2 Discussion

This section is a discussion relating to all the client characteristic data items within the scope of this report, including the main (short-term) recommendations, and also the long-term suggested modifications, which are summarised in Section 3 and detailed at Appendix A. In some cases, no changes have been recommended to data items, and they are discussed and mapped in terms of consistency and comparability with national standards, and across programs.

2.1 Date of birth, Sex, Given name and Family name

2.1.1 Research purposes

Date of birth and *Sex* are collected in all of the national program data collections within the scope of this report. *Age* or *Age group* is usually derived from *Date of birth* data. These data items can be used to describe the residential aged care population, and also to examine specific research questions, such as variations in median entry period to residential aged care. For example, in the AIHW report 'Entry period to residential aged care', using bivariate analysis, it was found that the median entry period for low care residents increased with increasing age from 33 days for the under 65 age group to 60 days for the 85–89 age group (AIHW: 2002:3). When using *Sex* as a variable in bivariate analysis for low care residents, the median entry period for women was marginally longer than that for men (35 days compared to 31 days) (AIHW: 2002:3).

2.1.2 Statistical record linkage

Date of birth, Sex and selected letters of the *Given name* and *Family name* can also be used for the purposes of statistical record linkage. A Departmental ID number is currently assigned to each 2624 form when the form is entered onto the system. However, in most cases this ID number will not link individuals between different programs in the aged and community care system. For example, one person will have a separate ID number for CACP, a separate ID number attached to their 2624, and, if they later enter residential aged care, a separate ID number for residential aged care.

Statistical record linkage using *Date of birth*, *Sex* and selected letters from the person's *Family name* and *Given name* can be used to link records for clients of HACC, Community Mental Health, admitted patients and the CACP Program to records for residents of aged care services. As mentioned previously, *Date of birth, Given name* and *Family name* are collected on every form used within the residential aged care program, and *Sex* is collected on most. All these data items are currently recorded on the 2624 using a method that is mostly consistent with national standards. However, changes to enhance consistency have not been recommended due to the January 2003 implementation of the ACAP MDS Version 2.0.

Reporting requirements for ACAP MDS V2.0 will be incorporated into the 2624 form, and guidelines for the reporting of *Date of birth, Sex, Given name* and *Family name* are fully consistent with national standards. This will increase the reliability of statistical record

linkage between residential aged care data and other related program data (such as the CACP Program). Likewise, the new CACP Survey, due for collection in the second half of 2002, also includes these record linkage variables, which are fully consistent with national standards, and include all necessary guidelines.

When a person enters a residential aged care facility, the residential aged care provider completes a Resident Entry Record form and sends this into the State office of DoHA. The Resident Entry Record is manually matched up to the 2624, previously sent in by the ACAT, in order to verify that the person entering residential aged care has been approved as eligible by an ACAT. The matching is usually based on the person's *Given name*, *Family name, Sex* and *Date of birth*. Guidelines for the reporting of these data on the Resident Entry Record are not included, and therefore the reporting of this information may sometimes be different to the information on the current version of the 2624 (e.g. the spelling of names). The inclusion of guidelines on the Resident Entry Record for the reporting of these data would ensure consistency with national standards, and also help to reduce any errors in the form matching process.

Recommendation 1: Resident Entry Record form:

Include the following guidelines for the reporting of *Date of birth, Sex, First given name* and *Family name/surname* on the Resident Entry Record, to ensure that information is reported according to national standards. These changes will make identifying information on the Resident Entry Record form consistent with both national standards and the next version of the 2624 (that will include ACAP MDS V2.0 reporting requirements). Improved consistency in the way data is reported on the two forms will assist in the manual matching of the Resident Entry Record to the 2624. In turn, this may assist to minimise any incorrect matching of forms and electronic records that may occur.

1. Change *Date of birth* field on the Resident Entry Record form to include 8 separate boxes, to ensure that all numerals are reported. Include guidelines for how to estimate a person's *Date of birth* if their date of birth is not known, as follows:

   'If not known, estimate year; enter 01/07 for the day and month.' The 01/07 convention is recommended in the ACAP MDS Version 2.0, however, the HACC MDS uses the convention of 01/01. In future, standardisation between programs would be advisable.

2. Include guideline for coding *Sex* where uncertainty exists:

   'Where uncertainty exists about the sex of the person, the sex to be recorded is to be based on the observations/judgement of the interviewer'.

