PERIODICAL SURVEYS

NATIONAL INSURANCE INSTITUTE

Recipients of Long-Term Care Insurance Benefits in Israel

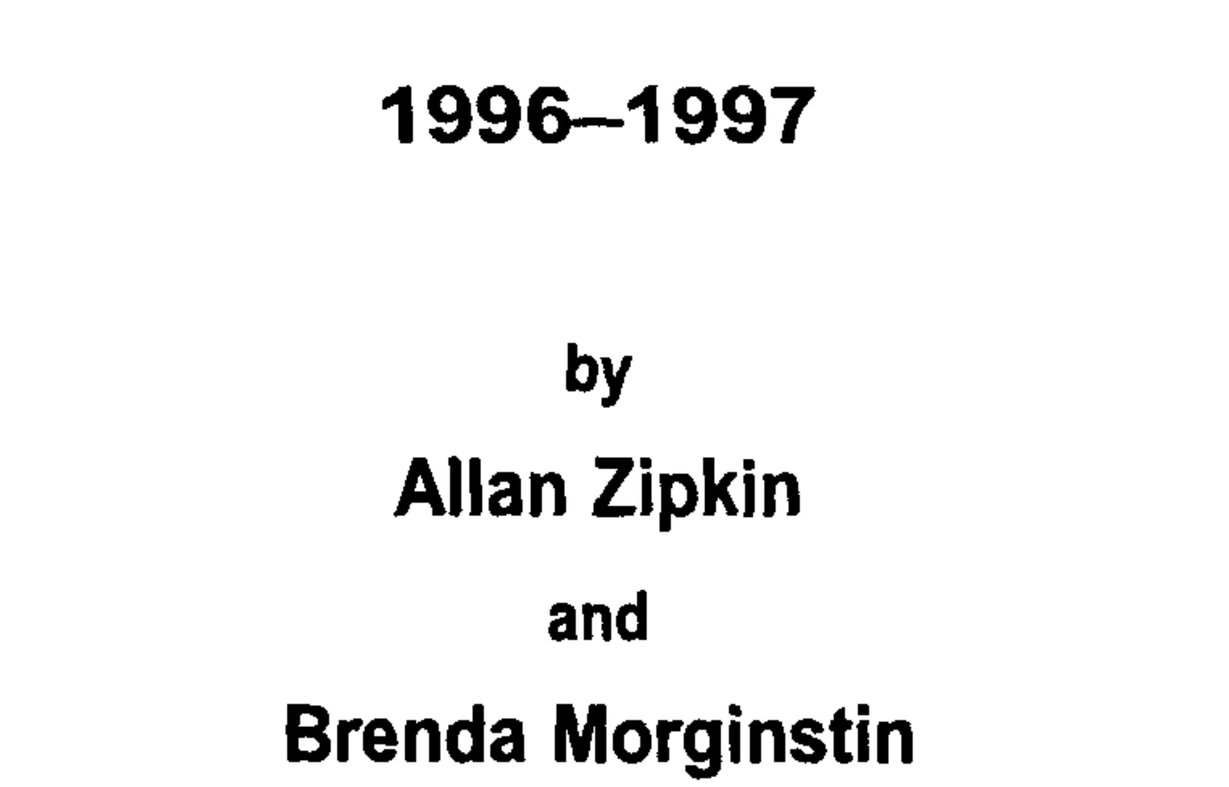
1996–1997

by

Allan Zipkin

and

Brenda Morginstin



No. 156

Jerusalem, July 1998

Research and Planning Administration

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Introduction and Background

This report is the second to appear in English providing descriptive data on the long-term care insurance (LTCI) program administered by the National Insurance Institute (NII). A previous report, issued in 1991, surveyed in some detail the principles of LTCI, as well as data from the first two years of the law's implementation. A short, general review of the principles of LTCI is presented here for the benefit of those who are unfamiliar with that previous report.

The LTCI Law, passed by Israel's parliament in 1980, became operative on the community level in April, 1988. Its set objectives are twofold: to maintain the elderly in their community settings for as long as feasible by approving personal care services to functionally dependent elderly, and to provide relief to the prime care-giver(s) of the elderly. Home-help services and personal care are provided on the basis of personal entitlement. For a relatively small but growing segment of the eligible population, day-care is provided (cf. below on services provided).

Eligibility requirements include the qualifying conditions of appropriate age (60 and over for women, 65 and over for men), permanent residency in the State of Israel, as well as dependency in the ability to perform activities of daily living (ADLs), living arrangements, and a relatively liberal income test. The dependency assessment which determines the level of eligibility is based on two primary components: the ability to perform activities of daily living and the need for constant personal attendance. This need is defined as the risk that the individual will, if left unsupervised, harm either himself or others. In addition, a determination is made in the case of an individual who lives alone whether there are any close family members resident in the vicinity of his home. The dependency test is administered by public health nurses from the Ministry of Health, contracted by the National Insurance Institute.

Two benefit levels exist for the long-term benefit, the lower level being equal to the basic disability benefit provided by the NII to a single person (25% of the national average wage) and the higher benefit level (equal to 37.5% of the national average wage). These levels are intended to provide, respectively, approximately 10

and 15 hours of weekly care. The benefits are given almost exclusively on an in-kind basis, with cash benefits being provided only to those eligible persons for whom services are unavailable. In these few cases, the benefit is provided at a rate of 80% of the relevant in-kind benefit level, the difference being attributed to the approximately 20% administrative costs of providing benefits in-kind.

Once eligibility is established by the NII, further responsibility is delegated to a local professional committee, comprised of representatives of the NII, the social welfare department of the local authority, and the nursing division of the major Sick Fund. The local committees have the role of assessing the needs of the beneficiaries, devising a care plan, and choosing the agency which will provide home care services. Services provided range from personal care, light food preparation, light cleaning, laundry, essential errands, personal alarm units and disposable undergarments. Day centers are a service option, and are generally substituted for personal care, while some beneficiaries receive a mix of both. Although funded by the NII, local committees act independently both in choosing service providers and formulating care plans. Contracting of services is limited to those providers who are approved by the Ministry of Labor and Social Affairs, and in practice those providers with a poor service record are less frequently selected. In most localities, local committees typically have a pool of from 20-30 provider companies to choose from. Exceptions are in certain rural areas, where availability is considerably more restricted.

Concerning the scope of this report, it furnishes descriptive data concerning the activities of the LTCI branch in calendar year 1996, ranging from applications submitted, eligibility determinations, and the characteristics of beneficiary population. Additionally, data for 1997 is provided, to the extent it is available. Included as well is information on services provided, and other activities of the LTCI branch beyond direct benefits. It is noted that special emphasis has been given in several of the analyses of the long-term care population to those who have immigrated to Israel since 1990 (also referred to in the report as *new* immigrants). While other sub- populations warrant separate analysis, this group is distinguished by several unparalleled factors. These include, firstly, a precipitous rise in their proportion from approximately zero in 1991 to almost fifteen per cent of all beneficiaries in 1996, matching their

proportion among the population of elderly in Israel, and secondly, a demographic profile dissimilar to the total population[1] .

[1] In the years 1990-1991 over 200,000 Jews from the former Soviet Union annually emigrated to Israel. By 1996, their total population exceeded 600,000, increasing the existing population by over 13%. Emergency regulations passed in 1992 helped alleviate the social and economic needs of these immigrants: its relevancy for the LTCI Act was the relaxation of the one-year residency requirement for eligibility.

Applications and Eligibility Rates

Stages of Assessment

Upon submission of an application, a dependency evaluation is carried out by a public health nurse in the home of the applicant. This stage generally takes no longer than two weeks, sometimes shorter, including the receipt of the evaluation by the local NII office, where eligibility is officially determined. For those eligible, the file is transferred to the local professional committee which both devises an individual care plan and chooses a service provider. The LTCI does not operate in a vacuum, and there are many elderly who are already receiving personal services by the time they submit an application. These services are usually arranged by the Sick Fund of the applicant, by the local welfare bureau, or by a private company in the expectation that the applicant will be found eligible and will choose that company as a provider of services under LTCI. None of the arrangements preceding a finding of eligibility are binding on the local professional committee and the committee reserves the professional independence to both revise the care plan and to change the service provider, if either or both of these are warranted. In practice, though, existing providers are generally retained. By law, services are to be provided to a beneficiary within sixty days of the first day of the month subsequent to submission of the application and on the average are provided 30 days following application. In special cases, when the applicant is critically ill, the above process are accelerated, and services can begin within several days.

Applications

For the year 1996, the number of applications totaled 48,626 (7.6% of the elderly population) or 4,052 per month. The annual number of applications has remained stable for the last several years, while the rate of re-application has shown a consistently steady rise. Table 1 presents the number of applications and approval rates for the last years 1988-1996, along with the re-application rate. The total number of applications in 1997 is estimated at about 51,000, with an approval rate of

about 52%, which has remained stable over time. The overwhelming reason most applications were rejected in 1996 was failure to evidence sufficient dependency – 91%, while another 8% were rejected on a preliminary eligibility basis, i.e. residency status or age. Only 1% were rejected on the basis of the means test; however, the low number of rejections due to income cannot be projected as representative of the entire population of potential applicants. A process of self-selection deters those who assume, rightly or wrongly, rejection on the basis of their income, and do not submit an application.

Table 1 - Applications, Re-applications, and Approval Rate, 1988-1997

Budget Year	Number of	Approval Rate (%)	Percent Re-applications
1988	14,019	56.8	8.8
1989	30,475	48.3	24.3
1990	27,734	47.3	30.0
1991*	24,766	46.4	33.3
1992	38,500	50.1	34.4
1993	43,741	48.8	35.7
1994	44,398	48.0	39.1
1995	47,560	50.6	39.6
1996	48,626	50.5	41.5
1997 (estimated)	51,000	52.0	45.0

* Nine months, from April-December 1991.

The LTCI law does not proscribe re-applications within a defined time frame, so as to accommodate situations of a sudden deterioration in functional ability. Perhaps partially on account of this lack of time restriction, the phenomenon of re-applications has grown over the years, to the extent that by 1996 it counted more than two out of every five applications (cf. Table 1). Of all applications received in

1996, 42.3% were from an individual who had already applied at least once before and was either rejected or had received a benefit which was halted. For 1997, the estimated rate of re-applications approaches half of the total applications – 45%. For most of those re-applying in 1996, this was their second application (57% of all multiple applications were the second one submitted), but a large group has applied more times than that. For some applicants – 9% of all re-applications – it was as much as their fifth or more application. Three factors may account for re-applications: a gradual deterioration in physical condition, acute episodes of disability or, for those just under the eligibility threshold, a desire for re-evaluation. The fact that no costs are incurred for the applicant probably contributes as well. Over the course of time the pattern might increasingly be application consequent to a spell of acute, time-limited needs, as well as, subsequently, for long-term care – for example, hospital discharge followed by rehabilitation and cessation of long-term care, subsequently followed after a period of time by the necessity again for long-term care services after a period of deterioration in functional ability. While not the original focus of the law, intended for the chronically disabled, this paradigm is clearly included within the program scope. This could well be a growing pattern in a maturing system which sanctions multiple applications, and which recognizes that elapsed time will reflect changing functional condition. In the aged population a great deal of dynamism is evidenced in individual needs. Little research has as yet been undertaken in the area of changing functional profiles over time for LTCI beneficiaries.

As for the re-application rate among new immigrants, it lags several years behind that of the veteran population, which is only natural given that for this group the LTCI program effectively started in 1990. It should be expected that, given previous experience, the two rates will continue heading towards convergence. By immigrant status, the reapplication rate for veterans in 1996 was 44.0% and for immigrants it was 29.8 %.

More significant, however, than the number of re-applications as a percent of the total, is the time interval between applications. These figures show considerable exercise of the right to reapply without minimum time constraints (see Table 2). About a third (33.5 %) of those who reapplied during 1996 had also applied within

the previous half-year and more than half (53%) within a year of their previous application. Overall, in 1996 the eligibility rate for these multiple applications was 70.8%. There is not much differentiation in the eligibility rate according to time interval between applications. Because approval rates of re-applications are so much higher than the overall rate of about 51% in 1996, the high number of re-applications seems to be justified.

