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Bureau of Research and Planning

LONG-TERM CARE NEEDS AND PROVISION OF SERVICES FOR THE ELDERLY:

Summary of Selected Data

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Bureau of Research and Planning

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PREFACE

In response to repeated requests for data in English on Israel's long-term care system, expenditures and need estimates from the National Insurance Institute, this report includes primarily a summary about data from two recent reports prepared by the Institute:

PART I: A survey of personal assistance and home help needs and service provision by family and community bodies, sponsored by the National Insurance Institute;

PART II: The National Insurance Institute's response to a survey questionnaire from the International Social Security Association (I.S.S.A.) within the framework of a cross-national comparison survey of long-term care. A summary is presented according to the order of items in the questionnaire.

We hope this report will contribute to a broader understanding of Israel's long-term needs and available services.

Yossi Tamir
Deputy Director General
for Research & Planning

CONTENTS

PART I: Personal and household assistance: service provision by family and comminity — Page 1-33

INTRODUCTION 1

1. Comparison of survey population in Bene-Beraq and Beer-Sheva with the General population: Demographic composition 3

2. Methods and definitions used to estimate the scope of need for help in personal assistance and household management 6

3. Differences in functional condition of the two populations 8

4. Need for personal assistance and home help and the extent of coverage by family and community 12

   4.1 Personal assistance 13

   4.2 Homemaker services 20

5. Need for personal assistance and home help according to living arrangements 23

6. Summary 30

Bibliography 34

PART II: Summary of National Insurance Institute's response to I.S.S.A survey questionnaire 36 - 65

1. Health care expenditures and Health schemes 36

2. Sources of funds (public/non public) for total national health care expenditure 40

3. Changes in health cost index compared with changes in Consumer Price Index 41

4. Brief description of publicly financed health care schemes focusing particularly on eligibility conditions and types of health care benefits provided 43

5. Expenditure on institutional long-term care 45

6. Expenditure on community long-term care 47

7. List of long-term care services for the elderly 49

a. Institutional services for long-term care 49

b. Community services for long-term care 50

8. The use of long-term care residential facilities by the elderly 58

9. The main types of organizations providing long-term care services for the elderly 59

10. Application and eligibility criteria for institutional long-term care facilities 61

11. Financing of residential facilities 61

12. Financial assistance for long-term care 63

13. Problems related to the coordination of long-term care services for the elderly 63

14. Assuring and regulating the quality of long-term care services for the elderly 64

15. Philosophy in regard to public financing of long-term care for the elderly 64

16. Major trends in long-term care policy 65

Bibliography 66

LIST OF TABLES

Page

PART I: Personal and household assistance: service provision by family and community

Table 1: Distribution of the survey population in Bene-Beraq, by sex and age, 1979 ... 3

Table 2: Distribution of the survey population in Beer-Sheva, by sex and age, 1978 ... 4

Table 3: Distribution of the general Jewish population in Israel, by sex and age, 1979 ... 4

Table 4: Distribution of the elderly population in Bene-Beraq and Beer-Sheva, by continent of origin ... 5

Table 5: Functional disability by continent of origin ... 10

Table 6: Recommended hours of help in terms of level of need ... 12

Table 7: Distribution of aged by level of need for personal assistance and home help ... 13

Table 8: Aged requiring personal assistance and proportion receiving help from family and community in Bene-Beraq, by age ... 14

Table 9: Aged requiring personal assistance and proportion receiving help from family and community in Beer-Sheva, by age 15

Table 10: Coverage of needs by community and family for dependent elderly requiring personal assistance 19

Table 11: Aged requiring and receiving household assistance from family and community in Bene-Beraq, by age 20

Table 12: Aged requiring and receiving household assistance from family and community in Beer-Sheva, by age 21

Table 13: Coverage of household assistance needs by family and community for persons in need of services 22

Table 14: Level of need for household assistance in Bene-Beraq, by household composition 25

Table 15: Level of need for household assistance in Beer-Sheva, by household composition 26

Table 16: Level of need for personal assistance in Bene-Beraq, by household composition 28

Table 17: Level of need for personal assistance in Beer-Sheva, by household composition 29

PART II: Summary of national insurance institutes response to I.S.S.A questionnaire.

Table 1: National health care expenditure for fiscal years 1974/75 to 1983/84 and as a percentage of gross national product 38

Table 2: Source of funds for national health care expenditures 40

Table 3: Annual percent increase in health cost index and consumer price index 42

Table 4: Public expenditure on health by operating sector, type of expenditure and service, 1982/83 44

Table 5: National expenditure on long-term care in institutional facilities by source of finance, 1981 46

Table 6: National expenditure on community long-term care services by source of finance, 1981 48

Table 7: Distribution of residential facility long-term care beds according to type of ownership, 1985 60

PART I

Personal and Household Assistance: Service Provision by Family and Community Services

INTRODUCTION

Following is a summary of a publication of the National Insurance Institute (N.I.I.) on the subject of long-term care needs, which has been at the center of the Institute's research activity in recent years as part of the preparation for legislation of Long-Term Care Insurance.

The findings presented herein constitute an estimate of the need for community long-term care services in Israel. The pattern of need for personal assistance and home help among two elderly populations is described, including the rate of coverage by services provided by family and by organized community services, and the proportion of unmet needs. The report is based on a secondary analysis of data from two identical surveys aimed at examining the needs of disabled elderly persons. The surveys were carried out simultaneously in Bene-Beraq and Beer-Sheva, two localities in central and southern Israel, respectively. The survey in Bene-Beraq (including Pardes Katz) was carried out under the direction of Dr. J. Silberstein, who also developed the survey tools and methods, and the survey in Beer-Sheva was carried out under the direction of Dr. J. Galinski.

Due to the similarity between the kinds of needs examined in the surveys and the types of benefits which will be provided under Long-Term Care Insurance (Morginstin and Shamai 1984), the information obtained through these surveys, which were based on professional estimations of the elderly's needs, is particularly important as an initial basis for the development of uniform tools for assessing and estimating the scope of entitlement to basic long-term care benefits for personal assistance and home help.[1]

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1 The main findings of the present report were presented as an official report to the Commission for Long-Term Care Insurance (Morginstin, 1982) and served the commission as a basis for estimating the scope of needs, proposing alternative levels of benefits, initial estimates of the number of persons entitled to benefits at various levels and the cost of implementing Long-Term Care Insurance (Cohen et al, 1983). The comparative findings of the Bene-Beraq and Beer-Sheva surveys were presented at the Israeli Gerontological Congress, 1983.

1. Comparison of survey populations in Bene-Beraq and Beer-Sheva with the general population: demographic composition

Tables 1 and 2 show that at the time of the survey (1979) the survey population in Bene-Beraq was very similar to the general elderly population in Israel in its age distribution. However, it differed in distribution by sex: in the 65-69 and 70-74 age groups there was a higher proportion of men in Bene-Beraq than in the general population. Compared with Bene-Beraq, the survey population of Beer-Sheva was characterized by a higher proportion of younger elderly, aged 65-74, and a much lower proportion of the over 80 group. The sex composition of the Beer-Sheva population was more similar to that of the general population: in each age group the number of women exceeded that of men.

Table 1

Distribution of the survey population in Bene-Beraq, by sex and age, 1979 (Absolute Numbers)*

Age Group	Men	Women	Total
65-69	1,440	1,212	2,652 (39.6)
70-74	996	814	1,810 (27.0)
75-79	597	613	1,210 (18.1)
80+	494	528	1,022 (15.2)
T o t a l	3,527 (52.7)	3,167 (47.3)	6,694 (100.0)

* Numbers in brackets are percentages.