3. Include guidelines about the recording of *First given name* and *Family name/surname*, as follows:

   'Please record the person's full (formal) given name and full family name.

4. Include information about which name to use when the person has a variety of names for *First given name* (sometimes the case with Aboriginal clients). This will help to minimise discrepancies in the recording and reporting of name information.

   'At times, a person may be known by many names. This is sometimes the case with Aboriginal clients. Where uncertainty exists about which name to record, the name recorded on the person's Centrelink card should be used.'

Additional modifications in relation to other forms have been suggested for the long-term, and are included in Section 3, under *Date of birth, Sex, First given name* and *Family name/surname*.

2.2 Accommodation setting

Data on the accommodation setting in which people reside is included in the current version of the 2624, the ACAP MDS Version 2.0, the CACP data collection and the HACC MDS. These data are not included in the Admitted Patient NMDS or the Community Mental Health Care NMDS.

In view of Australia's ageing population and the move towards 'deinstitutionalisation' in the aged care sector; there is considerable policy interest in the types of accommodation in which older people live. Information is provided on the current 2624 about the type of setting a person has lived in for the 2 years preceding their ACAT assessment. However, the codes used in the current 2624 are not fully consistent with national standards or the other national data collections, which are detailed in Table 2: Accommodation setting and Tenure. Shaded cells in the table indicate data items that are not mappable to the national standard codes. Version 2.0 of the ACAP MDS includes information about the setting in which the person 'usually' lives at the time of their ACAT assessment. Information about the type of setting the person lived in immediately prior to entry into residential aged care is currently not available, although the addition of a new data item to the Resident Entry Record has been proposed by the AIHW (see Section 2.2.2 for more information).

Table 1: Accommodation setting and Tenure

NCSDD Version 2 Residential setting	NCSDD Version 2 Tenure type	2624 (normal residence for past 2 years)	ACAP MDS Version 2.0 Accommodation setting – usual	CACP DD Version 1.0 Accommodation setting	HACC MDS (Guidelines Version 1.5) Accommodation setting
Private setting	**Owner** **fully owned** **being purchased**	House/flat owner/purchaser	Private residence—owned/purchasing	Private residence—owned/purchasing	Private residence—owned purchasing
	Renter				
	Public housing	House/flat public tenant	Private residence—public rental or community housing	Private residence—public rental or community housing	Private residence—public rental
	Community housing				Private residence rented from Aboriginal community
					Temporary shelter within an Aboriginal community
	Private housing	House/flat private rental tenant	Private residence—private rental	Private residence—private rental	Private residence—private rental
		Board or lodgings	Boarding house/rooming house/private hotel	Boarding house/rooming house/private hotel	Boarding house/private hotel
					Private residence—mobile home
	Rent free				
	Shared equity or rent/buy scheme				
		Remote Aboriginal community[1]			
Community-based setting			Short-term crisis, emergency/transitional accommodation	Short-term crisis, emergency/transitional accommodation	Short-term crisis, emergency/transitional accommodation

[1] 2624 Remote Aboriginal community does not map to NCSDD Tenure type, as it does not distinguish between whether land is owned by the residents (Code 2 Owner), or by a community organisation such as an Aboriginal Land Council (code 22 Community housing).

Table 1 (continued): Accommodation setting and Tenure

NCSDD Version 2 Residential setting	NCSDD Version 2 Tenure type	2624 (normal residence for past 2 years)	ACAP MDS Version 2.0 Accommodation setting – usual	CACP DD Version 1.0 Accommodation setting	HACC MDS (Guidelines Version 1.5) Accommodation setting
Community based setting (cont.)			Supported community accommodation	Supported community accommodation	Supported accommodation facility (e.g. hostels for people with disabilities)
					Domestic-scale supported living facility (e.g. group home)
	Life-tenure scheme	Independent unit within a retirement village[2]	Independent living within a retirement village [3]	Independent living within a retirement village [3]	Independent living within a retirement village [3]
Institutional setting		Residential aged care facility	Residential aged care service—low level care		Residential aged care facility
			Residential aged care service—high level care		
		Psychiatric facility			Psychiatric/mental health community care facility
			Hospital		
			Other institutional care		
None/homeless/public place	**None/homeless**		Public place/temporary shelter	Public place/temporary shelter	Public place/temporary shelter
		Other accommodation	Other	Other	Other

Note: some codes in NCSDD Tenure type have been repeated on different rows, as they relate to more than one Residential setting code.2.3.1

[2] 2624 and HACC Independent unit as part of a retirement village does not map to NCSDD Residential setting, as codes do not distinguish between whether support is provided (which would be coded to 'Community-based setting') or without support (which would be coded to 'Private setting').