Table 2 - Time Interval Between Re-applications, and Approval Rate, 1996

Re-applications	Time Interval Months					
	Total	0-3	4-6	7-12	13-24	25+
Percentage of Total	100.0%	18.7%	14.8%	19.8%	20.4%	26.2 %
Approval Rate	***70.8%***	***74.3%***	***71.4%***	***70.0%***	***69.0%***	***70.2%***

To further analyze the dynamics involved in multiple applications, ADL scores in the two periods were analyzed by length of the time interval between applications, here divided into only two intervals, up to six months and greater than six months. When the dependency assessment scores are compared between the last and the immediate previous application of those who reapply, there is a large and consequential increase in the score, regardless of the time interval. Those re-applying after half a year or more have results identical to those re-applying in less time, with respective average ADL scores of 2.57 and 2.56 (see Table 3). Both of these dependency scores are just above the eligibility threshold of an ADL score of 2.5 (excepting those in need of constant personal attention and those living totally alone). This indicates that on average most applicants do have some cause to re-apply, albeit insufficient in many cases to assure eligibility for benefits. It further attests to the difficulties in attempting to curb re-applications.

Table 3 - Time Interval between Applications and Change in Average Dependency Scores, Re-applicants, 1996

Time Interval from Previous Application	Application Period		Difference
	Latest Score	Previous Score	
Total	*2.56*	*0.93*	*1.63*
0-6 Months	2.56	0.90	1.66
Over half a year	2.57	0.94	1.62

Eligibility Criteria

Consequent to meeting the preliminary eligibility requirements of age, income, and residency, the dependency assessment determines the benefit level. It is comprised of the following:

- An ADL assessment;
- An assessment of the need for constant personal attendance;
- A determination if the applicant lives alone (without close family in the immediate vicinity).

Dependency assessments are carried out through a protocol by public health nurses, who administer all the assessments on a contractual basis. As part of the assessment, the nurse observes and records impressions of various aspects of the applicant's standard of living, including his appearance, his home, and the existing informal/formal support structures. The ADL assessment is in the following five areas: mobility, dressing, bathing, feeding, and continence. Scores are given in each area of disability ranging from total independence to total disability. Intermediate scores in each area reflect either the ability to perform an activity only when assisted and/or the need for prompting to perform the activity. This assessment has legal standing as the basis for eligibility determination and is subject to judicial review on appeal.

The second part of the assessment is the determination of the need for the constant presence of another individual in the home, in order to prevent the applicant from doing harm to himself or to others. This assessment takes into account the applicant's awareness of surroundings, his judgmental ability, memory and history of accidents. Risk factors include any history of exceptional behavioral incidents. Moreover, evidence is required of actual constant supervision by the family or hired attendants. A person assessed as requiring constant personal attendance (hereon, CPA) is automatically eligible for the higher benefit level. No score is assigned for a determination of a need for partial personal supervision in ADL areas, as this is incorporated in the scores of the ADL assessment as the need for prompting to perform an activity.

The third component in dependency assessment is a determination if the applicant lives alone, with no close relatives in the home or same apartment building. In such cases, two points are added to the dependency score, on condition that the cumulated score from the ADL assessment is at least 2.0. ADL scores may range from 0 to a maximum of 8.0 points. With a potential of 6.5 points for constant personal attendance, and another 2.0 points for living alone, the maximum obtainable total score is 16.5 points. To be eligible for the lower benefit level, a minimum of 2.5 points is required, while eligibility for the higher benefit level requires a total minimum score of 2.5 points. Table 4 summarizes the eligibility criteria by their scoring and benefit level. The weight of each component in determining eligibility is illustrated in Table 5, showing the distribution of the total number of people found newly eligible in the years 1994-96 by the various enabling criteria. For purposes of comparison, the distribution of new beneficiaries in the initial year of the program, 1988, is also presented.

Table 4 - Point Range Accredited for Eligibility Criteria and Benefit Level

Benefit Level	Criterion			
	ADL Score	Need for CPA	Living Alone*	Total Score
Lower Benefit	**0.0-6.0**	**0.0**	**2.0**	**2.5-6.0**
Higher Benefit	**6.5+**	**6.5**	**2.0**	**6.5+**

* Conditional on the accumulation of at least 2 points by either of the other criteria.

Table 5 - Eligibility Determination by Qualifying Criteria, New Beneficiaries, 1994-1996

Year	Total Eligible During Year	Received At Least 2.5 Pts, ADL	Received 2.0 Pts in ADL, Lives Alone	In Need of Constant Personal Attendance*
1988	20,966	75%	7%	18%
1994	23,933	83%	10%	7%
1995	25,645	83%	10%	7%
1996	26,024	83%	10%	8%

Note: totals may not add up to 100% due to rounding.

* Includes all beneficiaries who scored 6.5 in CPA, whether or not points in ADL were received.

For the last few years, the ADL component of the dependency test as the determinant of eligibility has been consistently about 83% of those newly eligible, with the rate of those found in need of constant personal attendance among the newly eligible being a constant 7-8%.

Distribution of Dependency Test Scores

Table 6 shows the distribution of scores of applications submitted in 1996 for the ADL dependency test and total points accumulated. Total scores include the need for constant personal attendance and points for living alone, when applicable. Score distributions for applications submitted by new immigrants and veterans are presented separately in Table 7. Several points about the distribution of scores are worth noting. Firstly, there is a very large population, 21.8%, which has a zero score, that is there are no disabilities and no need for constant personal attendance. Another 10% scores only 0.5%. This indicates an inefficient self-selection process and a large proportion of what are probably unwarranted applications, perhaps based on lack of basic knowledge of eligibility criteria on the part of applicants or professionals who referred them. Altogether, 48.5% of the applicants were ineligible, having a total score less than 2.5 points. Secondly, there is a large clustering around the ADL score of 2.5 points, that is the primary eligibility threshold (see Figure 1). This would seem to indicate a tendency to "slide" applicants into eligibility.

Figure 1
Distribution of ADL Score
Applications Submitted in 1996

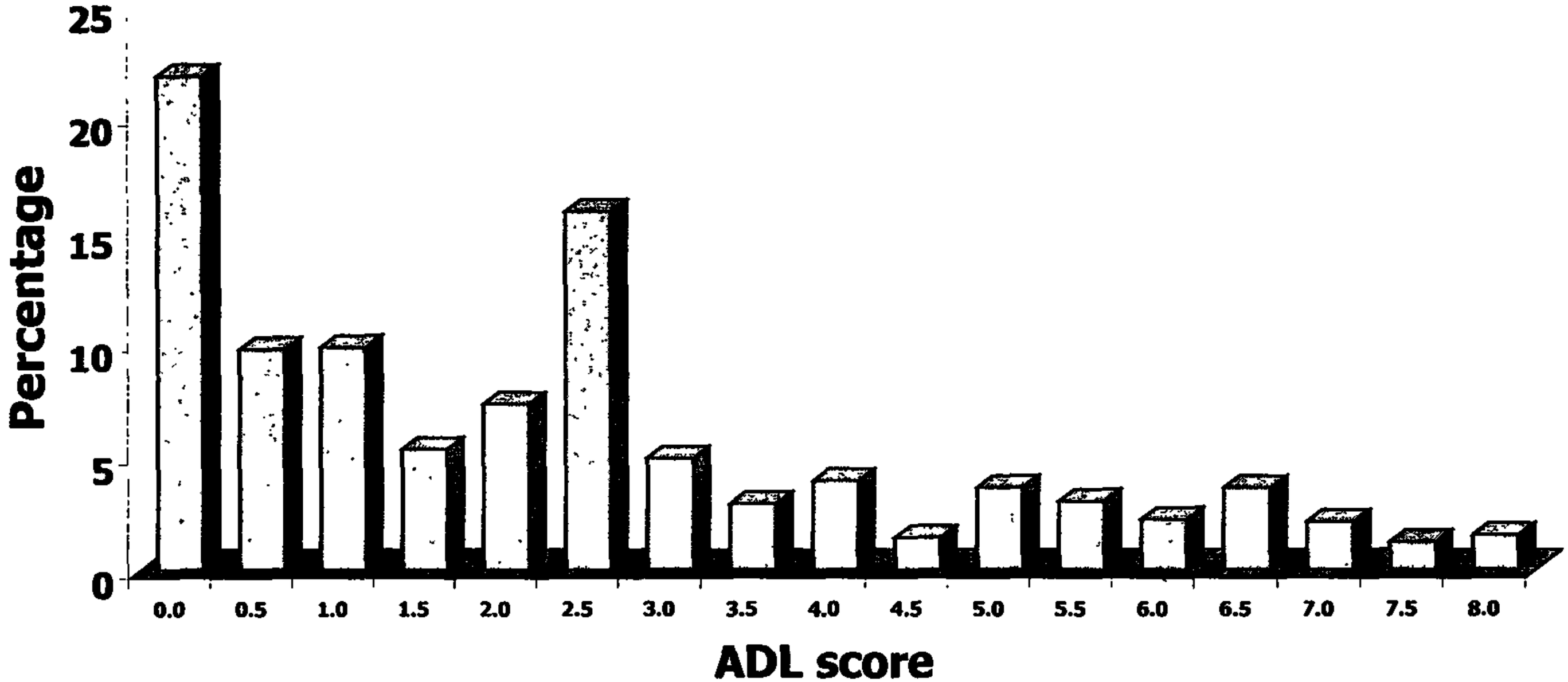


Table 6 - Distribution of Dependency Scores of Applications, 1996

Score	ADL Only	Total Score *
Number of Applications	48,626	48,626
Percent	100.0	100.0
0.0	21.8	21.8
0.5-1.5	24.8	24.4
2.0	7.3	2.3
2.5	***15.8***	***10.9***
3.0-4.0	11.6	13.5
4.5-5.5	8.0	10.8
6.0	2.2	1.9
6.5	***3.6***	***3.5***
7.0+	4.8	11.0

* Includes scoring for individuals reported living alone and in need of constant personal attendance. Included are those applicants who died during the year.
Percentages italicized in bold type are the threshold of an eligibility level.

Table 7 shows the distribution of ADL and total scores by immigrant status. While the general patterns for each population group are similar, there are some striking differences. The proportion of immigrant applications for which there were no disabilities, i.e. a zero ADL score, is considerably lower than that among veteran applicants, 14.3% versus 23.4%. Again, as in the entire population, there is a clustering among both groups at the 2.5 ADL score level, being slightly more prominent among immigrants than veterans. Lastly, while the proportion of immigrants scoring above 4.0 points on the ADL test is higher than among veterans (22.6 % versus 17.8 %), this difference disappears in a comparison of total scores of over 4.0 points (27.5% and 27.1%). This balance reflects the greater likelihood of veterans to qualify for constant personal attendance than immigrants.

Table 7 - Distribution of Dependency Scores among Applicants By Immigrant Status, 1996

Score	Immigrants*		Veterans	
	ADL Only	Total Score**	ADL Only	Total Score**
Number of Applicants	8,461	8,462	40,164	40,164
Percent	100.0	100.0	100.0	100.0
0.0	14.3	14.3	23.4	23.4
0.5-1.5	25.7	25.4	24.6	24.2
2.0	5.5	3.4	7.7	2.0
2.5	***17.5***	***14.7***	***15.4***	***10.1***
3.0-4.0	14.4	14.7	11.0	13.2
4.5-5.5	9.1	10.7	7.8	10.8
6.0	3.1	2.9	2.0	1.6
6.5	***4.2***	***4.1***	***3.5***	***3.4***
7.0+	6.2	9.8	4.5	11.3

* Immigrated after December 31, 1989.

** Includes scoring for individuals reported living alone and for constant personal attendance. Percentages in bold italics are threshold scores for the two benefit levels.

Number and Type of ADL Disabilities

The ADL test measures five areas of disability: bathing, dressing, mobility, eating, and incontinence. An examination of the scores in each item for all applicants in 1996 (see Table 8) shows that the least frequent area of disability is mobility (only 25% needed at least some assistance), while the most frequent area is a need for help in washing (76%). A score of half a point in a disability signifies either the need for prompting the elderly to perform the activity or some mild physical assistance to perform the activity, while a score of one point or more was considered a severe disability, requiring a great deal of or full assistance to perform the activity.