Source: J. Silberstein et. al. (1982), Medical and Social Needs of the Handicapped Elderly in Bene-Beraq, p.3.

Table 2

Distribution of the survey population in Beer-Sheva, by sex and age, 1978 (Absolute Numbers)*

Age Group	Men	Women	Total
65-69	1,337	1,500	2,877 (41.7)
70-74	993	1,099	2,092 (30.3)
75-79	563	622	1,185 (17.2)
80+	330	414	744 (10.8)
Total	3,263 (47.4)	3,635 (52.6)	6,898 (100.0)

* Numbers in brackets are percentages.

Source: Processed data made available by Central Bureau of Statistics, 1979.

Table 3

Distribution of the general Jewish aged population in Israel, by sex and age, 1979 (Thousands)*

Age Group	Men	Women	Total
65-69	59.1	66.5	125.7 (40.7)
70-74	43.9	45.2	89.1 (28.8)
75-79	25.8	29.5	55.3 (17.9)
80+	17.8	21.4	39.2 (12.7)
Total	146.6 (47.4)	162.6 (52.6)	309.2 (100.0)

* Numbers in brackets are percentages.

Source: Statistical Abstract of Israel, 1980, Table II/18, p.54.

In addition to the sex and age differences, there is a significant difference in continent of origin between the two localities: 44% of the elderly population in Beer-Sheva were of Asian-African origin, compared with 23% in Bene-Beraq, which was more similar to the national proportion.

Table 4

Distribution of the elderly Population in Bene-Beraq and Beer-Sheva, by continent of origin (Percentages)

Continent of Origin	Bene-Beraq	Beer-Sheva
Total-Absolute numbers	6,690	6,807**
	Percentages	
Asia - Africa	23.1	43.8
Europe - America*	76.9	56.2

* Including a small number born in Israel.

** Excluding cases in which the country of origin is unknown.

2. Methods and definitions used to estimate the scope of need for help in personal assistance and household management

The system, methods, and instructions to interviewers were detailed in J. Silberstein (1982) in "Methods and Rules for conducting the survey"[2]. The interviewer determined for each interviewee the number of hours of help needed for personal assistance and household management. During training it was emphasized that interviewers were to identify needs deriving directly from the functional dependency of the elderly and not from illness, economic situation, social factors, etc. Accordingly, the interviewers were asked to indicate only those services required by the elderly which arise from functional dependency in the various areas examined. These were defined as required services. According to this guideline the level of need for personal assistance was determined as objectively as possible, according to an estimate of dependency (the need for help of others) in mobility, in activities of daily living (A.D.L.), and in dealing with incontinence.

Activities of daily living covered a broad range of functions, as follows:

- getting in and out of bed, transferring from bed to chair and from chair to toilet
- dressing and undressing
- washing, drying hair, using bath or shower

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2. In Bene Beraq the interviewers were nurses and nursing school students, while in Beer Sheva they were students at the School of Medicine of Beer Sheva University. All interviewers were supposed to operate according to the methods detailed in the guidance booklet.

- eating
- emptying bedpan
- getting to and use of toilet
- nail cutting
- changing position in bed
- taking medicine according to the doctor's orders

The level of need for home help was determined according to the amount of assistance required in performing the following tasks:

- shopping
- preparation and serving of meals; clearing table
- everyday cleaning of apartment
- domestic laundry and ironing

It is important to point out that the determination of need in household management depended on the household composition. With regard to couples it was assumed that the wife was charged with this function. Therefore, a husband was regarded as requiring help only if his wife could not carry out tasks due to functional impairment. Old people living with their children or with other persons who managed the household were not assessed as requiring home help, on the assumption that it is impossible to calculate the additional burden placed on household management as a result of their presence. Persons living alone were determined in need of home help if they had functional disabilities that made it difficult to carry out the aforementioned tasks.

The aim was to arrive at an estimate of total number of hours per week required by each person, in order to enable him to continue living at home, on the basis of an estimate of met and unmet needs. Total need in each area of personal assistance, household management and supervision was calculated as follows:

Total need = met needs + unmet needs

Met needs (hours per week)

a. Required services provided by the family in the week prior to the interview;
b. Required services provided by the community (including the Social Welfare Bureau, the Sick Fund, the Ministry of Health, etc) in the week prior to the interview.

Unmet needs (hours per week)
Additional services required according to the interviewer's professional assessment but not provided during the previous week.

Met needs included only those hours devoted directly to personal assistance, home help and supervision and did not include all hours of care and support generally provided by the family which are usually over and above the hours of actual A.D.L. care.

3. Differences in functional condition of the two populations

Whereas there might be different patterns of formal and informal service provision, it was expected that rates of functional disability would be similar in each age group for the two localities, on the assumption that a general direct relationship should exist between

health - functional ability and age. However, one of the most difficult problems in the survey findings stemmed from the considerable differences in the functional condition and the different levels of total need in the two localities. The question was whether these differences originated from real variations in the patterns of need of these populations due to different demographic composition, for example, or whether they were the result of exogenous factors such as uncontrolled methodological variation in survey methods or especially the differential supply of community and institutional services in each locality.[3]

Findings indicate that most elderly are independent in activities of daily living or need partial help only. As expected, the rate of dependency increases with age in each functional area. Higher rates of dependency were found in Beer-Sheva, particularly in mobility and daily activities. These differences between the two localities characterized all age groups.

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3 Comparison to other surveys conducted in various areas in Israel suggests that findings in Bene Beraq are a more valid estimate of national figures. As a result the Bene Beraq figures have been utilized for national estimates of needs and costs of long-term care, as well as for forecasting purposes.

Table 5

Functional disability by continent of origin
(Percentages)*

	Bene-Beraq			Beer-Sheva		
	Total	Asia-Africa	Europe-America	Total	Asia-Africa	Europe-America
Absolute dependence in mobility	0.9	2.1	0.5	4.1	5.1	3.0
Absolute dependence in A.D.L.	2.1	2.6	2.0	7.1	11.7	3.6
Urinary incontinence	8.8	6.3	9.0	5.8	8.0	4.0
Bowel incontinence	1.2	1.1	1.2	3.4	3.9	2.9

* Percentages in this table are the proportion of dependency in each functional area out of the total population in each continent of origin group.

Table 5 shows that there were differences in the rates of disability by continent of origin in both localities. Aged of oriental origin were generally characterized by higher rates of disability. It would seem that the higher proportion of elderly from Asia-Africa in Beer-Sheva partly explains the more serious condition of Beer-Sheva's aged population in terms of functional disability.

However, the ethnic composition of the aged population in these areas is not the only factor which should be considered in explaining differences in functional disability rates, since in Beer Sheva the proportion of functional disability was higher in both ethnic groups compared to Bene-Beraq (Table 5). In the area of mobility, for instance, less than 1% of aged of western origin in Bene-Beraq were completely dependent, compared with 3% in Beer-Sheva. The proportion for persons of oriental origin was 2% in Bene-Beraq and 5% in Beer-Sheva. As regards activities of daily living, in Bene-Beraq 2.6% of the oriental aged needed full assistance compared with 11.7% in Beer-Sheva. Thus the differences in functional disability between the two localities cannot be explained by population composition alone but might be attributed to other factors as well (see below).

4. Need for personal assistance and home help and the extent of coverage by family and community

As stated above, the level of need in personal assistance and home help was determined on the basis of a professional estimation of the total number of weekly hours of help required (met and unmet) in order to enable the older person to continue living at home. For purposes of research, the hours of help recommended by the interviewers were converted into levels of need according to the following table.

