

## Input Document Unit 2

# Borderline issues of long-term care (LTC)

### Summary

Sweden's proposal is to report long-term care in three separate sub-groups:

- Long-term health care excluding ADL (LTHC) – *slightly modified*
- Long-term nursing care (LTNC) – *new sub-group*
- Long-term social care (LTSC) – *same as before*.

LTHC should be classified as HC.3 (only medical procedures) and the others as HC.R.6 (all activities related to ADL and IADL should be grouped together as a health related activity). This proposal is supported by the revision of SNA according to NACE. As a possible approach in drawing the borderline between LTHC and LTSC, Sweden recommend option "Professional qualification of providers" as the guiding principle and as a second best solution "Types of institutions". The proposal continues with a complete makeover of HC.R.6 into only comprising of the sub-groups LTNC and LTSC, all other activities should either be removed completely from the new SHA manual, or be moved to a new and separate HC.R. The new HC.R.6 would then be the following:

- *HC.R.6 – Long-term care excluding long-term health care*
- *HC.R.6.1 – Long-term nursing care (LTNC)*
- *HC.R.6.2 – Long-term social care (LTSC)*

These new LTC sub-groups would then be introduced in the SHA totals.

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## Borderline issues of long-term care (LTC)

The functional approach is the leading principle for the Swedish interpretation and application of System of Health Accounts (SHA). In this respect Sweden agrees with the definition of the functional approach stated in SHA (1.0). But Sweden deviates regarding the treatment of Activities of Daily Living (ADL). The political view that ADL should not be considered as health care was manifested in the Swedish “Ädel reform” in 1992, when long term care was split up into social care and health care<sup>1</sup>.

In this input paper Sweden presents a proposal in four parts of how to deal with the borderline issues of long-term care (LTC). This proposal is based on the documents:

1. *“Guidelines for estimating long-term care expenditure in the joint 2006 SHA data questionnaire”*
2. *“Key lessons for the system of health accounts revision from the concepts, definitions and data sources for long-term care expenditure” project DELSA/HEA/HA(2007)6*

### i) The three sub-groups of LTC

The first part of the Swedish proposal is to report long-term care in three separate sub-groups. This is based on the idea that long-term care can be viewed as three different sub-groups. Each of these are relevant from a policy analysis perspective and can also be used as components in other analysis as well for their own merit as together.

*Long-term care comprises of these three sub-groups:*

1. **Long-term health care (LTHC):** service of long-term **health care excluding ADL activities**. **LTHC** would then comprise medical procedures in health care provided by doctors and other skilled health personnel<sup>2</sup>.
2. **Long-term nursing care (LTNC):** assistance with ADL restrictions, including accommodation in nursing homes. **LTNC** would then comprise **ADL activities**, such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom.

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<sup>1</sup> Due to this reform, institutional units producing long-term care can not be identified any more. All sorts of accommodation as e.g sheltered living, institutional facilities and other accommodation for elderly and disabled persons are grouped together and hence classified as social care. The persons living in these “units” can in some cases only be requiring either IADL or ADL services, and no health care at all, whereas others need all three kinds of care. So for Sweden the health care component that might be produced in these units has to be extracted somehow.

<sup>2</sup> In the context of long-term care, this often refers to skilled nursing care that is provided to clients on a daily/ongoing basis. This type of care can include administering medication, medical diagnosis and minor surgery, or wound dressing, Sometimes this refers to care by less qualified personnel but provided under the supervision of a (higher) qualified health professional. See page 11 §57 in “Guidelines for estimating long-term care...”. Including palliative care.

3. **Long-term social care (LTSC):** lower-level care of home help, also called help with instrumental activities of daily living (IADL). **LTSC** would then comprise **IADL activities** more generally, such as help with activities of home making, meals etc.

In this part of the proposal a new name for two of the sub-groups in LTC are introduced, i.e. long-term nursing care (LTNC) and long-term social care (LTSC)<sup>3</sup>. The reason for this introduction is to make the distinction between the different sub-groups more visible. Long-term health care (LTHC) should in this proposal have the same definition as before but with the addition of ADL services being excluded. To clarify how different countries are defining long-term care, Sweden proposes that these three sub-groups will be *reported separately* in the SHA manual.