Table 8 - Distribution of Scores for Individual ADL Disabilities, 1996
All Applicants

ADL Item	Score (Percentage)					
	Total	0	0.5	1.0	1.5	2.0+
Bathing/ showering	100	23.4	22.2	40.3	14.1	-
Dressing	100	34.7	14.5	50.8	-	-
Mobility	100	74.6	17.1	8.3	-	-
Eating	100	42.3	49.5	8.1	-	-
Incontinence	100	65.4	7.6	8.0	-	19.0

The analysis of the assessment scores for 1996 closely matches that of previous research from 1992, while noting that the former study showed both the presence of slightly more disabilities per individual, as well as a slightly higher average severity for each disability[2]. While in most ADL assessments the number of disabilities is considered a close reflection of needs, our research has emphasized the significance of the severity of the disability as well in establishing eligibility. Among applicants who had any level of disability in mobility, 98% were found to be eligible (at any benefit level). At the other extreme, a disability in bathing was a poor predictor of eligibility – only 67% of applicants with any bathing disability were found eligible. Such data suggest the possibility for developing a hierarchical order in administering the ADL test, with a savings both to the applicant in unnecessary intrusions into privacy, and to the system in administrative costs. The adoption of a hierarchical screening instrument might be more efficient in establishing dependency levels, particularly in those cases of high-level needs.

[2] For example, in the 1992 study 81% of the population had a disability in bathing, see ***Dependency Assessment under Long-Term Care Insurance***, Sarit Baich-Moray, Allan Zipkin, and Brenda Morginstin, Israel National Insurance Institute, 1993.

Eligibility Reassessment

Reassessments of eligibility status is performed in one of either two circumstances:

- At the initiative of the Long-Term Care Insurance Branch, either due to the conditional nature of the eligibility, or because of new information received indicating some change in eligibility status.
- At the initiative of the applicant, in order to increase his/her eligibility level.

10,600 reassessments were performed in 1996, the vast majority (75%) of which were at the initiative of the applicant. Results of these reassessments were as follows:

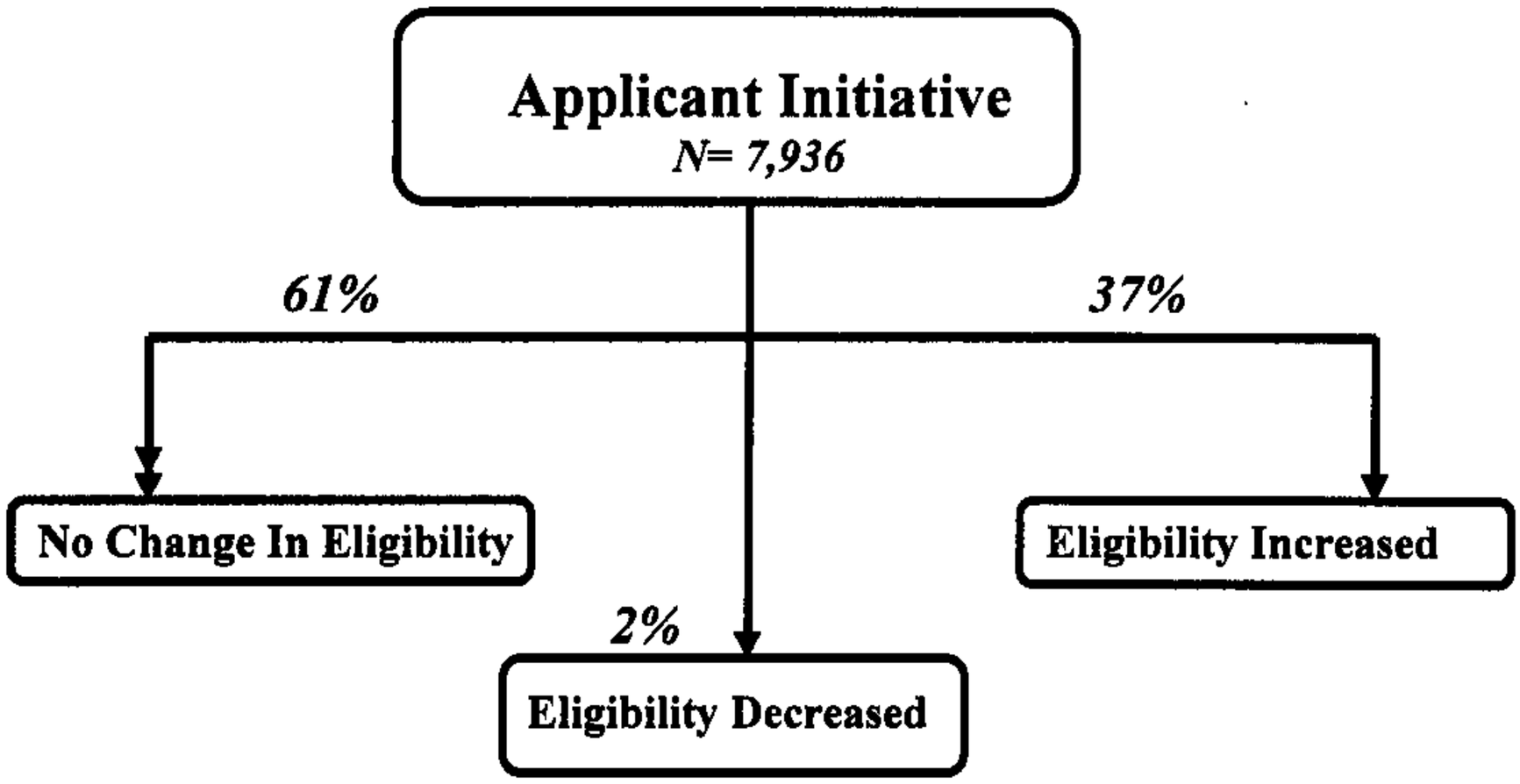
- 6,200 (59%) had no change in their eligibility, whether the previous level was at the high or low benefit level.
- 3,113 (29%) had their benefits increased, from the lower to higher benefit.
- 1,222 (12%) had their benefits decreased, whether from the higher to the lower level, or a finding of ineligibility (1,076 cases).

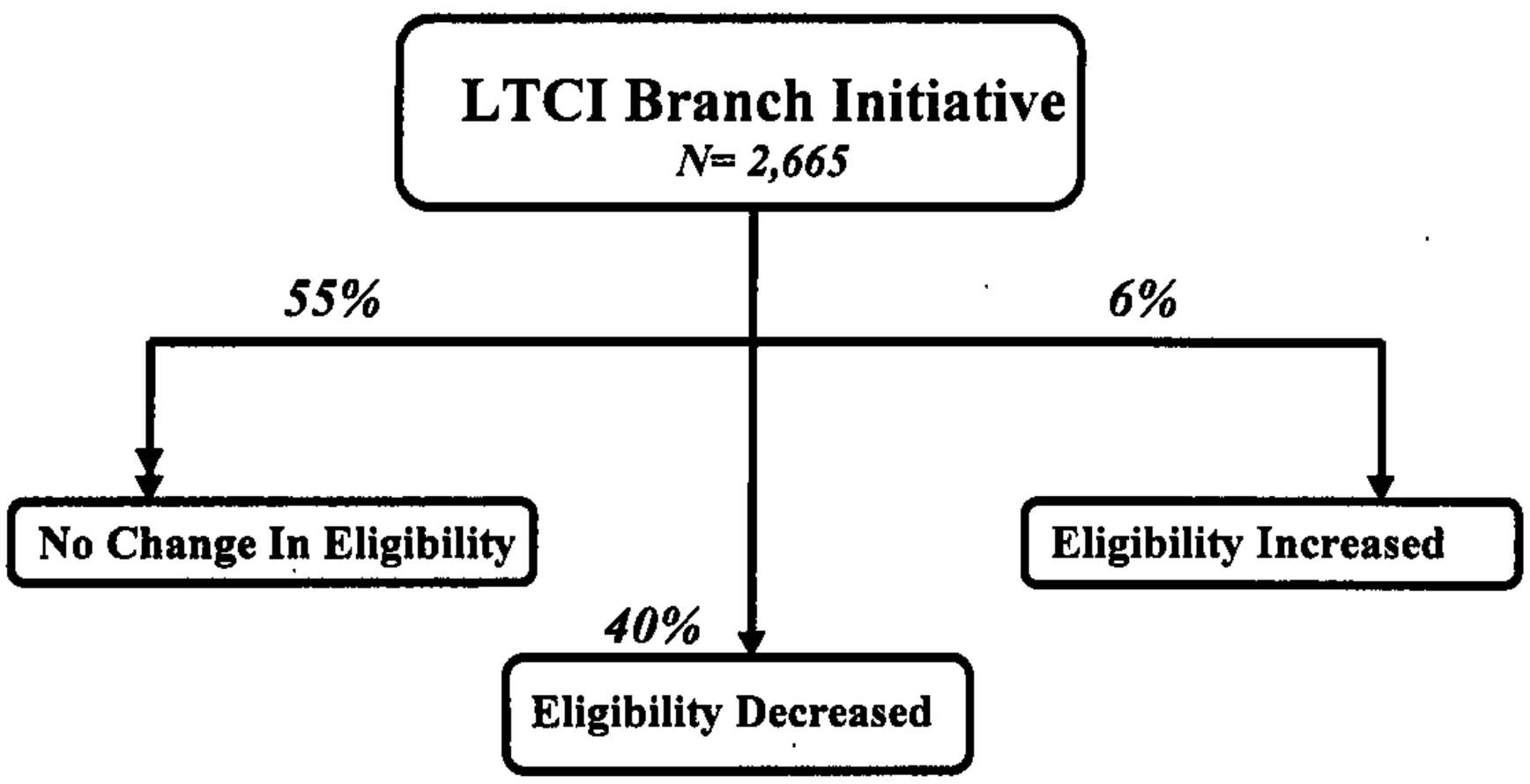
Analyzing the reassessment by initiating source highlighted contrasting results. The proportion of those cases whose benefit level remained unchanged was similar, whether the initiator was the LTCI Branch (55%) or the applicant (61%). Among applicant-initiated reassessments, however, 37% had their benefits increased (from the lower to higher level), and only 2% had their benefits decreased (of whom 96% were found ineligible). Among reassessments initiated by the LTCI Branch, in contrast, only 6% had their benefits increased, while 40% had their benefits decreased: of these, 87% were found ineligible. In other words, about two of every five dependency reassessments initiated by the LTCI Branch resulted in a denial of benefits.