Table 6

Recommended hours of help in terms of level of need

Level of need	Personal Assistance Number of weekly hours required	Home Help Number of weekly hours required
0	Does not need help	Does not need help
1	1- 2	1 -2
2	3- 5	3- 4
3	6-10	5- 6
4	11-22	7-10
5	23-42	11-22

Findings (Table 7) show that, in general, the proportion of need for home help was higher than that for personal assistance. The need for home help was surpisingly high, given the strict guidelines according to which a person was defined as not requiring home help if he lived with spouse or other family that managed a normal household. 28.3% of the elderly population in Bene Beraq and 40.8% in Beer Sheva, required at least one weekly hour of home help. On the other hand, only 7.5% of the population in Bene Beraq and 14% in Beer Sheva, required personal assistance at least one hour per week.

Table 7

Distribution of aged by level of need for personal assistance and home help (Percentages)

Level of Need	Personal Assistance				Home Help			
	Bene Beraq		Beer Sheva		Bene Beraq		Beer Sheva	
Total:								
Absolute numbers	6,694		6,898		6,694		6,898	
	100.0		100.0		100.0		100.0	
No help required	92.5		86.0		71.7		59.2	
1	3.2		2.1		8.7		4.7	
2	1.0		3.3		12.2		13.8	
3	1.3		3.5		4.1		7.2	
4	1.3	(4.3)	4.3	(8.6)	2.0	(7.3)	5.8	(22.2)
5	0.8		0.8		1.2		9.2	

4.1 Personal Assistance - Level of need

As mentioned, 7.5% of the total elderly population in Bene Beraq compared with 14% in Beer Sheva required at least one hour weekly of personal assistance, with 3.4% and 8.6% respectively requiring a level of six or more weekly hours. Looking at need by age group one finds, as expected, that in both localities the proportion requiring services increases with age (Tables 8 and 9). It is interesting that the differences between the localitities is reduced in the 80+ age category.[4]

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4 This seems to indicate that this group receives priority in nursing home placement in Beer-Sheva, which has a relatively low rate of nursing beds, with the result that the proportion of those requiring help in the community among the over 80 age group is closer to that of Bene-Beraq.

Table 8

Aged requiring personal assistance and proportion receiving help from family and community in Bene Beraq, by age (Percentages)*

	Total	65-69	70-74	75-79	80+
Total: Abs. number	6,694	2,652	1,810	1,210	1,022
Total aged requiring personal assistance**	7.7	2.2	6.4	6.8	24.3
Require at least 3 hrs/wk	4.4	1.1	4.1	3.4	14.4
Require at least 6 hrs/wk	3.4	1.1	2.9	2.6	10.8
Receive personal assistance from community agencies	1.1	0.5	0.7	1.3	3.1
Receive personal assistance from family	6.7	1.1	7.1	7.5	19.7
Require additional services	2.0	1.6	2.2	-	4.7

* Table shows percentages of the total number of persons in each age group.

** At least one hour of personal assistance.

Table 9

Aged requiring personal assistance and proportion receiving help from family and community in Beer Sheva, by age (Percentages)*

	Total	65-69	70-74	75-79	80+
Total: Abs. number	6,898	2,877	2,092	1,185	744
Total aged requiring personal assistance**	14.0	10.2	10.7	19.4	28.9
Require at least 3 hrs/wk	11.8	7.8	9.8	16.8	25.1
Require at least 6 hrs/wk	8.6	5.0	7.6	10.9	21.2
Receive personal assistance from community agencies	1.8	0.6	1.4	3.7	4.6
Receive personal assistance from family	7.9	4.6	7.7	8.2	20.0
Require additional services	8.8	6.4	5.0	16.2	16.7

* Table shows percentages of the total number of persons in each age group.

** Requiring at least one hour of personal assistance.

Tables 8 and 9 show the proportion of need for personal assistance in each age group and the extent to which formal and informal services are received. The coverage rates indicate the proportion of those receiving services out of the total population in each age group, (i.e., not only of those who require help). Immediately obvious is that the primary source of services is the family. In each age group the proportion of elderly receiving services from family and community agencies increases with age, concomitant with the increase in need.

Corresponding to the higher proportion of need in Beer Sheva, its percentage of aged receiving help from community and family is also higher: 1.8% receive services from the community in Beer Sheva compared with 1.1% in Bene Beraq and 7.9% receive family help in Beer Sheva compared with 6.7% in Bene Beraq.[5]

Unmet Needs

Recipients of services from the community or the family do not always receive the full amount required: interviewers found that in both populations there were unmet needs. Persons in need of additional services included:

a. Persons not receiving any help at all.
b. Persons receiving some services from the community or the family but, according to professional assessment, require additional hours.

It was found that 2% of the population in Bene Beraq required additional services compared with 8.8% in Beer Sheva. The proportion of aged with unmet needs also increased with age as did rates of total need for personal assistance.

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5 It should be noted that the proportion of recipients of services in Beer Sheva is higher than the national average. In a National Survey on Mapping of the Long-Term Care System for the Aged in Israel (Factor et. al., 1982), it was found that only 1% of the total population received personal assistance services from organized community agencies.

It is interesting that the percentage of elderly with unmet needs already receiving services both from family and community is twice as high in Bene Beraq than in Beer Sheva, while the percentage receiving from community alone is the same, again indicating that elderly in Bene Beraq are receiving more family care. Moreover, in Bene Beraq most of the aged with unmet needs actually required only 1-2 additional weekly hours, while in Beer Sheva they required a greater number of hours.

Proportion of need coverage

Up to now we have referred to patterns of need and service provision among the total elderly population in the two localitities studied. We shall now look at the proportion of coverage only for those defined in the surveys as requiring services, i.e., the dependent aged (Table 10).

Whereas formal coverage (by community agencies) of personal assistance needs was similar in Bene Beraq and Beer Sheva (13.3% and 13.0% respectively), 86.3% of the dependent aged in Bene Beraq received services from family, in contrast to 56.6% in Beer Sheva. In other words, while public bodies in both localities have organized to provide services to approximately 13% of those requiring such services, families in the two localities do not provide services at the same rate according to the surveys' findings. Again, the family seems to be providing more care in Bene Beraq. Interestingly, contrary to expectations, no significant differences were found in the rates of family coverage for personal assistance according to continent of origin. Thus while the ethnic composition of these localities is different, this does not seem to explain variations in provision of care by family.

Comparing unmet needs, we find a considerable difference between the two localities: 26% of the dependent elderly in Bene Beraq, compared with 63% in Beer Sheva, had unmet needs in the area of personal assistance. A comparison of the number of dependent persons not receiving any services at all indicated 36% in Beer Sheva as against 10% in Bene Beraq.

Table 10

Coverage of needs by community and family for dependent elderly requiring personal assistance (Percentages)*

Locality	Total requiring services (Abs.no.)	Receive from family only **	Receive from community only	Receive from family and community	Do not receive	Have unmet needs	Need to alleviate family burden
Bene Beraq	504	76.6	3.6	9.7	10.0	26.0	12.1
Beer Sheva	963	50.9	7.3	5.7	36.1	63.1	19.3

* Percentages are not exclusive.

** Excluding a small number of cases receiving family help, since they were not defined as requiring personal assistance.

In addition to determining total needs and unmet needs, interviewers were asked to estimate in each case whether there was a need to alleviate the burden of family care by reducing the number of hours the family was currently providing. This information is interesting in itself as an estimate of the need for substituting formal for informal services. It was recommended that the family's burden be reduced for 12% of the cases in Bene Beraq and 19% in Beer Sheva. Interestingly, this was the case for all household composition types, whether the old person lived alone or together with a spouse or children.