[3] This code includes the instruction that persons receiving support services as part of an accommodation package should be coded to 'Supported accommodation', which is consistent with the NCSDD.

2.2.1 People living in retirement villages

There has been recent policy interest in people that live in retirement villages, and their need for and access to support services. In *Australia's Welfare 2001*, the process of deinstitutionalisation is discussed, which is the movement away from the long-term institutional-care sector towards a home-based care sector. A key component of these reforms was reducing the reliance on institutional care for older people, and increasing the range of services available in the community. Gibson et al. (AIHW 2001: 114) notes that unlike the disability and mental health sectors, the aged care sector has not moved towards cluster housing or group housing. Instead, an alternative style of accommodation for older people has been the emergence of retirement villages, which are becoming increasingly popular for people that do not have high care needs. No data is currently collected on the growth of retirement village. Thus, the collection of information about people that live in these types of accommodation settings may be a policy area of growing interest.

Mapping of HACC, ACAP and CACP data on retirement villages

A mapping of the data domains used in each of the above national data collections (Table 1 in Section 2.2) shows that there is information about whether clients of these services live in retirement villages. Currently, 'independent living within a retirement village' is included as a code on the 2624, ACAP MDS Version 2.0, CACP and HACC, as a type of 'community-based setting'.

Some retirement villages provide services to residents, such as a linen service, domestic assistance, meals or personal care, as part of a package together with the accommodation. In the ACAP MDS Version 2.0 and the CACP data collection, instructions are that people who receive support services as part of a package within a retirement village should be coded to 'supported accommodation', as they are not, in effect, living in an 'independent' setting. This means that people living in and receiving support services from retirement villages are classified within the same category as people living in group homes and cluster apartments where support workers live on-site, which may or may not include 24-hour supervision and care.

In regard to community-based settings, group homes and cluster apartments are traditionally used by younger people with disabilities, and are not commonly used by the older population, who tend to live in age-specific retirement village complexes or residential aged care facilities. Therefore, the category of 'supported accommodation' is not very specific to the aged population.

In the HACC and 2624 data collections, there are no instructions for coding people that live in and receive services from retirement villages to 'supported accommodation'. Instead, people that live in this type of setting may be coded to 'Independent living within a retirement village' or 'Supported accommodation' (in HACC) or 'Other' which does not allow for 'clean data' on people that live in retirement village settings and receive support services as part of a package.

ABS data on retirement villages

The ABS classification of accommodation setting does not report information about levels of support received in retirement villages, therefore there is no ABS standard that may be adopted here. In the 1996 and 2001 Population Census, the Australian Bureau of Statistics

(ABS) classifies accommodation settings according to private and non-private settings. 'Accommodation for the retired or aged (self care)' falls under private dwellings, and 'Nursing home' and 'Accommodation for the retired or aged (cared)' falls under non-private dwellings. The code 'accommodation for aged (self care)' appears to be consistent with the concept of a retirement village setting. However, the levels of support available to people in retirement villages are not collected, as is the case with HACC and current 2624 data.

2.2.2 Addition of *Accommodation setting prior to admission to residential aged care* to the Resident Entry Record

Twelve months can elapse between when a person's ACAT assessment is completed, and when they enter residential aged care. The person's place of residence may change in this time. Information about a person's accommodation setting immediately prior to entry into residential aged care is not currently collected. It has been proposed in an AIHW paper for the Australian Health Minister's Advisory Committee about the feasibility of linking hospital morbidity data with residential aged care data (AIHW: June 2002), that a new data item *Accommodation setting prior to admission to residential aged care* be added to the Resident Entry Record. The data domain proposed is primarily aimed at identifying people that enter residential care from an inpatient setting. The codes are:

1. Hospital (acute care)
2. Other inpatient setting
3. Residential aged care service
4. Living in the community—receiving formal services
5. Living in the community—not receiving formal services
6. Other

9 Not stated/inadequately described

The addition of this data item is primarily designed to assist with record linkage between the acute and residential aged care sectors, by identifying people who enter residential care directly from hospital. However, it will also provide further information about the types of settings and levels of support received by people immediately before they enter residential aged care.