Figure 2

Dependency Reassessments by Initiating Source

1996





Beneficiaries

Growth in the Number of Beneficiaries

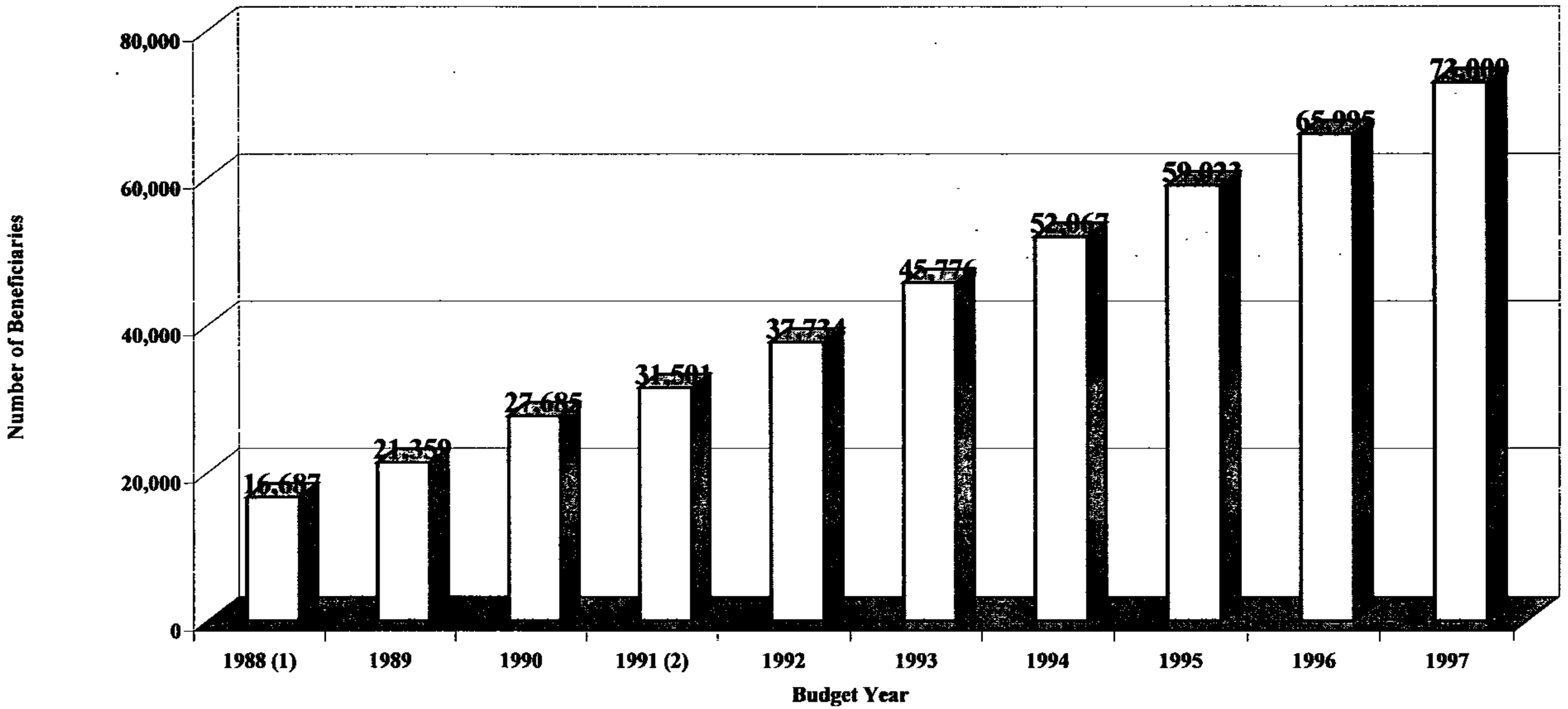
The growth rate in the number of beneficiaries of long-term care has far exceeded both that of the elderly population overall (women aged 60 and over, men aged 65 and over), and that of the population of those 80 years of age and older in particular. During the period 1990-1996 the total population of elderly in Israel has increased at an annual average rate of 4.0%, while in the same period the population aged 80 and over experienced an annual rate of increase of 7.1%. Neither of these rates approaches the annual increase in number of beneficiaries during the same period – 15.6%. That is, in the period 1990-1996, the number of LTCI beneficiaries increased at a rate approaching four times that of the rate of increase of the general elderly population in Israel. Were it not for the impact of the immigrants, especially in 1992 and 1994, the rate of increase in the period 1990-1996 would have been a smaller, yet still considerable, 12.3 % per annum. It should be noted that the lower rate of increase in 1995-1997 – approximately 10% – reflects lower immigration numbers in those years. Because the average age of the beneficiary population is approximately 80, the expected high rate of increase of the over 80 population portends continued high growth of the beneficiary population. Figure 3 shows the increase in the average annual number of beneficiaries during the years 1988-1996, as well as an estimate for the number of beneficiaries in 1997.

Table 9 - Number of Long-Term Care Beneficiaries, by Period of Immigration Monthly Average, 1988-1997

Year	Total	Immigrated Prior to 1990	Immigrated from 1990	Recent Immigrants as Percent of Total
1988 *	16,687	16,687	-	-
1989	21,359	21,359	-	-
1990	27,685	27,685	-	-
1991 **	31,501	31,270	231	**0.7 %**
1992	37,734	36,277	1,457	**3.9 %**
1993	45,776	42,220	3,556	**7.8 %**
1994	52,067	46,506	5,561	**10.7 %**
1995	59,023	51,691	7,332	**12.4 %**
1996	65,995	56,678	9,317	**14.1 %**
1997	73,000	61,353	11,647	**16.0 %**

* End of fiscal year 1988-March 1989.
** Fiscal year was April-December, 1991.

Figure 3
Number of LTCI Beneficiaries
Monthly Average, Years 1988-1997



1 End of fiscal year 1988-March 1989.
2 Fiscal year was April-December, 1991.

Coverage

In 1996 on a monthly average, more than a tenth of the relevant, potentially eligible elderly population (males aged 65 and over, females aged 60 and over) received the NII long-term care benefit . This coverage rate has risen steadily and appreciably since the initial years of the program's implementation, 1988-1990, when coverage was in the range of 4-5% of the elderly population. The rapid increase in the population aged 80 and over, of course, accounts substantially for this rise. Of even greater significance is that this coverage rate does not appear to have peaked yet, and has continued to rise steadily from 4.4 % in 1989, reaching 10.3 % in 1996 (see Table 10).

Table 10 - LTCI Coverage Rates in Selected Years, 1989-1996

Year	1989	1992	1993	1994	1995	1996
Averege Number of Beneficiaries (000)	21.4	37.7	45.8	52.1	59.0	66.0
Population (000)*	487.7	570.3	588.9	606.5	624.0	641.4
Percent Receiving Long-Term Care	***4.4 %***	***6.6 %***	***7.8 %***	***8.6 %***	***9.5%***	***10.3 %***

* Women aged 60 and over, men aged 65 and over; includes elderly living at home and in institutions.
Source: *Central Bureau of Statistics Annual Reports, 1989-1997.*

For the data of beneficiary coverage by age group and sex, Table 11 and Figure 4 show the coverage rate for each group as a proportion of the number of individuals in that particular population group. As mentioned, 10.3% of the elderly population on a monthly average were eligible for LTCI in 1996. Rates among women are substantially higher than among men in each age group: overall they are 11.6% and 7.9%, respectively. In the lowest age group for both sexes, the rates are relatively

low: for the 65-69 age group the coverage rates for men and women are 1.2% and 4.8%, respectively. For the highest age group, 85 and over, the rates are 47.7% for women and 34.3% for men. Excluding the elderly in institutions, the rate of community coverage is even higher, as this group is generally not eligible for long-term care (excepting a small number of disabled elderly living in independent housing). Recently published data from the United States show much lower limitation rates among elderly living in the community, but similar patterns with regard to the correlation of age and gender with ADL limitations[3]: for example, while 1989 data show 12.8 % of the community elderly aged 65 and over with any ADL limitation, females had a rate 60% higher than males (15% versus 9.4%). These U.S. rates – 14.9% of females and 7.9% of males – are not very different from the relevant Israeli figures of the proportions of LTCI beneficiaries of the population aged 65 and over.

However, taking into account the elderly population in Israel with any ADL limitation substantially raises the rate of ADL limitation from 10.3% to approximately 13.8%. This latter rate is a projection based on the inclusion of 1996 applicants with any level of disability. It should be considered an underestimate of those with any disability, since there are elderly who refrain from applying in the expectation of being denied benefits, primarily because of income.

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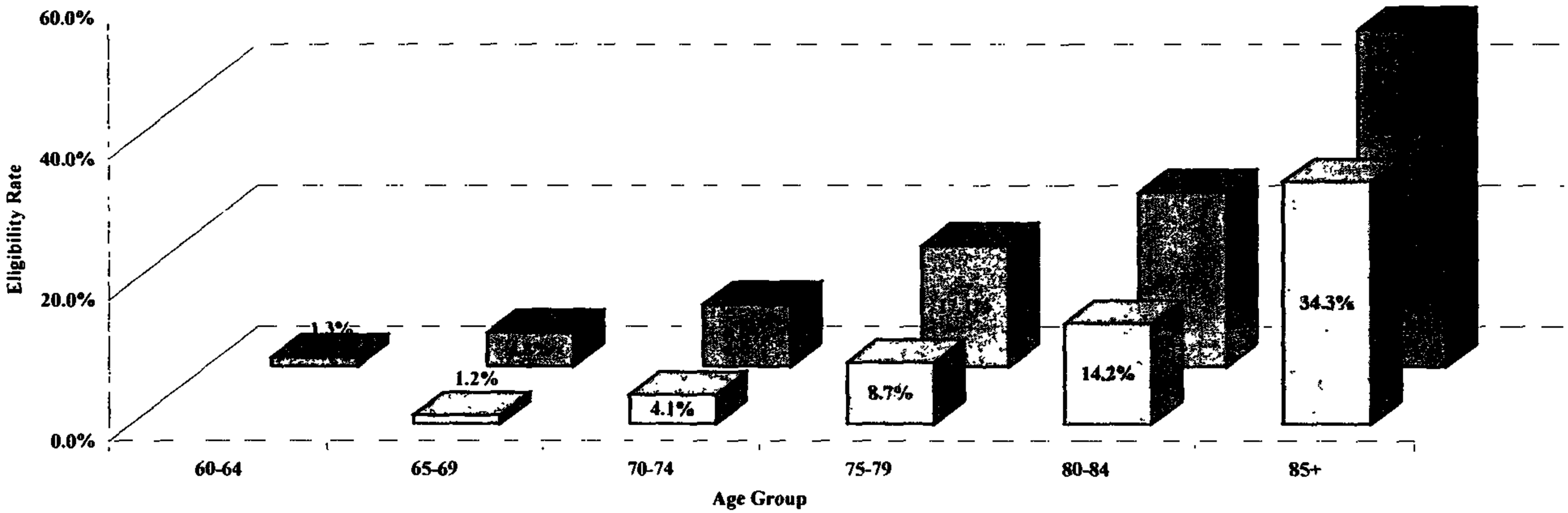
[3] ***Limitations in Activities of Daily Living Among the Elderly***, National Aging Information Center, Washington, 1996.

Table 11 - Eligibility Rates for Long-Term Care, by Age and Sex, 1996

Age Group and Sex	Total Population*	Average Number of Recipients	
		Number	Percent of Total Population
Total	641,000	65,955	10.3
Percentage	*100.0*	*100.0*	
60-64	15.3	1.9	1.3
65-69	26.6	8.3	3.2
70-74	23.9	15.9	6.8
75-79	15.1	19.8	13.5
80-84	11.4	22.6	20.5
85+	7.7	31.4	42.1
Males - Total	232,700	18,434	7.9
Percentage	*100.0*	*100.0*	
65-69	32.6	4.9	1.2
70-74	27.8	14.3	4.1
75-79	18.1	19.8	8.7
80-84	12.7	22.8	14.2
85+	8.8	38.2	34.3
Females - Total	408,700	47,521	11.6
Percentage	*100.0*	*100.0*	
60-64	24.0	2.7	1.3
65-69	23.1	9.6	4.8
70-74	21.8	16.5	8.8
75-79	13.5	19.8	17.1
80-84	10.6	22.6	24.7
85+	7.0	28.8	47.7

* Includes institutionalized and non-institutionalized individuals, men aged 65+ and women aged 60+.

Figure 4
Eligibility Rates by Age and Sex - 1996



Characteristics of Beneficiaries

Benefit Level

In 1996 on the monthly average, 78.1% of all beneficiaries were eligible for the standard, lower benefit rate (including those whose benefit was halved due to incomes testing), while 21.9% were eligible for the higher benefit rate. For 1996 the lower and higher benefit levels were valued at approximately U.S. $370 and $555 monthly, respectively. Figure 5 illustrates the higher proportion eligible for the higher benefit at the program's inception, 28.3%, with a gradual decline to 21.2% in 1994, and subsequently rising very moderately in the last three years, 1995-97. This slight rise in those receiving the higher benefit is most likely due to the aging of the recipient population: in 1989, for example, 27% of all beneficiaries were aged 85 and over. By 1996, this proportion had risen to over 31% among the veteran population. Were it not for the lower rate at which new immigrants required constant personal attendance, in spite of their greater percentage aged 85 and over (cf. below), the proportion receiving the higher benefit would surpass what it currently is.