4.2 Homemaker Services

In contrast to the estimation of need for personal assistance, which was based on a relatively objective assessment of A.D.L. requirements, the assessment for homemaker services (for assistance with household chores) was based on a larger degree of discretion regarding the elderly's ability to manage his household, as well as his social and economic situation. Thus, the estimate of need for homemaker services was less "objective" than that of personal assistance, which was more directly a translation of functional disability. For example, widowers were determined as requiring homemaker services since they were not accustomed to, or did not want to, manage a household, even when they were independent in A.D.L. functioning.

Table 11

Aged requiring and receiving household asssistance from family and community in Bene Beraq, by age (Percentages)*

	Total	65-69	70-74	75-79	80+
Total: Abs. number					
Total aged requiring	6,694	2,652	1,810	1,210	1,022
household assistance**	28.2	16.1	27.3	40.5	46.9
Require at least 3 hrs/wk	19.9	12.1	17.7	26.5	21.0
Require at least 5 hrs/wk	7.3	2.5	5.5	10.9	18.8
Receive household assistance from community	2.0	1.2	2.6	0.7	4.3
Receive household assistance from family	17.3	9.1	15.7	26.1	30.8
Require additional services	12.3	7.7	11.5	17.4	18.6

* Table shows percentages of the total number of persons in each age group.

** Requiring at least one hour per week.

Table 12

Aged requiring and receiving household assistance from family and community in Beer Sheva, by age (Percentages)*

	Total	65-69	70-74	75-79	80+
Total: Abs. number	6,898	2,877	2,092	1,185	744
Total aged requiring household assistance**	40.8	35.6	35.2	52.2	58.8
Require at least 3 hrs/wk	36.1	31.3	31.8	45.3	51.9
Require at least 5 hrs/wk	22.3	16.9	19.5	32.1	34.7
Receive household assistance from community	3.3	2.2	2.0	6.0	7.1
Receive household assistance from family	25.1	21.5	23.4	27.8	39.8
Require additional services	22.1	18.6	18.0	33.0	30.2

* Table shows percentages of total number of persons in each age group.

** Requiring at least one hour per week.

Tables 11 and 12 show the total need for homemaker services for the total aged population in both localities and the percentage of old people receiving services from the community and the family. Total need for at least one hour assistance was 28% in Bene Beraq and 41% in Beer Sheva, with need for at least 5 weekly hours being 7% and 22%, respectively.

As in the case of personal assistance the need for homemaker services increases with age. As for services from the formal sector, 3.3% of old people in Beer Sheva received services from the community, compared with 20% in Bene Beraq. [6] In accordance with the higher proportion of those requiring help in Beer Sheva, the proportion of those receiving help from the family is also higher than that in Bene Beraq.

12% of the aged in Bene Beraq and 22% in Beer Sheva were defined as having unmet needs, this percentage increasing with age. Generally, the addition required in Bene Beraq was only 2-4 weekly hours whereas in Beer Sheva it was higher.

Proportion of Need Coverage

Looking at patterns of coverage only for those aged requiring homemaker services[7] we find that a similar percentage in both localities received services from family (about 60%) and community (7%-8%) (Table 13).

Table 13

Coverage of household assistance needs by family and community for persons in need of services (Percentages)*

Locality	Total requiring services (Abs.no.)	Receive from family only	Receive from community only	Receive from family and community	Do not receive	Have unmet needs	Need to allevi ate family burden
Bene Beraq	1,891	58.5	4.2	2.8	34.7	43.6	10.7
Beer Sheva	2,816	61.6	6.0	2.1	30.2	54.2	16.9

* Percentages are not exclusive.

6 According to Factor et. al. (1982), the national average was 2.5%.

7 Those defined as reqiring at least one weekly hour of home help.

Approximately 44% of those requiring services in Bene Beraq and 54% in Beer Sheva had unmet needs, including a similar proportion of old people in both localities who did not receive home help at all: 35% in Bene Beraq and 30% in Beer Sheva.

Furthermore, as with personal assistance, interviewers recommended that in the case of homemaker services the family burden should be alleviated by a reduction in the number of hours devoted to providing this type of service. A recommendation to reduce hours of care was given in 10.7% of the cases in Bene Beraq and 16.9% of the cases in Beer Sheva. In terms of absolute number the largest group for which it was suggested that the family's burden must be reduced was that of persons living alone or with spouse only. Interestingly, when we looked at living arrangement categories, the highest proportion for whom interviewers recommended easing the burden of home help was found among aged living with married children, despite the fact that it may be assumed that these children manage a household for the younger family and, according to the surveys' guidelines, should not have been assessed as requiring home help.

5. Need for personal assistance and home help according to living arrangements

One of the most important variables in assessing needs for personal and household assistance in long-term care is the elderly's living arrangements. Living arrangements is an important indicator of potential family resources for caring and thus will inevitably affect care management decisions regarding the level and type of services required by the elderly and his family, the need for monitoring, the person's ability to continue living in the community or the need for institutionalization.

Tables 14 and 15 show that the group in greatest need of services in the two locali ties is that of persons without spouses and living alone. Non-married elderly living with non-married children were also found requiring relatively high levels of household assistance. In Beer Sheva, persons living with children or others were predominant in terms of the many hours of household assistance required.

Table 14

Level of need for household assistance in Bene Beraq, by household composition

(Percentages)

Level of need for household assistance	Total	Live alone	Live with spouse only	Live with spouse & unmarried children	Live with spouse & married children	Live with unmarried children only	Live with married children only	Live with others
Total:								
Abs Num.	6,694	2,146	2,932	620	65	266	397	267
0	71.7	53.6	80.2	90.3	94.0	54.8	87.7	69.9
1	8.7	13.4	7.9	4.8	-	4.2	2.8	5.0
2	12.2	18.0	8.3	3.4	6.0	29.7	5.7	23.3
3	4.1	9.7	1.8	1.5	-	2.2	-	-
4	2.0	3.7	0.8	-	-	9.1	1.6	0.7
5	1.2	1.7	1.1	-	-	-	2.1	1.0

Table 15

Level and need for household assistance in Beer Sheva, by household composition

(Percentages)

Level of need for household assistance	Total	Live alone	Live with spouse only	Live with spouse & unmarried children	Live with spouse & married children	Live with unmarried children only	Live with married children only	Live with others
Abs. Number	6,893	1,581	2,826	991	207	412	543	334
0	59.2	47.8	60.6	70.1	56.2	53.2	66.1	60.5
1	4.7	11.9	2.2	2.8	-	3.9	5.6	-
2	13.8	20.4	13.7	12.4	2.3	6.5	6.9	15.8
3	7.2	5.9	8.7	5.2	10.5	10.9	0.9	9.7
4	5.8	6.6	8.0	3.8	-	8.4	-	-
5	9.3	7.3	6.8	5.9	21.0	17.1	20.6	14.0

Examining the need for personal assistance by living arrangements reveals a different pattern (Tables 16 and 17). While the groups required some services, the higher proportion was found among non-married (mainly widowed) elderly living with married children. In Bene Beraq for instance, approximately 32% of this group required some personal assistance in contrast to 7.5% for the total population. A similar pattern was found in Beer Sheva. Married persons living with married children were also characterized by a high percentage requiring personal assistance. In both localities these groups required a higher level of assistance than other groups.