### **ii) How to classify the three LTC sub-groups**

The second part of the Swedish proposal is how the three long-term care sub-groups should be classified, as HC.3 or as HC.R.6.1 (according to the current terminology). This part of the proposal is based on table 2 in "Key lessons ... DELSA/HEA/HA(2007)6". The Swedish proposal is as in the compilation and description below:

<b>LTC</b>	<b>Proposal:</b>	<b>Comment:</b>
Long-term health care (LTHC)	HC.3	Medical procedures
Long-term nursing care (LTNC)	HC.R.6.1	ADL
Long-term social care (LTSC)	HC.R.6.1	IADL

Only medical procedures are reported under HC.3. All activities related to ADL and IADL should be grouped together as a health related activity in HC.R.6.

The Swedish proposal is supported by the revision of SNA according to NACE. Nursing care facilities will then be re-classified, i.e. a shift in the NACE group from health care to residential care, which is an important aspect to consider when finding solutions to the long-term care borderline issues.

Regarding the possible approaches for the drawing of the borderline between LTHC and LTSC, Sweden would from its perspective like to recommend option B2 "Professional qualification of providers" as the guiding principle. If option B2 is not possible, as a second best solution option B3 could be used.

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<sup>3</sup> LTSC was previously named Social services of Long term care, see page 10 in "Key lessons... DELSA/HEA/HA(2007)6"

### **iii) Complete makeover of HC.R.6**

The third part of the Swedish proposal is a complete makeover of HC.R.6 into only comprising the sub-groups LTNC and LTSC, i.e. the sub-groups that are classified as HC.R.6.1 in the 2nd part of the proposal. This means that all the other activities that can be found in HC.R.6<sup>4</sup> should either:

- be removed completely from the new SHA manual
- or be moved to a new and separate HC.R.

Today HC.R.6 **also 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). From the Swedish perspective none of these activities should be a part of SHA.

#### **The “new” HC.R.6 should have the following structure:**

HC.R.6 – Long-term care excluding long-term health care

HC.R.6.1 – Long-term nursing care (LTNC)

HC.R.6.2 – Long-term social care (LTSC)

### **iv) Introducing the new LTC sub-groups in the SHA totals**

In order to achieve a dynamic and versatile SHA a few but well established totals are needed. The strength of having these totals would be a benefit to all. From the Swedish perspective the totals presented in table 3 in “Key lessons ... DELSA/HEA/HA(2007)6” are near to fulfilling these requirements. Nevertheless a slight modification is needed: The fourth part of the Swedish proposal is to use the new LTC sub-groups and the treatment of them that were introduced in the previous parts of the proposal.

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<sup>4</sup> Both in the SHA manual 1.0 and in “Guidelines for estimating long-term care...”.

**Sweden's modified version of table 3: Aggregate in ICHA-HC:**

HC.1 & HC.2	Services of curative and rehabilitative care
<i>HC.3</i>	<i>Long-term health care (LTHC)</i>
HC.4	Ancillary services to health care
HC.5	Medical goods dispensed to out-patients
HC.6	Prevention and public health services
HC.7	Health administration and health insurance
HC.1-2, HC.4-7	EXPENDITURE ON PREVENTIVE, CURATIVE and rehabilitative HEALTH CARE
<b>HC.1-7</b>	<b>TOTAL CURRENT HEALTH CARE EXPENDITURE</b>
<b>HC.1-7, HC.R.1</b>	<b>TOTAL HEALTH CARE EXPENDITURE</b>
<b>Memorandum items</b>	
<i>HC.R.6</i>	<i>Long-term care excluding long-term health care</i>
HC.3, HC.R.6	Total LTC EXPENDITURE
<b>HC.1-7, HC.R.6</b>	<b>TOTAL CURRENT HEALTH AND LONG TERM CARE EXPENDITURE</b>