By immigrant status, veterans are slightly more dependent in ADL than new immigrants: 23% of the former group are eligible for the increased benefit (including 1% at the income-reduced benefit), versus 19.1% of the latter group (see Table 12). This effect has moderated what otherwise appears to be a trend in the increasing proportion of beneficiaries at the higher benefit level.

Figure 5
Beneficiaries by Eligibility Level
Years 1988 - 1997

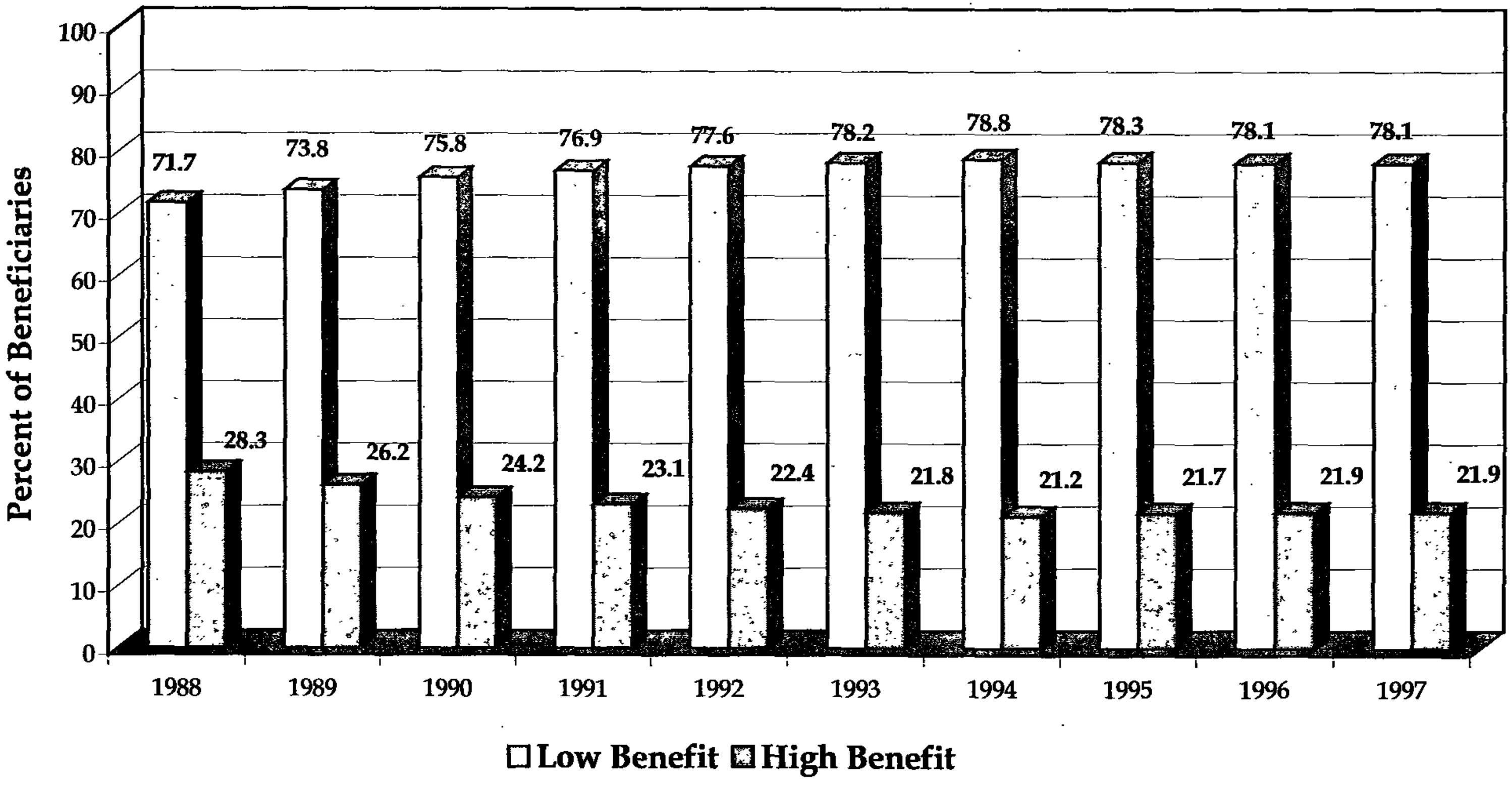


Table 12 - Distribution of Recipients by Benefit Level* and Veteran Status in Israel, December , 1996 (*Percentage*)

Veteran Status	*N*	Total	Benefit Level			
			Reduced Lower	Reduced Higher	Lower	Higher
Total	***69,839***	100%	2.0%	0.9%	75.5%	21.6%
Immigrants**	***10,430***	100%	0.2%	0.1%	80.7%	19.0%
Veterans	***59,409***	100%	2.3%	1.0%	74.6%	22.0%

* The lower benefit level is the reference level, set at 25% of the average wage. Benefits are reduced by half as a result of incomes testing. The higher benefit is 37.5% of the average wage.

** Arrived in Israel after December 31, 1989.

Immigrant Status

Presented in Table 13 is the demographic profile of LTCI beneficiaries at the end of 1996, with a separate analysis of new immigrants. By gender, females outnumber males by a 3 to 1 margin, with no differences by immigrant status. By age, more than a quarter are over 85 years, with about a half of the total aged 80 or greater. The new immigrant group has proportionately slightly more people aged 85 and over than veterans, but there is no significant difference in the median age of the two groups. By living arrangements, only two in every five (41.2%) beneficiaries live with a spouse, almost one in two (46.6%) lives alone, and one in eight (12.2%) lives with someone other than a spouse – usually a child. Among immigrants, a far smaller proportion lives with a spouse, only 32%, and a much larger proportion lives with someone other than a spouse – 31.4%. This pattern of living arrangements among new immigrants may be due to a higher proportion living in situations of economic duress as well as cultural factors.

Table 13 - Demographic Characteristics of Long-Term Care Beneficiaries, December 1996

Demographic Characteristic	Total	Veterans	Immigrants
Population Size	69,839	59,409	10,430
Sex			
Total	100.0%	100.0%	100.0%
Females	72.3%	72.3%	72.6%
Males	27.7%	27.7%	27.4%
Age Group			
Total	100.0%	100.0%	100.0%
60-64	3.2%	3.3%	2.7%
65-69	9.9%	9.8%	10.3%
70-74	17.5%	17.3%	18.5%
75-79	19.7%	20.1%	17.6%
80-84	23.4%	23.5%	22.7%
85+	26.4%	26.0%	28.3%
Median	*79*	*79*	*80*
Family Composition			
Total	100.0%	100.0%	100.0%
Alone	45.1%	46.6%	36.8%
Married	39.8%	41.2%	31.9%
With children or others	15.1%	12.2%	31.4%

Seniority

Of the almost 70,000 beneficiaries by the end of 1996, more than a third (35%) had been receiving benefits less than a year, while about 10% have received the long-term care benefit for 5 years or more. Among veterans, about 13% have received benefits for over 5 years. A proviso is noted that seniority is calculated here as the number of years since eligibility was first established, and includes interim periods when the beneficiary may have been temporarily considered ineligible for a variety of reasons (hospitalization, reclassification, etc.). Only 1.4% of the present group of beneficiaries have been receiving a benefit since the initial year of the program in 1988. Table 14 shows the distribution of seniority of the beneficiaries, by immigrant status.

Table 14 - Distribution of Beneficiaries by Seniority (Percentage)
December 1996

Year First Eligible	Total	Veterans	Immigrants
Total - Number	*69,839*	*59,409*	*10,430*
Total - Percentage	100.0	100.0	100.0
1996	35.0	33.6	42.9
1995	21.5	21.1	23.6
1994	14.9	14.9	15.3
1993	10.8	10.7	11.2
1992	6.9	7.1	5.8
1991	3.8	4.3	1.2
1990 and before	7.1	8.3	0

* Seniority data for immigrants should not be compared to those of veterans, since number of years in the system is related to year of immigration. The more "valid" seniority data are those for veterans.

Need for Constant Personal Attendance – Demographic Characteristics

As noted above, the proportion of those in need of constant personal attendance (CPA) as determined in the dependency test declined sharply from the initial year of implementation (1988) when it was 18% of all beneficiaries receiving that year. For the years 1994-1996 it has consistently been in the range of 7-8% of the newly eligible population of each year. Table 15 presents the coverage rates of CPA for demographic characteristics in the December 1996 population of beneficiaries, by immigrant status. Overall, of a total of 69,839 beneficiaries in that month, 7% of them were in need of CPA. Males had a greater propensity to be in need of CPA than females, 8.2% to 6.5%. By family composition, married beneficiaries had a greater need of CPA than those living without a spouse, and this is correlated with gender: a much higher percentage of males lived with spouses than do females. By age, while need for CPA did generally go up as age increased, the relationship did not appear to be a linear one. For the oldest group, those aged 85 and above, the proportion actually declined from that of the next younger age group (80-84), from 7.7% to 7.4%. This pattern is particularly pronounced among men.

Analyzed by immigrant status, there is considerable differentiation in the rates for the need of CPA: 7.4% of veterans and only 4.7% of the new immigrants. Among new immigrants, for example, the proportions of those in need of CPA by gender are very similar, 4.4% for females and 5.6% for males, whereas among veterans they are 6.9% and 8.7%, correspondingly. These differences in proportions are not explained by age structure, as every age group shows this considerable variation. About one in twenty new immigrants who receive long-term care are in need of constant personal attendance, within the range by age group between 4.0%-5.3%. Among veterans, this range is wider, between 5.4% - 8.3%. This phenomenon suggests more homogeneity in dependency among new immigrants than among veterans, perhaps the result of the lower likelihood of cognitively impaired elderly to immigrate. As a result, immigrants have significantly different cognitive impairment rates than the veteran population.

Table 15 - Percent Beneficiaries in Need of Constant Personal Attendance, by Immigrant Status and Demographic Characteristics, December 1996

Demographic Characteristic	Total	Veterans	New Immigrants
Total	**7.0**	**7.4**	**4.7**
Age Group			
60-64	5.4	5.4	4.0
65-69	5.8	5.9	4.5
70-74	6.2	6.4	4.2
75-79	7.8	8.3	4.9
80-84	7.7	8.2	5.3
85+	7.4	8.2	4.7
Females	6.5	6.9	4.4
60-64	5.4	6.5	4.0
65-69	5.0	5.1	3.2
70-74	5.7	5.9	4.1
75	7.4	7.9	4.3
80-84	7.2	7.7	4.9
85+	7.3	8.1	4.9
Males	8.2	8.7	5.6
65-69	8.2	8.4	7.0
70-74	7.7	8.1	4.5
75-79	9.0	9.4	6.4
80-84	8.8	9.2	6.3
85+	7.5	8.3	4.1
Family Composition-Total			
Married	8.0	8.5	4.7
Alone	6.3	6.6	4.0
With children or others	6.2	6.6	5.7
Females	6.5	6.9	4.4
Married	7.3	7.7	3.6
Alone	6.3	6.5	4.0
With children or others	6.1	6.5	5.5
Males	8.2	8.7	5.6
Married	9.0	9.5	5.8
Alone	6.7	7.1	4.2
With children or other	6.9	7.3	6.6

Payment Mode

In-kind services are virtually the only method of benefit provision. In 1996, an average of ninety-eight percent of all those eligible to receive services received them either in their home or in a day center. A negligible number, 73 out of a monthly average of 65,995, received cash benefits due to the unavailability of a service provider. A relatively large group of elderly, 1,311 or 2% of the total, refused to accept the services for which they were eligible. This is in spite of having had a care plan drawn up for the individual by a social worker, after discussions with the beneficiary and his/her family. When an individual persists in refusing the services offered, a brief report is submitted to the local committee coordinator, explaining the circumstances and reasons for refusal. Those who refuse services are on average functionally relatively better off than those who actively receive services and this may affect their decision to refuse. In the summer of 1996 a study was undertaken by the Counseling Service for the Elderly and Pensioners of all those who had refused to receive services, examining such issues as alternate sources of home care, the role of the family in determining refusal to accept services from the NII, and the reasons for refusal[4]. Volunteers from the Counseling Service conducted the interviews. At the time, the names of 930 elderly were listed as refusing services: of these, only 566 were found at home by the volunteer/interviewer. Many of these had moved to a residential setting. Results of the study were very helpful in understanding why services were refused. Firstly, the information and support of the volunteer/interviewer led to a sizable number (39%) of those previous refusing NII long-term care to change their mind subsequent to the volunteer's visit, and to decide to accept services. From past experience, many of these would have changed their mind in any case, but the visit/interview accelerated this process. Of the 61% remaining elderly, a majority (55%) indicated that they were not in immediate need of services, or that they were receiving help from another source. A large group, 29%, indicated that their objection was due to a stranger taking care of them. Only a small minority (6%) cited their preference for a cash benefit as their reason for refusal. These results contradict somewhat a previous NII study conducting shortly

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[4] "Agency Initiated Home Visits for the Aged Who Refuse Nursing Assistance", Givoli, Z. and Sharon, V. ,**Surveys and Reviews in Gerontology,** Israel Gerontological Society, No. 103, Summer

preference for a cash benefit as their reason for refusal. These results contradict somewhat a previous NII study conducting shortly subsequent to refusal of services, indicating that the primary reasons for refusal were the preference for a cash benefit and the lack of receptivity to strangers as home care helpers. The difference between the two studies is most likely to be explained by the expansion of the reasons for refusal in the second study: a large proportion of those in the earlier study who refused because they wanted a cash benefit instead of services also claimed that their physical condition had improved to the extent that they no longer had a need for personal services.