Evidence of the high frequency of need for personal assistance among old people living with married children is similar to findings in another study which indicated a significant relationship between shared households and the poor health condition of the elderly (Morginstin and Cohen, 1980) and testifies to the difficult situation of this small group. It may indeed be assumed that one of the resons for shared households was the poor health of the old person who would otherwise not be able to remain living at home. Moreover, the aforementioned study indicated that these shared households are characterized by poor economic conditions and a low standard of housing. There is no doubt that the burden of caring for an old parent is especially heavy for this group. This group should be assured coverage in terms of entitlement to benefits and services, especially in the development and provision of suitable community services such as day care, in order to assist the younger families providing care and enable them to continue functioning in their home, in society and at work as much as possible.

Table 16

Level of need for personal assistance in Bene Beraq, by household composition

(Percentages)

Level of need for personal assistance	Total	Live alone	Live with spouse only	Live with spouse & unmarried children	Live with spouse & married children	Live with unmarried children only	Live with married children only	Live with others
Total:								
Abs. Num.	6,694	2,146	2,932	620	65	266	397	297
0	92.5	93.6	94.5	94.7	85.1	92.7	67.8	95.1
1	3.2	3.6	2.3	1.5	6.0	4.9	9.6	1.4
2	1.0	1.0	0.4	2.0	-	1.0	3.5	2.0
3	1.3	0.8	0.3	0.3	6.0	1.5	12.1	1.5
4	1.3	0.8	1.7	-	3.0	-	4.5	-
5	0.8	0.3	0.8	1.5	-	-	2.5	-

Table 17

Level of need for personal assistance in Beer Sheva, by household composition

(Percentages)

Level of Need for personal assistance	Total	Live alone	Live with spouse only	Live with spouse & unmarried children	Live with spouse & married children	Live with unmarried children only	Live with married children only	Live with others
Total:								
Abs Num.	6,893	1,581	2,826	991	207	412	543	334
0	86.0	87.3	89.2	86.9	73.0	88.7	73.2	79.0
1	2.1	2.3	1.9	1.4	-	1.2	7.1	-
2	3.2	2.8	2.2	3.8	16.5	2.8	2.6	6.9
3	3.5	4.9	3.6	1.6	2.3	1.7	3.5	4.9
4	4.3	2.8	2.8	3.8	8.3	5.6	11.5	9.1
5	0.8	-	0.4	3.5	-	-	2.2	-

6. Summary

A study of the patterns of needs for personal and household assistance indicates that proportion of need were higher in Beer Sheva than in Bene Beraq. 7.5% of the aged population required personal assistance in Bene Beraq compared with 14.1% in Beer Sheva. Home help was required by 28.3% in Bene Beraq and 40.8% in Beer Sheva. Despite the fact that Beer Sheva had a higher proportion of elderly of Asian-African origin, who also had a higher level of functional disability, these differences should not be attributed only to the different ethnic composition of the two localities.

Other reasons for the more serious condition in Beer Sheva apparently stem from:

a. The low supply of nursing beds in the southern region. Due to the lack of beds a relatively larger number of disabled elderly live at home;

b. Differences in the type of interviewers and the methods of estimating needs used in the two surveys. These differences in need assessment emphasize the need for developing uniform procedures, methods and tools for estimating needs in order to determine eligibility, especially under a statutory Long-Term Care Insurance program which would seek to provide benefits based on principles of uniform personal entitlement, personal and regional equity.

On the other hand coverage of needs by formal community agencies was similar in Bene Beraq and Beer Sheva. Approximately 13% of the population in both areas requiring personal assistance and 7%-8% of

those requiring household assistance, did in fact receive some formal services. Hence, in spite of the differences between the localities with regard to the total proportion of old people requiring help in these areas, community agencies covered needs at a similar level. In fact, the extensive system of community services in Beer Sheva seems to have compensated for the shortage of nursing beds.

While in both localities a similar proportion of those in need of household assistance received services from the family (about 60%), a considerable difference was found in the area of personal assistance: 86% of those requiring help in Bene Beraq in contrast to 57% in Beer Sheva received services from the family. This difference did not derive from ethnic composition in the localities, since there was no variation by continent of origin with regard to the degree of informal help provided by family members.

The patterns of formal and informal service coverage may be summarized as follows:

- In both localities, personal assistance and household assistance is provided primarily by the family.

- Formal community agencies provide services on a smaller scale and fewer hours of care than the family. However, examining coverage among those requiring services in both localities, one finds a similar proportion of coverage, both in personal assistance and household assistance, even though total absolute need is different. This finding suggests a similar pattern of community development in accordance with the differential scope of local needs.

- The degree of overlap between formal and informal care is very small. Only a small proportion of persons received help from both family and community. This would seem to suggest the intervention of formal agencies primarily when family care is absent, and not as a complement to family caring.

- In both localities there are unmet needs both in personal and household assistance. Some of those requiring additional services already receive partial help from the family and/or community, but a substantial group does not receive any assistance at all.

- In both need areas it was recommended that the burden of care on the family must be eased, thus reducing the number of hours the family provides by providing formal services. This suggests an important target group for community service development which would complement family care rather than substitute for the lack of family care, which seems to be the current pattern of service provision.

- It would seem that most dependent elderly indeed have family who already provide some of the help and may thus be able to take responsibility for case management, given the assistance by formal resources. This fact is of consequence for any Long-Term Care Insurance program which might be developed. If we assume that many of these elderly will become entitled to benefits under law, it will be possible in some cases to grant the benefit directly to the beneficiary and his family so that the family can continue to provide the required help either on its own or by purchasing supplementary formal services in the community. On the other hand, it is clear that in determining the need for services in kind, account should be taken of factors such as the adequacy and quality of the help provided, the

extent of the family's responsibility and its readiness to provide permanent and regular help for the benefit of the old person, etc. However, the very existence of a family that provides at least part of the care indicates the possibility of including cash transfer as one option in a long term care program which would encourage the family's continued caregiving responsibility at the same time enhancing its ability to acquire complementary services for the old person's care.

- At the same time, the infrastructure of formal manpower and services must be expanded and developed in order to provide accessible alternatives to the family that desires to continue caring for the dependent person within his home. Of great importance would be services that provide support, counseling and referral to the caregiver.

- The main effort in the development and provision of in-kind services and case management should be directed at designated at-risk groups: those elderly who do not have access to family help, as well as those families on whom the burden of care is excessive and who therefore require supplementary services from the formal system.

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PART II

Summary of National Insurance Institute's Response to I.S.S.A Survey Questionnaire

A. Health Care Expenditures and Health Schemes [1]

1. In Israel, national health care expenditure includes current expenditure and fixed capital formation. Current expenditure comprises the value of all health services currently consumed by the population in the years surveyed excluding health services provided by the Israel Defence Forces, but including participation by the Ministry of Defence in hospital expenses. Fixed capital formation includes expenditure on building construction and purchase of equipment for provision of health services.

   National expenditure on health is classified by sector and by type of service. The sectors included are:

   a. Government health care expenditure - includes expenditure within the ordinary budget and the development budget of the Ministry of Health, the Ministry of Labor and Social Affairs, the Unit for Treatment of Nazi Victims and expenditures of the National Insurance Institute and other national institutions.

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1 Data and description of health care and expenditures are based on following sources: National Expenditure on Health 1982/83 and Preliminary Estimate for 1983/84, Supplement to the Monthly Bulletin of Statistics No. 2 Central Bureau of Statistics, 1985.
Statistical Abstract of Israel; Central Bureau of Statistics.
Factor, H. M. Guttmann and A. Shmueli: Mapping of the Long Term Care System for the Aged in Israel, Brookdale Institute of Gerontology and National Insurance Institute, Jerusalem, October, 1982.

b. Local authority health care expenditure - includes expenditure of municipalities, local and regional councils within ordinary and special budgets of the Health Department and also expenditure on medical supervision and dental treatment in schools from the budget of local Education Departments.

c. Non-profit institution health care expenditure - includes expenditure of non-governmental institutions. Non-profit institutions include the various sick funds, public non-governmental hopitals, etc.

d. Private health care expenditure - includes purchases of health services and goods by households from commercial bodies such as the purchase of services from private physicians and private medical institutions, or purchase of medicine and medical equipment. Estimates of private purchase of physician and nursing services are partial. This item does not include private purchase of health services by institutions. These estimates are of low reliability.