Recommendation 2: Accommodation setting:

In the short-term, include the following codes in future versions of the ACAP MDS, HACC MDS and CACP data collections to identify levels of support received by people living in retirement villages:

- **Independent living within a retirement village** (the person lives in a retirement village and **does not** receive any services such as domestic assistance, meals or linen service, as part of a package purchased from the establishment).
- **Supported living within a retirement village**: (the person lives in a retirement village setting and receives services from the establishment such as domestic assistance, meals and linen service, as part of a package purchased from the establishment)
- **Other supported accommodation** (includes community living settings or accommodation facilities in which residents are provided with support in some way by

staff or volunteers. This includes group homes, and cluster apartments where support workers are often present, sometimes 24 hours a day).

In effect, this information is already available in ACAP MDS Version 2.0 and CACP data collection. An instruction in the Guide for use states that people who live in retirement villages and receive support services as part of a package should be coded to 'Supported accommodation'. This code also includes group homes and cluster apartments where support workers are often present, sometimes 24 hours a day. These other types of supported accommodation are more specific to people with disabilities, and may not be as relevant to the older population. The inclusion of a separate code 'Supported living in a retirement village' would help to separate out this code from other types of supported accommodation, and may increase the likelihood of service providers reporting it.

The implementation of the recommended codes in the HACC MDS would introduce a new code for people living in a retirement village setting who receive support services as part of a package, as there is currently no guidelines or code for identifying this type of accommodation.

There are no long-term modifications suggested in relation to *Accommodation setting.*

2.3 Income characteristics

The *National Community Services Data Dictionary* Version 2 (NCSDD) data domain for *Sources of cash income* does not provide detailed codes for government pension types. Code 31 Australian Government Cash Transfers includes all pension types. According to the NCSDD, the ABS is currently developing an Australian Standard Classification of Sources of Cash Income, which will probably provide a more detailed classification of government pension types.

Within the scope of the programs included in this report, HACC and residential aged care data are the only programs that collect income information. This information is mapped in Table 2 (below). HACC specifies the main pension types under *Government pension benefit status*, whereas data available from the 2624 only distinguishes between Department of Veterans' Affairs (DVA) pensioners, other pensioners and self-funded retirees. However, the majority of 'other pensioners' will be receiving the aged pension, as the majority of people living in residential aged care are aged over 65.

In addition, the residential aged care form 'Helping you with your residential aged care fee' includes questions asking for the person's Centrelink and DVA number (where applicable), and permission for Centrelink and DVA to give information to the DoHA. This information is used by the Department to calculate the person's residential aged care fee.

The Resident Entry Record (question 5) and the Residential Aged Care Payment Claim form collect information on whether the person is a full-pensioner, a part-pensioner or a non-pensioner. DoHA uses this information to determine the provisional fee payable to the residential aged care facility in the short-term. Question 6 on the Resident Entry Record includes a field for the person's Centrelink number and a field for the person's Veterans' Affairs number, if applicable. If this information could be used in conjunction with information from question 5, the type and amount of pension could be derived from these questions.

Currently, questions 5 and 6 from the Resident Entry Record are loaded onto SPARC but are not loaded onto ACCMIS and are therefore not available for analysis. If both the pension type and status (full-, part-, and non-) of aged care residents is of policy interest, the loading

of these data would improve the information available about pensions received by aged care residents.

Recommendation 3: Income information on the Resident Entry Record

In the short-term, load data relating to questions 5 and 6 from the Resident Entry Record onto ACCMIS for the purposes of data analysis. Currently, data from the 2624 is used to provide information about the pensions status received by aged care residents (Centrelink/Veterans' Affairs or Self-funded retiree). The ACAP MDS Version 2.0 will be implemented from January 2003, and will replace client characteristics information currently reported on the 2624. The ACAP MDS Version 2.0 does not include information about client income, therefore data from the Resident Entry Record could be used to provide these information, including whether the person is a full-, part- or non-pensioner, and the type of pension they may receive (Centrelink or DVA).

There are no long-term modifications suggested in relation to income characteristics.