Service Provision

By locus of service delivery in October 1996, the overwhelming majority of beneficiaries received personal care services in their home (see Table 16). A significant proportion attended day centers, 8%. The increasing popularity and availability of this service is reflected in the growth of beneficiaries attending day centers from 1,600 in 1991 to 4,855 in 1996. There remains an uneven geographical distribution in areas of the country served by day centers, and the remedying of this situation has been one of the continuing foci of the Fund for the Development of Long-Term Services (cf. below), administered by the NII Branch for Long-Term Care. Disposable undergarments were received by 7% of all beneficiaries, with 1% receiving laundry services. Many elderly, of course, receive multiple services. As in previous years, the personal alarm unit has become an increasingly popular service, and 13% of all beneficiaries had one as of October 1996.

Table 16 - Beneficiaries by Type of Service, Average Hours and Cost of Care October 1996 (N 61,706)

Service Provided *	Number of Recipients	Percent of Total
Personal Care	58,689	95%
Day Center	4,855	7.9%
Disposable Undergarments	4,569	7.4%
Distress Alarms	8,204	13.3%
Laundry, other	618	1%

* Beneficiaries may receive more than one service.

Service Plans and Level of Benefits

Table 17 looks at services received for the population of all elderly who were newly eligible in 1996, by the level of benefit. Overall, more than three quarters of all new beneficiaries in 1996 received only personal care in their homes. Another 2.2% attended day centers only, while an additional 2.7% combined day centers and personal care. The total figure for day center attendance, 4.9%, is considerably less than that in the previous table, which related to the entire beneficiary population. It is not at all clear at this point whether this decline is temporary representing a trend either in utilization patterns or supply. Moreover, day care is often not included in initial care plans for new beneficiaries but is added later with a decline in ADL functioning when day care becomes more necessary. Those receiving the higher benefit (including the reduced higher benefit) utilized day centers in proportionally greater numbers than beneficiaries of the lower benefit.

A large group of the new beneficiaries in 1996, 17.2%, had both personal care and at least one other service, generally either disposable undergarments or personal alarm units. This service package was most pronounced among those new beneficiaries eligible for the higher benefit, where 30.5% received personal care and other services.

Table 17 - Types of Service Plans by Benefit Level, New Beneficiaries, 1996

Type of Service Plan	Benefit Level				
	Total	Reduced Low *	Reduced High *	Low	High
Total Recipients** - 1996	23,171	673	259	16,125	6,114
Percentage	**100**	**100**	**100**	**100**	**100**
Personal Care at Home Only	77.3	90.3	84.9	82.0	63.3
Day Center Only	2.2	2.4	5.8	1.8	3.2
Personal Care & Day Center	2.7	0.4	0	3.0	2.2
Personal Care & Services	17.2	5.7	8.9	12.8	30.5
Other	0.6	1.2	0.4	0.5	0.8

* Benefit reduced by 50% due to incomes test.

** Not included are those new eligible for whom the service plan was not yet formulated by the local committees.

Service Provider Agencies

By 1997, the number of agencies providing home care services to LTCI beneficiaries had grown to over five hundred. Many of these agencies were subsidiary or local branches of the same parent organization. All agencies are authorized by the Ministry of Labor and Social Affairs, while the conditions of service delivery are contractually determined between the NII and the particular agency. Such conditions oblige, for example, the inclusion of social benefits for home-care attendants The largest single agency, with its local multiple branches, was the non-profit MATAV, which prior to the LTCI Law was effectively the sole provider of home care services, albeit to a small number of elderly. In 1988, MATAV alone provided services to about one-third of LTCI beneficiaries, this at a time when there was little provision of home care by privately-owned companies. By 1997, MATAV's share had been reduced to 20%, but this reduction has occurred in a hugely expanded market of more than three times the number of home-care recipients in 1988.

A conspicuous feature of the market for home-care services has been the rapid expansion of the private sector in the years since the law was enacted. Starting from a market share of 45.7% of total hours provided in January 1989, by July 1997 private companies were supplying 62.4% of all hours provided (see Figure 6). There appears to be no evidence of differentiation by case mix – the proportion of recipients who receive the higher benefit (and are thus more dependent) is similar for both the for-profit and non-profit service providers, about 21% each. The providers labeled cooperative (kibbutzim and other collective agricultural settlements) have a considerably higher proportion of beneficiaries who receive the higher benefit.

Figure 6
Number of Service Hours Provided by Proprietary Ownership of Agency – July 1997 (Percentages)

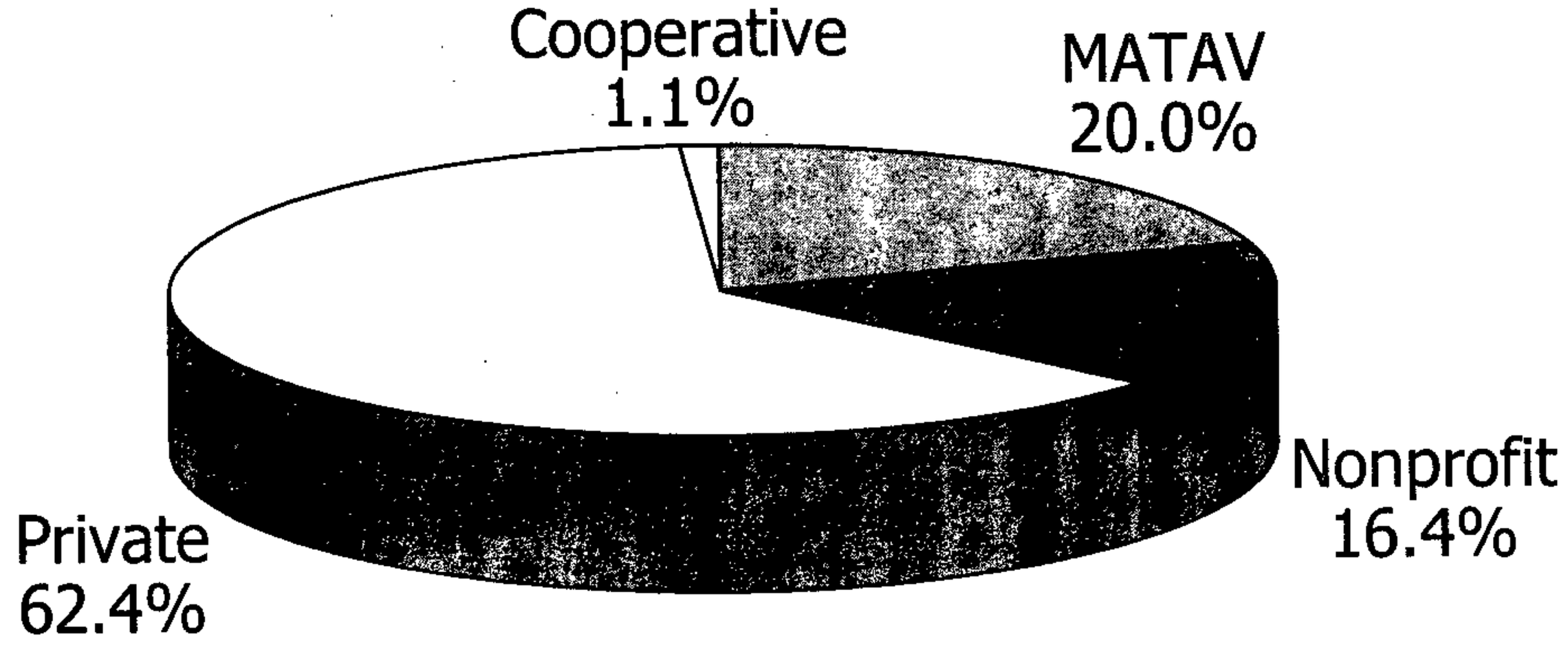
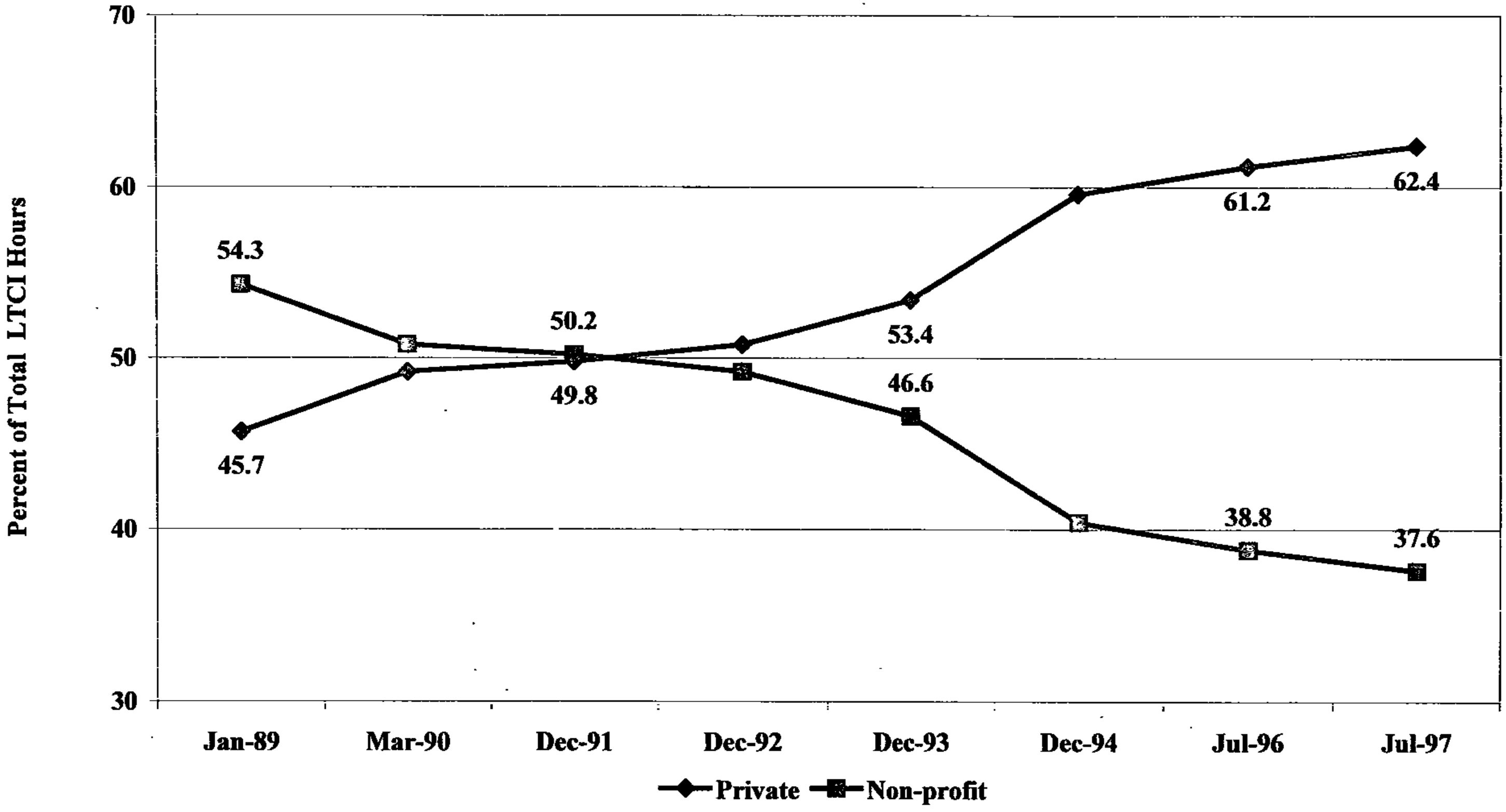


Figure 7
Distribution of Hours by Service Provider Ownership
LTCI Beneficiaries, 1989-1997



Monitoring and Quality Control

The LTCI Law places responsibility on the National Insurance Institute for determining the amount and level of services for the beneficiary. The local committees are delegated the responsibility for the delivery of these services. Accordingly, there are two monitoring systems each of which operates at two levels:

Routine Activities for Monitoring and Quality Assurance.