Table 1

National Health Care Expenditure for fiscal years 1974/75 to 1983/84 and as a percentage of Gross National Product

(I.S Million, $ Million, at current prices)*

Fiscal year	I.S. Million	$ Million	% of G.N.P.
1974/75	356	726	5.9
1975/76	489	734	6.0
1976/77	703	841	6.5
1977/78	1,113	908	6.9
1978/79	2,029	1,106	7.5
1979/80	4,014	1,332	7.6
1980/81	9,170	1,465	7.1
1981/82	21,069	1,538	7.3
1982/83	49,536	1,703	7.3
1983/84	132,000	1,656	7.1

Source: National Expenditure on Health 1982/83 and preliminary estimate for 1983/84. Supplement to the Monthly Bulletin of Statistics No.2, Central Bureau of Statistics, 1985.

* In this and following tables the conversion of Israeli Shekel to dollar value is based on an average dollar rate for the given fiscal year.

Table 1 shows that expenditures on health have increased steadily and doubled over the past decade, from $ 726 mil lion in 1974/75 to $ 1,656 million in fiscal year 1983/84. There was a slight decrease in the real value of expenditures in 1983/84. In terms of percentage of Israel's Gross National Product, the rate of increase has been lower: from 5.9% in 1974/75 to 7.1% in 1983/84.

2. Sources of funds (public/non-public) for total national health care expenditure for most recent years available; amounts and percentage distribution by source of funding.

Table 2

Source of funds for National Health Care Expenditures

(I.S Million, $ Million, at current prices)*

Years	Total (I.S. Million)	$ Million			
		Total	Government	Local Authorities	Private non-profit institutions
1974/75	356	726(100)	411(56)	18(3)	297(41)
1975/76	489	734(100)	413(56)	20(3)	301(41)
1976/77	703	841(100)	427(51)	18(2)	396(47)
1977/78	1,113	908(100)	506(56)	15(2)	387(42)
1978/79	2,029	1,106(100)	562(51)	16(1)	528(48)
1979/80	4,014	1,332(100)	795(60)	20(1)	517(39)
1980/81	9,170	1,465(100)	854(58)	18(1)	593(41)
1981/82	21,069	1,538(100)	885(58)	16(1)	637(41)
1982/83	49,536	1,703(100)	965(57)	19(1)	719(42)
1983/84	132,000	1,656(100)	935(56)	18(1)	703(43)

Source: National Expenditure on Health 1982/83 and preliminary estimate for 1983/84. National Accounting Statistics Series, Central Bureau of Statistics, 1985.

* Numbers in brackets are percentages.

Comparing Health Care Expenditures for the two last years shown in Table 2, we find a decrease of 1% in the total real expenditures. However, distribution of expenditures by source of funding remained almost the same during the last ten years. In 1983/84 general government financed about 57% of national expenditure on health - similarly to preceding years. The remaining expenditure (43%) was financed by private non-profit institutions (including donations and grants from abroad) and direct payments by households (e.g. for medicines, private physician's services, etc.).

3. Changes in Health Cost Index compared with changes in Consumer Price Index for the past ten years.

Between 1982 and 1983 the health cost index increased by 152% while the consumer price index increased by 145.7%. Following is a comparison of the two indices during the past ten years:

Table 3

Annual Percent Increase in Health Cost Index and Consumer Price Index

Year	Health Cost Index	Consumer Price Index
1972	11.1	12.9
1973	14.7	20.0
1974	31.8	39.7
1975	33.4	39.3
1976	36.0	31.3
1977	61.5	34.6
1978	72.2	50.6
1979	73.3	78.3
1980	139.8	131.0
1981	194.7	116.8
1982	128.8	120.3
1983	152.3	145.7

Source: Price Statistics Monthly, Central Bureau of Statistics

4. Brief description of publicly financed health care schemes, focusing particularly on eligibility conditions and types of health care benefits provided.

Israel's publicly financed health care schemes are of two basic types: services provided by non-profit sick funds and services provided by the government via its Ministry of Health. Although there is some overlap in types of services provided, sick funds are primarily responsible for providing primary health care and medicine in public clinics and for funding acute hospital care. The Ministry of Health is primarily responsible for providing community preventive medical care (such as clinics for mother and child care as well as mental health care) and long-term care in institutions for the chronically ill and nursing homes. Hospitals are operated by both sectors. Eligibility for health services provided by sick funds is based on membership and payment of dues in an insurance-based system. All citizens are eligible for services provided by the Ministry of Health. Following is a table showing national public expenditure by service, for 1982/83. Data is unavailable according to age. Data on expenditure on long-term care for the elderly will be described in the following items.

Table 4

Public Expenditure on Health by Operating Sector Type of Expenditure and Service, 1982/83*

($ Million, at current prices) **

	Government	Non-profit sickfunds	Institutions Other	Local Autho-rities
Grand Total	408	683	204	21
(IS Million)	(11,872)	(19,875)	(5,939)	(611)
Total current expenditure	359	649	182	17
Government administration	13	-	-	-
Public clinics and preventive medicine	45	412	36	12
Total hospital and research	301	224	142	3
-General hospitals	232	196	111	-
-Hospitals for mentally ill	44	9	4	-
-Hospitals for chronically ill	25	16	20	3
-Convalescent homes	-	3	-	-
-Research	-	-	7	-
Dental clinics	-	13	4	2
Total fixed capital formation	49	34	22	4
-Hospitals	41	17	18	1
-Clinics	8	17	4	3

Source: National Expenditure on Health 1982/83 and preliminary estimate for 1983/84. National Accounting Statistic Series, Central Bureau of statistics, 1985.

* Including services provided by non-government bodies, public hospitals, etc.

** 1 $ U.S = I.S. 29.087

B. Expenditures on Long-Term Care: Institutional and Community Services

5. Expenditure on institutional long-term care

Following expenditures on institutional services include residential homes for the independent and frail aged; nursing home beds for the chronically ill and the mentally infirm aged.

In 1981 national expenditure for long-term care institutions amounted to IS 1,011 Million (July, 1981 prices) ($ 83 Million), which constituted 7% of the total national health care expenditure in that year. More than half (56%) of the expenditure went to the severely dependent elderly, about 15% to the frail and 29% to the independent elderly. In other words, the Israeli economy spent approximately an annual average of IS 3,180 ($ 262) on this item for every old person over 65 and approximately IS 80,400 ($ 6,617) on every old person in an institution of this type. Calculation of these expenditures are based on estimates of current expenditure only. Development expenditures and investments were not taken into account, i.e. the expenditure data refer only to the maintenance costs of existing institutions. Moreover, no account was taken of entrance fees paid to institutions and intended, in priciple, to cover the institution's development expenditure.[2]

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2. Official data currently available on expenditure for institutional long-term care is for 1981 only, although more recent data on institutionalization rates are available.

About 53% of total national health expenditure on institutional care is financed by government sources, 8% by public sources and 39% by private sources (see Table 5). Government participation in expenditure on severely disabled and mentally infirm elderly is particularly high - 75% — and declines to 10% for independent elderly persons in residential homes.

