADL and IADL are required and the expenditure is included in LTC.

91. Overall, implementation of the Guidelines depends on country-specific data availability. Pragmatic solutions to problems must be found. In the German case, some deviations from Guidelines remain, for example, medical treatment (wound dressing, injections etc…) for persons requiring LTC in their home is accounted for under Curative Home Care.

92. This summary was taken from a presentation by Michael Müller of the German Federal Statistical Office entitled "Application of the Guidelines on the Treatment of LTC – A Pragmatic Approach" and presented at the OECD Health Accounts Experts Meeting, Paris on 8-9th October 2007.

Japan

93. Japan implemented a new long-term insurance scheme (LTCI) for the frail and the elderly on 1 April 2000. Japan has the most rapidly ageing population in the world and will soon have the highest percentage of the elderly and the very old in its population. The new public long-term care insurance system was introduced with the aim of responding to society's major concern about care of the aged and disabled. Everyone aged 40 and older pays premiums, and everyone aged 65 and older is basically eligible for benefits based strictly on physical and mental disabilities.

94. After an application for care, a care manager conducts an assessment of the client's physical disability during a home visit using an approximately 82-item questionnaire developed by the Ministry of Health, Labour and Welfare. The assessment forms are processed using a computer program that classifies applicants according to the degrees of support/care required. Eligibility status is classified into one of the following six levels after an assessment of the physical and cognitive functions of the individuals: Support Level, which is for individuals who are generally capable of conducting basic daily activities, but require some assistance; and five Care Levels, which are Care Level I (for individuals requiring partial care) to Care Level V (for those whose ability to conduct daily activities is almost impossible without extensive assistance).

95. The number of benefits an individual receives from long-term care insurance varies with eligibility status, increasing with the amount of support or care required. Benefits under this system are provided in the form of services, with money being paid to service providers directly. In principle, the recipients can receive services under LTCI either at home or in appropriate facilities. Individuals eligible for the Support Level only can only receive services at home.

96. Further information is available at www.mhlw.go.jp/english/topics/elderly/care/2.html

Spain

97. Social security protection has been extended in line with the "Libro Blanco de la Dependencia" (White paper on Dependency) published in 2004 by the Spanish Government. This extension is based on legislation concerning dependency promulgated in December 2006. This legislation defines the basic conditions which

ensure equal treatment regarding the promotion of personal autonomy and the care provided for those who are dependent, through the creation of a System for Autonomy and Care for Dependents (Sistema para la Autonomía y Atención a la Dependencia or SAAD). The System took effect in January 2007 and will be fully operative in 2015 for all types of dependency.

98. The legislation defines dependency as a permanent state affecting persons who, for reasons connected with their age, state of health or disability leading to the loss of physical, mental, intellectual or motor (sensorial) autonomy, require the help or assistance of a third party to carry out the basic activities of daily life or, in the case of those with a mental handicap or mental illness, other support for their personal autonomy.

99. Various types of dependency have been identified as follows: economic, physical, and mental or cognitive dependency. These types of dependency have been split up into moderate, severe or total dependency. Each of these divisions is further divided into two levels.

100. The aim of the benefits allocated by the system for those in a state of dependency is to provide a better quality of life and a greater degree of personal autonomy, to provide real equality of opportunity and to facilitate their active inclusion in community life.

101. The data for LTC expenditure is derived from the White paper on Dependency that gives extensive information about the number, health conditions, different dependence levels and expenditure for the elderly and people with physical and mental impairments.

102. For many data classifications for long-term care, the National Accounts and Household Budget Continuous Survey (HBCS) provide the core data. Data from the White paper on Dependency is then used to estimate the LTC expenditure data. .For both LTHC (HC3.1) and social LTC (HCR6.1), the White paper on Dependency is used to provide the parameters of estimates for public and private expenditure.

103. Reference document(s): Ley No. 21990 del 14 de diciembre de 2006; Libro Blanco de la Dependencia, Diciembre de 2004.

Annex II

The linkage of the SHA classifications to those applied in SNA

104. The new ISIC Rev 4 classification distinguishes three new divisions under **Section Q - Human health and social work activities:** Human Health Activities (Division 86); Residential Care Activities (Division 87); and Social work activities without accommodation (Division 88). Under Human Health Activities, the Group "Hospital activities" includes LTC provided in hospitals, but no longer contains nursing homes. Division 87 "Residential Care Activities" includes all nursing care facilities and all types of residential care facilities.

Health and long-term care under the International Standard Industrial Classification of All Economic Activities (ISIC)

Section Q - Human health and social work activities

New Division 86 – Human Health Activities consisting of:

861 – Hospital activities

862 – Medical and dental practice activities

869– Other human health activities

New Division 87 – Residential Care Activities, consisting of:

871 Residential nursing care facilities

872 Residential care activities for mental retardation, mental health and substance abuse

873 Residential care activities for the elderly and disabled

879 Other residential care activities

New Division 88 – Social work activities without accommodation, consisting of:

881 – Social work activities without accommodation for the elderly and disabled

889 – Other social work activities without accommodation