1. The local professional committees monitor the quality of services both routinely and in response to complaints and irregular actions which are received and dealt with. A professional contact person, either a social worker or a nurse, is designated to each beneficiary by the local committee. The professional contact ascertains that the service plan is carried out, as well as constituting an address to whom the beneficiary can turn for any problem that arises. The name and phone number of the designated professional appear on the notice informing the elderly of eligibility.

2. Service providers are obliged to supervise the provision of services, and to ensure that the professional supervisor conducts home visits to each beneficiary at least once every two months. The service providers are further obliged to provide the local committees, on a monthly basis, with a written report of those beneficiaries visited in that month, along with the invoices for services rendered. These reports are passed on to the committee coordinator, who utilizes them as needed to take any necessary action.

Monitoring Activities by Sampling

The National Insurance Institute monitors long-term care in two ways: through sample interviews with the elderly in their homes, and through an organizational review of service providers.

Home Interviews

In this framework, home visits and interviews are conducted on a sample basis to examine whether the beneficiary receives the services at the level and scope determined for him, and whether he is satisfied with the services received. Any deficiencies uncovered as a result of the visit are reported to the local professional committee.

In 1996 there were approximately 5,000 interviews conducted, half of these by an external aditory agency and half by volunteers of the Counseling Service for the Elderly. This latter mode of monitoring is unique since home visits are conducted by specially trained elderly volunteers, who are able to ascertain quality of care in an informal, friendly setting.

Organizational Review of Service - Provider Agencies

These reviews are conducted on an annual basis on about one-third of the service providers, so that each provider is reviewed at least once in three years. Those providers who have been found deficient in the previous year are included again in the current year's review. The review consists of an audit of the daily logs of the personal care attendants, and the billing invoices submitted by the agency to the National Insurance Institute. Salaries of the personal care attendants are examined, to ensure that all the social benefits covered by applicable wage agreements are paid.

Financing and Expenditures

Financing

There are two sources of financing of the Long-Term Care Insurance Law: payroll contributions, and government support. The latter source is earmarked to cover those beneficiaries who either have not accumulated a minimum residency period or are dependents of such a beneficiary. Virtually all new immigrants receiving long-term care fall into one of these categories.

Payroll contributions began in 1980, and were set at a rate of 0.2 percent of employee wages. They were equally divided between employers and employees, 0.1 percent from each. As a result of subsequent government policy over the years since then, the rate for employers has been reduced, and in 1997 stands at 0.06 percent of employees' wages. The government has matched this reduction, and pays the 0.04 percent difference. Employee contributions continued at the same rate. In addition, government support is granted to cover those immigrant elderly who would have otherwise been ineligible under previously existing residency requirements (twelve months resident in the country), as well as housewives who are uninsured under social security law. This has constituted an increasingly large share of total benefits paid for LTCI over the last five years. In 1990, it amounted to only 12% of total direct benefits for recipients, while by 1996 the share had grown to almost 20% (cf. below).

Expenditures

Along with expenditures for benefits, the LTCI Law directs the payment of several additional items related to long-term care. Fifteen percent of annual contributions are transferred to both the Ministry of Health and the Ministry of Labor and Social Affairs, covering the cost of providing additional nursing beds. The former Ministry is responsible for beds in skilled nursing facilities, while the latter Ministry is responsible for residential beds for the frail elderly. For both Ministries these transfers represent a significant portion of the respective budget for geriatric

Table 20 - Expenditures and Contributions under the Long-Term Care Law, 1986-1997, In Constant 1996 Prices (000's Israeli shekels) *

Budget Item	Budget Year												
	Total	1986	1987	1988	1989	1990	1991**	1992	1993	1994	1995	1996	1997
Total Receipts	**2,933,733**	**126,937**	**145,956**	**172,384**	**192,651**	**193,095**	**154,764**	**231,628**	**268,979**	**310,836**	**341,780**	**376,375**	**418,349**
Collections	2,075,513	126,937	145,956	156,800	153,853	151,462	123,787	172,982	184,386	200,536	214,097	216,278	228,440
Treasury	858,220	0	0	15,584	38,798	41,633	30,977	58,646	84,593	110,300	127,683	160,097	189,908
Expenditures	**6,110,761**	**31,604**	**69,119**	**160,238**	**333,486**	**441,367**	**365,979**	**561,696**	**643,777**	**738,577**	**845,061**	**898,996**	**1,020,860**
Direct Benefits	4,923,082	0	1,139	79,029	251,524	351,868	296,061	454,846	538,601	607,734	691,204	763,920	887,156
Service Development	171,021	0	9,372	7,124	12,347	21,417	14,407	20,509	15,954	20,700	17,341	16,254	15,596
Administrative Costs***													
Of which: Indirect	172,381	0	0	10,261	11,106	9,531	8,279	12,177	13,945	21,179	27,238	28,388	30,275
Direct	167,877	1,264	14,144	14,457	13,417	13,000	10,712	15,115	14,222	15,433	16,348	17,610	22,156
Transfers to Other Ministries	668,409	30,329	44,231	49,212	44,571	45,059	36,094	58,390	60,612	72,933	92,066	71,518	63,394
Other ****	7,991	11	233	155	521	492	426	659	443	598	864	1,306	2,283

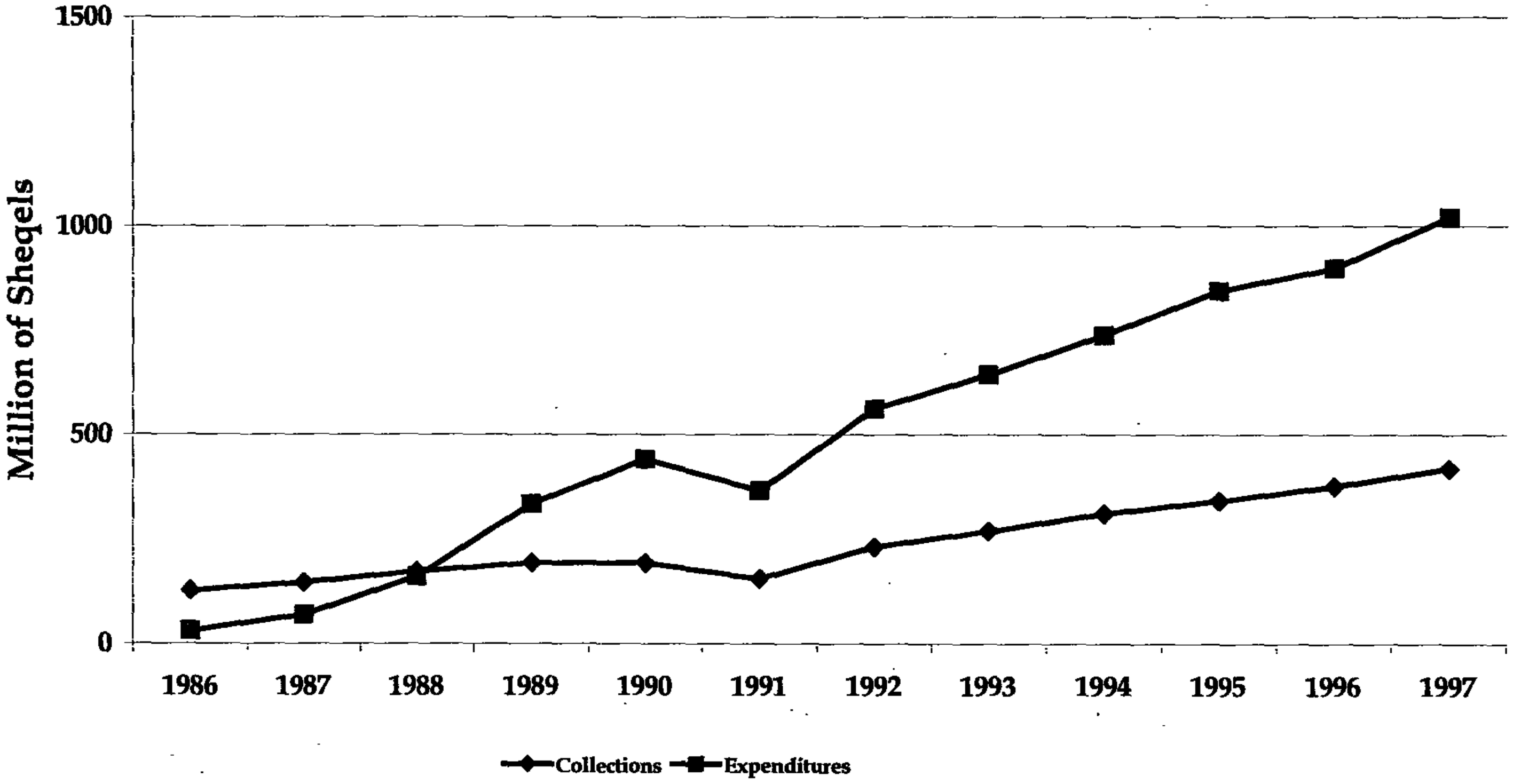
* In 1996: US $1 = IS 3.19.

** Budget year was nine months only, April-December, 1991.

*** Indirect costs are those paid to the nurses and social workers for administering the dependency tests and staffing the local professional committees. Direct costs are the overhead of the National Insurance Institute.

**** Includes funds for research, legal assistance and demonstration projects.

Figure 8
Expenditures and Collection for Long-Term Care, 1986-1997
In Constant 1996 Prices



beds. In the Ministry of Labor and Social Affairs, the proportion in the years 1990-1995 has been in the range of 20%, while in the Ministry of Health it was considerably less, about 5% - 6% per year. An additional section of the law established a fund in the initial years of program implementation for the development of both community and institutional services for the elderly within the two government Ministries mentioned. These funds were temporary, and were meant to ease the transition to the new LTCI Law, but have been renewed by Parliament. Table 16 shows the expenditures by budget item for the LTCI Law in the budget years 1988-1997, in constant 1996 shekels. The budget item administrative costs refers to overhead expenses in the administration of the law: the costs of administering dependency tests by public health nurses, and the salaries of nurses and social workers who sit on the local professional committee or are responsible for monitoring. Not included here are the overhead costs within the National Insurance Institute to administer the law. In 1996, benefits together with overhead costs accounted for about 90% of all expenditures.

Annual operating expenditures have outstripped contributions almost from the inception of full program implementation. In 1996 collections covered only 42% of expenditures. For the year 1997, the operating deficit is an estimated 600 million shekels (in 1996 shekels), and is expected to continue to grow. Interim measures taken to cover this deficit have included transfers from other insurance branches of the NII. Factors accounting for the growth in the number of beneficiaries will be the subject for extensive analysis in the coming year.