Table 5

National Expenditure on Long Term Care in Institutional Facilities by Source of Finance, 1981

($ Millions, Percentages)

Source of Finance	Total	Nursing & Mentally infirm	Frail	Independent
Total	83.2	46.8	12.2	24.2
Percentages	100.0	100.0	100.0	100.0
Total Government Sources	53.0	75.2	53.7	9.6
- Ministry of Labour & Social Affairs	11.9	0.3	55.4	66.9
- Ministry of Health	88.1	99.7	44.6	33.1
Total Public Sources	8.0	5.3	10.8	11.7
- Jewish Agency	1.5	4.1	-	-
- Local Authorities	45.6	48.5	96.3	19.5
- General Labour - Federation & Sick Funds	49.1	42.6	-	77.5
- Voluntary Organizations	3.8	4.8	3.7	3.0
Total Private sources	39.0	19.4	35.5	78.7

Source: Factor, H.; M. Guttman and A. Shmueli, "Mapping of the Long-Term Care System for the Aged in Israel", J.D.C. Israel, Brookdale Institute of Gerontology and Adult Human Development and National Insurance Institute, Bureau of Research and Planning, Jerusalem, October 1982.

In addition to long-term institutional care shown in Table 5, expenditures for acute and rehabilitation geriatric wards amounted to IS 309 Million ($ 25 Million) in 1981. These wards contained 1,174 beds in 19 institutions in 1981. Expenditure on sheltered housing amounted to approximately IS 40 Million ($ 3 Million) in 1981.

6. Expenditure on Community Long-Term Care

The following expenditures on community services include those services delivered to the elderly person's home (nursing care, personal attendance, home help, meals, ect.), and day care services delivered in central community facilities.

In 1981, national expenditure on these community services for the aged was IS 192 Million ($ 16 Million) which constituted about 87% of total expenditures on these community long-term care services. Since reliable data are unavailable on the breakdown of expenditures for the elderly by source of finance, Table 6 shows expenditures for the total population by source of finance.

Table 6

National Expenditure on Community Long-Term Care Services by Source of Finance, 1981

($ Millions, percentages)

Source of Finance	National Expenditure
Total amount	18.1 *
Total percentage	100.0
Total public sources	96.2
- Government and Municipal	60.7
- General Sick Fund	27.4
- Public	11.9
Total private sources	3.8

* 87% of this sum is for the aged (i.e. $ 15.8 Million).

Source: Factor, H.; M. Guttman and A. Shmueli. "Mapping of the Long-Term Care System for the Aged in Israel", J.D.C.Israel, Brookdale Institute of Gerontology and Adult Human Development and National Insurance Institute, Bureau of Research and Planning, Jerusalem, October 1982.

According to a recent updated study of coverage and expenditures by Israel's Brookdale Institute, 1983/84 public expenditures on three basic long-term care community services were as follows:

	Expenditures	Proportion coverage of elderly population
Personal Attendance	$ 4.6 Million	1.6
Home help	$ 0.99 Million	3.6
Meals	$ 1.66 Million	1.1

Source: National Needs of Disabled Elderly: today and in the future. Yedion, Israel Gerontological Society, No.62, 1985/86, by J. Habib, H. Factor and S. Be'er.

7. List of Long-Term Care Services for the Elderly

a. Institutional Services for Long-Term care

Institutional services for the elderly in Israel consist of various types of institutions which may be divided into two main groups:

1) Long-Term Care Institutions including: **(a)** beds for severely disabled (nursing) and mentally infirm in chronic care hospitals, in hospitals for chronical ill and in nursing wards of old-age homes and geriatric centers; **(b)** beds for the frail in old-age homes and geriatric centers; and **(c)** beds for independent elderly in old-age homes and geriatric centers (excluding sheltered accommodations).

2) Acute and Geriatric Rehabilitation Wards in general hospitals, geriatric rehabilitation hospitals, chronic care hospitals and geriatric centers.

Long-term care institutions are under the supervision of the Ministry of Health and the Ministry of Labour and Social Affairs. Chronic care hospitals and wards for severely disabled elderly patients and the mentally infirm in old-age homes are supervised directly and exclusively by the Ministry of Health, while wards for the frail and independent elderly in old-age homes are supervised by the Ministry of Labour and Social Affairs. This division of responsibility and supervision also reflected in the referral of cases to institutions and the source of finance of beds.

b. Community Services for Long-Term Care

The aim of community long-term care services for the elderly is to supplement informal help provided by the family so as to enable handicapped, dependent persons to remain living at home. Even though the network of community services is not intended only for the aged, the latter constitute the majority of recipients. The services provided for old people living in households in the community include a wide range: medical care, nursing, mental health, social activity, personal services, etc. These services may be divided into five groups:

1) Services delivered to the elderly at home;
2) Day care services delivered in central community facilities;

3) Other community services (meals, preventive care, foster families);
4) Housing services;
5) Cash transfer for the purchase of goods and services.

1. Services delivered to the elderly at home[3]

a. Professional medical nursing care

Medical nursing care is provided by sick fund clinics and by units for continued home care treatment: this service is provided by sick fund clinics for those insured in the sick funds who are home-bound for at least three months. The service includes treatment by a family doctor and nursing care by a nurse. Elderly who are home-bound and need additional treatment are cared for by special teams of the General Sick Fund (Labor Organization) and of a number of hospitals. These teams, which are called "continued home-care treatment and follow-up units", consist of a doctor, a nurse, a physiotherapist, an occupational therapist and a social worker. Professional medical nursing care in 1981 covered 9,365 elderly, i.e. 29.4 patients per thousand Jewish elderly in the population. The amount spent by units for continued home-care treatment was I.S 25.3 Million ($ 2.1 Million) in 1981, about 65% of which went to elderly people. This service is financed by the sick funds, primarily that of the General Labour Organization.

3. Source of data: H. Factor, M. Guttman and A. Shmueli, Mapping of the Long-Term Care System for the Aged in Israel, Brookdale Institute of Gerontology and National Ins. Inst., Jerusalem, 1982.

b. Para-medical treatment at home

This service includes physiotherapy and occupational therapy services for the home-bound and is provided by the General Sick Fund's continued home-care treatment and follow-up units and by hospitals. In 1981, 1,971 elderly received physiotherapy services and 413 received occupational therapy services. The annual expenditure on this item was IS 2 Million ($ 165,000). These services are financed mainly by the sick funds.

c. Non-professional personal care

This service is aimed at helping those persons who have difficulties in performing daily personal functions such as bathing, dressing, eating, grooming, etc. Today, help is concentrated primarily on bathing the patient. The service is provided by semi-professional personnel of the Homemakers Agency (Matab) and by private bodies. The Ministry of Health, the Ministry of Labour and Social Affairs and the sick funds participate in financing the service together with the elderly and their families, according to a means test.