Table 2: Sources of income

NCSDD V2	Aged Care Application and Approval form	Resident entry record	Residential aged care fee form	Residential aged care payment claim form	HACC MDS (Guidelines Version 1.5)
Primary cash income Employee cash income Entrepreneurial cash income			Income from business partnership, farm or operating as a sole trader?		
Property cash income Interest Rent Dividends Other property cash income			Rental income from property you own or partly own?		
Cash transfers Australian government	Veterans' Affairs				Veterans' affairs pension
			DVA disability pension (yes/no)		
	Centrelink (DSS)		Social security payment (yes/no?)		
		Centrelink (Entitlement No.)			
		Veterans' Affairs (Entitlement No.)			
			Is the payment a blind pension?		
		Full pensioner		Full pensioner	
		Part pensioner		Part pensioner	
		Non-pensioner		Non-pensioner	
					Aged pension
					Disability support pension
					Carer payment
					Unemployment related benefits

Table 2 (continued): Sources of income

NCSDD V2	Aged Care Application and Approval form	Resident entry record	Residential aged care fee form	Residential aged care payment claim form	HACC MDS (Guidelines Version 1.5)
					Other government pension or benefit
					No government pension or benefit
Superannuation/ annuities	Self-funded retiree		Superannuation pension (yes/no)		
Transfers from overseas governments			Pension, allowance or other payment from overseas?		
Other income					
Nil income					

2.4 Informal support networks: Marital status, Living arrangements and carer arrangements

Marital status is available from 2624 data, but is not included in the ACAP MDS Version 2.0 or any other national data collections within the scope of this report, except for the Community Mental Health Care NMDS. Measuring the level of informal support available to people in the community (particularly older people) is an area of policy interest. However, a number of working groups in aged and community care data development have decided that information about a person's living and carer arrangements provides more relevant information about informal support networks than *Marital status*. For example, a person may be married and still living alone, and generally more vulnerable than someone who is not married and lives with others.

The Community Mental Health Care NMDS includes *Marital status* as there is a correlation between people that are divorced or separated, and the incidence of depression and other types of mental illness. In this case, *Marital status* is collected primarily for correlation with *Principal diagnosis* data.

In the AIHW's 2002 report *Entry Period into Residential Aged Care*, a method of multivariate analysis was used (linear regression) to find out the main determinants for entry period into residential aged care. The analysis showed that variables with the most substantial effect on entry period were system characteristics such as whether a person had used residential respite prior to admission, whether they had been assessed in hospital, and whether they had used a care package.

For low care residents, *Marital status* had a modest effect on entry period. Those who were widowed or married entered on average 3 to 12 days later than those who were not. For high care residents, both *Marital status* and *Living arrangements* had a modest effect on entry period. Those who lived with others had an entry period around 6 days longer than those who lived alone.

Once data on carer arrangements is available from Version 2.0 of the ACAP MDS, it will be of policy interest to examine whether the availability of a carer is a strong determinant of entry period. *Carer availability* and *Carer residency status* are included on the current version of the 2624, however these data are not entered onto SPARC and are therefore not available for data analysis. *Living arrangements, Carer availability* and *Carer residency status* are all included as reporting requirements for the ACAP MDS Version 2.0.

Recommendations related to data on informal support networks

No changes are recommended for the short-term. See Section 3 for suggested long-term modifications regarding questions on *Marital status*. No changes have been recommended in relation to questions on carer arrangements or *Living arrangements*.

2.5 Geographic location

The person's *Area of usual residence* (or Statistical Local Area (SLA)) is collected in the Admitted Patient NMDS and the Community Mental Health NMDS. *Suburb/town/locality name* and *Postcode* are collected in the ACAP MDS Version 2.0 (from 2003), CACP data

collection and the HACC MDS, which can be used to derive SLA. For statistical reports, these data have traditionally been output according to the Rural, Remote or Metropolitan Area (RRMA). More recently, the ABS has developed a new standard classification called the Australian Standard Geographical Classification Remoteness Structure (ABS 2001). The more detailed SLA codes would normally be used by government departments for planning and allocation purposes.

Currently, the person's *Area of usual residence* immediately prior to admission to residential aged care is not collected on any of the residential aged care data collection forms. The current version of the 2624 includes address information for where the person may be contacted at the time of their ACAT assessment, which may not be the same as their place of usual residence (the person may be staying with relatives, or in an extended care or inpatient setting at the time of their ACAT assessment). AIHW national statistical reports on clients in residential aged care have included the region of the aged care facility as a variable for analysis, rather than the person's area of residence prior to entry.