Fund for the Development of Services for the Aged

Contributions for the Fund for Service Development are allocated equally between institutional and community long-term care facilities and services. The total annual budget for this fund is financed by 10% of annual contributions for LTCI. Long-term care facilities considered here are skilled nursing facilities. From the inception of the LTCI Law, a significant portion of community allocations has been directed at the development of adult day centers, which at the time (1988) had low public awareness and restricted availability. A secondary focus was the training of home care attendants, the need of which was urgent in light of the rapid growth in the number of home care attendants and the desire to invest in training so as to assure quality of care. The number of adult day centers has grown from 10 in 1988 to approximately 150 in 1997. Current policy in community services in general emphasizes improving and expanding existing facilities, in addition to building new ones, especially in Arab communities who had lagged considerably in building adult day centers. Currently attitudinal changes within this population towards caring for the elderly outside of the home are changing, thus enabling substantial new building activity of adult day centers.

Allocations for institutions include both the public and private sectors, and have included expanding the supply of nursing beds and upgrading services in existing nursing homes. Generally these beds are included in the multi-year plans of the Ministry of Health, whose goal is extensive expansion of the number of available geriatric beds, in accordance with population growth and geographic distribution. Table 21 details allocation for the development fund by broad category and the budget year. All allocations are in 1996 shekels. In looking at the annual allocations, it is evident that there is an uneven distribution: this reflects on the one hand the long-term planning process (5 years) for the development of geriatric beds and day centers, and on the other hand the reliance on local initiatives with regard to community development. Also, there are often time gaps between approval and implementation of programs. Community allocations chronically lagged behind institutional ones: by 1997, total aggregate allocations for the former had exceeded

the latter by more than 50%, resulting in a surplus. It should be noted, however, that in the last two years, 1996-1997 community allocations have been stepped up , with significant budgets allocated to minorities, as remarked above.

Table 21 - Fund for the Development of Long-term Care Services, Allocations by Category, 1986-1997 (In constant 1996 Shekels, in millions)*

Budget Year	Total Allocation	Allocation Category	
		Institutions	Community
Total	*220,394*	*134,145*	*86,249*
1986	19.3	16.4	2.9
1987	37.3	30.9	6.4
1988	15.8	1.2	14.6
1989	7.4	2.9	4.5
1990	26.7	21.2	5.5
1991 **	0.7	0.0	0.7
1992	4.4	0.6	3.8
1993	36.5	34.3	2.2
1994	14.8	0.8	14.0
1995	8.7	2.0	6.7
1996	35.8	23.8	12.0
1997	12.9	0.0	12.9

* The budget is allocated annually and unused funds are transferred to the following year. Expenditures are uneven since they are generally related to long-term planning and to patterns of implementation of building plans.

** Nine months April-December 1991.

Recent Developments and Studies

Due to its relative newness, there are a number of significant outstanding issues in long-term care which need to be examined, either through further research or changes in legislation. Quite often the former has led to the latter. Recent legislative initiatives have included a proposal to redefine benefits-in-kind by service hours rather than a monetary equivalent. This intent is to remedy the dual price structure, in which the costs of privately-owned providers are always higher than those of nonprofit providers, who have been exempt from paying the value added tax on services. The proposed legislation defines benefits in terms of hours, and ensures that beneficiaries receive the same level of services irrespective of the proprietary nature of the service provider.

Another legislative initiative has proposed expanding the number of benefit levels to three, instead of the present two, thereby improving the matching of needs and resources. Those recipients at the highest and middle benefit levels would have an increase of about 20% in their service hours, while recipients at the minimal threshold of benefits would face a cut of about 40% in service hours. The highest level was intended to include all those who are in need of constant personal attendance, as well as those severely disabled in all five ADL areas. The middle benefit level was designed to encompass beneficiaries with four or five disabilities, of which at least two are mild, that is the daily activity can be performed with only minor assistance or prompting. The lowest level typically includes those beneficiaries with the following pattern of disabilities: a severe disability in both bathing and dressing, and a mild disability in needing assistance in feeding. None of the beneficiaries in the lowest benefit level has any degree of disability in mobility, a crucial consideration when the benefit levels were proposed.

Research in the past years has concentrated on provision patterns and on examining the impact of services on family caregivers, on the demand for nursing home beds as well as comparison of agency providers. Current research in long-term care concentrates on two of the more problematical areas of the program: the

reliability of dependency testing, and the process of selecting service providers. In the former area methodologies have been developed to check the reliability of dependency tests done both at the local (public health) bureau administrative and at the individual nurse level. Not surprisingly, at the local level variation in total ADL scores is considerably less than at the level of individual nurses, which shows a much wider range of results, even when the tests are standardized to take into account population differences (age, sex, and family composition). The methodology developed, in the framework of a quality assurance program, assist in ensuring foremost the reliability of testing, and latterly, the equity of program implementation.

In the area of researching the validity of the assessment instrument for the need for constant personal attendance, research will focus on developing a more objective clinical instrument , whose criteria can be validated by other tests. The first stage of this proposed research is to be undertaken in three psychogeriatric centers among patients who have applied to the NII for long-term care insurance. These loci have been selected because of the high number of elderly seen in them per month who are given an extensive cognitive evaluation. The results of this preliminary stage will be analyzed by a focus group of professionals who will propose an improved instrument for assessing the need for constant attendance. This research study will be followed by a field study in which the proposed instrument will be tested and compared to decisions using the current instrument.

A broader study dealing with issues of validity of the assessment instrument is currently being conducted in conjunction with the Disability Insurance Branch which provides attendance allowances to severely disabled younger individuals.

The second area in which research has taken place in the last two years has been that of a pilot program to allow beneficiaries to choose their own service provider. While the normative procedure has been that upon determination of eligibility the service provider is selected by the local professional committee, each beneficiary in this pilot project received a brochure detailing the services available to him, and a list of service providers in his locale, from which he could choose. There was no compulsion to choose, in which case the choice reverted to the pre-pilot arrangement. In order to measure the impact on the beneficiaries, a comparison

group of 450 beneficiaries was first interviewed in the summer of 1996 in seven geographically dispersed localities. Criteria for selection were receiving services in the home (and not a day center) for a period of at least six months , this being the reasonable minimal period in which any meaningful relationship with the home care provider might be developed. Preliminary results of this comparison group established baseline measurements, which are then to be compared with the group of about 350 who have been given the opportunity to choose their service provider. The second group was selected randomly from among newly eligible beneficiaries in the same seven localities. Results from interviews of this group should be available by the beginning of 1998, and will form the basis, along with an evaluation of the organizational changes required, for a decision to allow all beneficiaries the opportunity to choose their service provider. In actual practice, the proposed change may prove to be more a procedural than substantive one, as those beneficiaries who have a priori formed a preference for a specific service provider are not often denied. Nevertheless, it is a real change in empowering beneficiaries, and requires increased diligence in the monitoring of service providers.

Other studies in the area of LTCI currently being conducted:

a. development and testing of a standard instrument for monitoring the quality of home care services;
b. a survey of home care attendants examining their characteristics, work expectations and experience, work performance, satisfaction with job, etc.;
c. a study examining the operation of non-profit and for-profit service provider agencies.

Subjects of further research include:

a. exploring possibilities for designing a more integrated spectrum of community and institutional health care for the elderly by examining current informal patterns of integration and management of services on the local community level which have developed via the local committees. Models for greater coordination of

dependency assessment and care provision among the NII, the Ministry of Health and the Sick Funds will be suggested.

b. Utilization patterns for differential groups of LTCI will be the focus of further data analysis by length of stay, ADL score, hospitalizations, service packages, service provider agencies and region. Special attention will be given to differences between ethnic groups.

c. A study of the factors which affect the decision to cease receiving benefits and enter an institution.

d. An in-depth study of the factors associated with the continued growth in the number of beneficiaries. Succeeding cohorts of new beneficiaries will be analyzed as well as practices with regard to reassessment. Special attention will be given to recipients receiving threshold ADL scores.

e. An analysis of medical, health and social data for recipients who become eligible for LTCI will be conducted, using the results of a longitudinal study of a single cohort of elderly. This study will be useful in defining predictors of disability as well as identifying groups who require short versus long-term care services.

Summary and Conclusions

Coverage provided under the LTCI Act has come to occupy a vitally important niche for the elderly in the community, when in 1996 more than one in ten elderly on the average per month were receiving home care. The numbers of applications continues to rise, as does the proportion of re-applications. Almost every second application in 1996 came from a person who had applied previously. As long as barriers to application are virtually non-existent, with no minimum interval set between applications, this trend seems unlikely to diminish. Although the administrative costs are not negligible at approximately $40 U.S. per assessment, there appears to be sufficient cause for most applicants to reapply, judging from the average higher scores received on re-application. With a relatively high proportions of these re-applications being approved (71%), it would seem that a system designed to filter out "nuisance" applications might be excessively difficult to devise.

The number of beneficiaries has continued to climb at a rate far exceeding overall population growth, as well as the rate of increase of the population aged 80 and over. There is at present no reason to question whether this general trend will continue. In the years 1990-1996 growth in the total beneficiary population stood at 15.6 % per annum. Excluding new immigrants, the average annual rate of increase in the same period would have been somewhat smaller – 12.3%. Growth rates have declined to some 10% during the past two years. By the end of 1996, the immigrant beneficiary population comprised approximately 15% of all total long-term care recipients, about equal to their proportion among the total elderly population. By the end of 1997, it is estimated that this proportion will have grown to almost 17% of all beneficiaries.

An area long in need of research is that of reassessment, to help clarify its utility. According to one school of thought, the dependency test is highly time-linked and that on the individual level the number of ADL limitations is fluid: hence, greatly augmenting the number of reassessments will result in denying eligibility to a greater number of people. Current data indicates that the outcome of reassessment is highly related to who initiates it. In those cases where the LTCI

branch was the initiator, more people tend to either lose or decrease their benefits. When the beneficiary initiated the reassessment, more benefits tend to be increased. In both cases, however, most of the reassessments (59%) confirm the previous assessment. On balance, more recipients had benefits increased than decreased. But this may be due to a technicality: reassessments initiated by beneficiaries outnumbered those initiated by the NII by about three to one. These outcomes do suggest that, on average, there may be minimal, if any, improvement over time in physical functioning in this population. Data quoted above from the U.S. National Long-Term Care Survey indicated that the prevalence of ADL limitations is fairly rigid over time: in comparing the rate of those with any ADL limitations lasting three months or longer with that those lasting six months or longer, there was a slight decline from 12.8% to 11.5%. Still, while this is an absolutely small difference of 1.3%, it is a rate of decrease of more than 10%, and for any large population translates into a potentially substantial savings.

As the proportion of those over the age of eighty continues to climb, the per capita demand for services is likely to grow at an increasing pace. This can only place even greater stress on budgetary means. Improvements can be anticipated, however, in a better matching of needs and services. The proposed legislation described above, in introducing a third dependency level and concomitant changes in services for each benefit level, should make for more efficient resource allocation.

In the area of service providers, privatization has continued to expand: as of mid-1997 more than three of every five beneficiaries received long-term care from a private provider. In contrast, in 1988 when the law began to be implemented in full, only 46% of beneficiaries were provided services by private companies. This increase in market share has come not at the expense of non-profit providers, but through growthin the number of beneficiaries. As for nonprofit providers, growth appears to be stagnating, with the number of clients remaining stable over a considerable period. Among likely reasons for this are the more aggressive marketing methods engaged in by private service providers and a differing set of objectives and constraints under which they operate.

Appendix

Income Test for Long-Term Care Insurance

Household Status and Eligibility	Incomes Ceiling as Proportion of Average Wage
Elderly living alone:	
Eligible for full benefit	up to the average wage
Eligible for half benefit	1-1.5 times the average wage
Elderly with spouse:	
Eligible for full benefit	up to 1.5 times the average wage
Eligible for half benefit	1.5-2.25 times the average wage
Increment for each child	
Eligible for full benefit	up to half the average wage
Eligible for half benefit	0.5 until 0.75 of the average wage

Note: The average monthly wage in 1996 was 4,693 New Israeli Shekels, or U.S. $1,472.

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