The *Area of usual residence* of the person at the time of their ACAT assessment will be available once data from Version 2.0 of the ACAP MDS becomes available. However, as noted in Section 2.2 regarding the person's *Accommodation setting*, this may not be the location the person was living in immediately prior to entry into residential aged care.

Recommendations related to data on geographic location of clients

No changes are recommended for the short-term. See Section 3 for long-term modifications suggested in relation to *Geographic location* data items.

2.6 Cultural and linguistic diversity

Country of birth is collected across all the national program data collections within the scope of this report. Within the residential aged care program, the ACAP MDS Version 2.0 and the current version of the 2624 are the only two primary data collection forms that include *Country of birth*. All of these collections, except for the 2624, specify the ABS 4-digit Standard Australian Classification of Countries (SACC) as the data domain. Draft versions of *Main language other than English spoken at home* and *Proficiency in spoken English* are also included in the ACAP MDS Version 2.0 and the CACP data collection, which, if retained, will allow for the analysis of potential disadvantage for different cultural groups, using the ABS methodology. However, these two data elements remain draft status, pending an investigation of an alternative methodology based on *Country of birth* data alone.

The Department of Immigration & Multicultural & Indigenous Affairs has developed a classification of the source countries of Australia's immigrants based on the English proficiency of recent arrivals between 1991 and 1996, using 1996 Census data. The use of English Proficiency (EP) groups allows for the measurement of social, cultural and economic disadvantage in Australia's multicultural society, based on *Country of birth* data. Thus, comparisons of EP groups' access to services will be comparable across residential aged care, HACC, CACP, Community Mental Health and Admitted Patients data.

Indigenous status is also collected consistently across ACAP MDS Version 2.0, the Admitted Patient NMDS, Community Mental Health NMDS, CACP data and HACC MDS. The current 2624 does not report Indigenous status using a method consistent with national standards (it does not allow for the separate reporting of Torres Strait Islander and Aboriginal status, and

does not include the standard question). However, no recommendations have been made to change this due to the fact that ACAP MDS Version 2.0 will be implemented in 2003.

Recommendations related to data on cultural and linguistic diversity

No changes are recommended for the short-term or long-term. See Appendix A for information on differences between the reporting of *Indigenous status*, *Country of birth* and language data according to current 2624 definitions and the ACAP MDS Version 2.0.

2.7 Insurance characteristics

The *National Health Data Dictionary* Version 10 (NHDD) data element *Funding source for hospital patients* is specific to a hospital setting, however some of the codes are also relevant to a residential aged care setting, and may apply as a funding source for aged care residents. These codes are:

- Worker's compensation
- Motor vehicle third party personal claim
- Other compensation (e.g. public liability, common law, medical negligence)
- Department of Veterans' Affairs

From the mapping in Table 4 below, the codes used in the Application for Classification form provide the most comprehensive information about the funding source for people in residential aged care. These codes are consistent with national standards.

Table 3: Insurance characteristics

NHDD	Admitted patient NMDS	Resident Entry Record	Application for classification	Payment Claim Form
Australian Health Care Agreements	Australian Health Care Agreements			
Private health insurance	Private health insurance			
Self-funded	Self-funded			
Worker's compensation	Worker's compensation	Workers' compensation	Worker's compensation settlement	Worker's compensation
Motor vehicle third party personal claim	Motor vehicle third party personal claim	Third party insurance	Third party insurance settlement	Third party insurance
Other compensation (e.g. public liability, common law, medical negligence)	Other compensation (e.g. public liability, common law, medical negligence)			
Department of Veterans' Affairs	Department of Veterans' Affairs		Veterans' Affairs pension	
Department of Defence	Department of Defence			
Correctional facility	Correctional facility			
Other hospital or public authority (contracted care)	Other hospital or public authority (contracted care)			
Reciprocal health care agreements (with other countries)	Reciprocal health care agreements (with other countries)			
Other	Other		Other forms of compensation	

Recommendations related to data on insurance characteristics

No changes are recommended for the short-term or long-term. See Appendix A, Insurance characteristics, for a more detailed mapping across the relevant programs.