In 1981 the service was provided to 2,874 old people, i.e. approximately 1% of the population. Despite the small number of recipients, expenditure on this item constituted about one third of the total expenditure on home care for the elderly (I.S. 21.6 Million - $ 1.8 Million) due to the frequency of

the required visits and the duration of the treatment which is longer than medical nursing care.

d. Homehelps to the aged (Mataz)

This service is provided by the Municipal Welfare Bureaus by semi-professional manpower. The homehelp visits the elderly's home in order to identify need, provide some basic care and follow-up the provision of other required services. Assistance is provided in shopping, light housework, administering medicines and accompanying the old person for medical treatment. In 1981 this service was provided to 8,480 elderly at an expenditure of I.S. 14 Million ($ 1.2 Million).

e. Homemaker service

This service is provided to old people who are incapable of managing their households (cleaning, laundry, meal preparation, etc.), by the Municipal Welfare Bureaus on the basis of entitlement and is means tested. Often financial assistance is given to the family to enable private purchase of homemaker services, and sometimes the homemaker is paid directly by the agency. In 1981, approximately 8,000 elderly received this service at an annual expenditure of I.S. 10.4 Million ($ 855,900).

f. Meals

A prepared meal per day for handicapped elderly who are

incapable of preparing a meal themselves is provided by the Ministry of Labour and Social Affairs and the local authorities to the person's home and in old-age homes, social clubs and day centers. About 3,155 persons received meals in 1981, about half of them at home. The annual expenditure amounted to I.S. 18 Million ($ 1.5. Million).

2. Day care services delilvered in the community

Day care services delivered in the community enable people who need various personal care and para-medical treatment to receive such services within organized community frameworks outside the home. Such services include:

a. Day hospitals

This service provides medical rehabilitation and day care for disabled people with rehabilitation potential who need physical and/or mental rehabilitation for a limited time (mainly people discharged from hospitals). The service includes: medical treatment, nursing, physiotherapy, occupational therapy, speech therapy, social care, breakfast and lunch and transportation.

Treatment is provided in geriatric day centers attached to general hospitals or to government chronic care hospitals, and in other medical centers. The Ministry of Health and the General Sick Fund are responsible for operating this service. In 1981, there were nine centers of this type, in which 870

elderly received treatment. The annual expenditure was I.S. 10 Million ($ 823,000).

b. Day care in old-age homes

This service is aimed primarily at old people who suffer from social isolation and are in danger of functional and/or mental deterioration. The following services are provided: physiotherapy, occupational therapy, sheltered work, social activity, personal care (bathing, chiropody, hairdressing), care by social worker and meals. The service is provided in old-age homes founded by Eshel (Association for the Planning and Development of Services for the Aged) and in some geriatric centers. The Ministry of Health (in the geriatric centers) and the Ministry of Labour and Social Affairs are responsible for this service. In 1981, 142 elderly received such services.

c. Care in day centers and in social clubs with special services

This service resembles the day care in old-age homes but the range of services differs from center to center and does not include all the services mentioned above. This service is operated by the local authorities, the Matnas (Youth, Cultural and Sport Centers) Association, local Societies for the Aged (founded by Eshel) and various voluntary organizations. In 1981 there were 110 clubs or day centers in which approximately 14,000 elderly were registered.

3. Other community care services

a. Preventive care: This service is intended to facilitate the early identification of old people at risk in order to diagnose their medical and social problems and refer them to the bodies responsible for direct treatment in order to prevent physical and mental deterioration. The service includes medicals, functional and social need assessment. It is operated by the Ministry of Health's Family Health Centers, by the General Sick Fund's clinics and by the Jerusalem and Tel Aviv municipal authorities. Approximately 19,000 old people received this service in 1981.

4. Housing services

These services are meant to facilitate the continued independence of the elderly within the community. They enable the elderly to live in a place adapted to their functional capacity by providing a special type of accommodation or adjusting the existing accommodation. Sheltered group-shared housing is the main type of congregate housing and is generally a concentration of apartments for elderly people who are mobile and independent in personal functioning and in home management, but have to move to sheltered accommodation for social, functional or family reasons, or due to inadequate housing conditions. Several bodies operate such programs. In addition to sheltered housing there are various programs for improving housing by adapting private accommodations

provided mainly by the Ministry of Housing, the Ministry of Health and some local authorities.

5. Cash transfers for the purchase of goods and services

a. Transportation

This program reimburses people with limited mobility who cannot use public transportation, for transportation expenses for the receipt of medical treatment and day care services or to visit relatives living in institutions. The General Sick Fund provides transfer of this type to insured members with full rights and the Ministry of Labour and Social Affairs provides it on an income-tested basis. In 1981, 500 elderly were reimbursed for traveling expenses by the General Sick Fund and about 1,500 by the Ministry of Labour and Social Affairs. The annual expenditure was about I.S. 7 Million ($ 576,000).

b. Medical equipment

Assistance is provided for the purchase of rehabilitation and medical equipment (such as prosthetic devices, wheelchairs, hearing aids, orthopedic footwear, etc.). The Ministry of Health finances expenditures on artificial limbs and the General Sick Fund is responsible, together with the Ministry of Health, for financing other equipment, including that required for medical treatment. Cash transfers for medical equipment were provided to 7,600 old people in 1981, at an annual expenditure of approximately I.S. 26 Million ($ 2.1 Million).

8. The use of long-term care residential facilities by the elderly

In 1981 approximately 4% of the aged population resided in long-term care institutions not including those receiving acute geriatric care. Of the 39.5 beds available per 1,000 elderly, 20.4 were for independent care in residential homes, 5.1 were for the frail elderly and 13.9 were for nursing beds (including 0.7 beds for psychogeriatric care). According to recent data collected by the Brookdale Institute[4] between 1981 and 1985 there was an 18% increase in the absolute number of beds, an a 6% increase in the number of beds per 1,000 elderly population (to 41.8 beds per 1,000). The greatest proportional increase was in psychogeriatric beds and beds for the frail elderly. In 1985 there were 18.8 beds per thousand aged for independent elderly, 6.4 beds for frail, and 16.5 nursing beds, including 1.0 beds for psychogeriatric care per thousand aged. In addition, there were a total of 766 beds for geriatric rehabilitation and 507 beds for diagnosis and acute geriatrics.

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4. For detailed tables on changes in availability of institutional beds see: Development of Beds in Institutions for Long-term Care, 1981-1985 and Expected Construction from 1985 Onwards, Brookdale Institute of Gerontology and Adult Human Development in Israel, Jerusalem, July 1985, by H. Factor, J. Habib and S. Beer.

9. The main types of organizations providing long-term care services for the elderly

Residential long-term care services for the elderly in Israel are provided primarily by three types of bodies:

1. Government-municipal bodies, including chronic care hospitals and nursing homes for the chronically-ill aged, geriatric wards and municipal old-age homes: 10 residential facilities.
2. Public bodies, including institutions owned by non-profit organizations such as sick funds and voluntary non-profit organizations; public hospitals and immigrant associations: 53 residential facilities.
3. Private profit organizations: 61 residential facilities.

Table 7 shows the distribution of beds in 1985 according to type of ownership (funding of beds is not identical to ownership).

Table 7

Distribution of Residential Facility Long-term Care Beds According to Type of Ownership, 1985

Type of Ownership	Total no. of beds	Medically Oriented Beds		Non-Medically Oriented Beds	
		Nursing Home Beds	Mentally Infirm	Frail	Independent
Total	14,821	5,487	370	2,280	6,684
	100.0	100.0	100.0	100.0	100.0
Government or Municipality	17.9	15.7	31.6	40.2	11.5
Public	50.3	38.1	53.5	29.5	67.4
Private	31.6	46.2	14.9	30.3	21.1

Source: Development of Beds in Institutions for Long-Term care, 1981-1985, and Expected Construction from 1985 Onwards, Brookdale Institute of Gerontology and Adult Human Development in Israel, July 1985, by H. Factor, J. Habib and S. Be'er.

Note that 46% of nursing home beds are provided by private organizations (although funded primarily by government funds), while 32% of beds for the mentally infirm and 40% of residential beds for the frail elderly are provided by government and municipally-owned facilities.

10. Application and eligibility criteria for institutional long-term care facility

Application for entry into a medically oriented facility for nursing and mentally infirm elderly must be made to the district offices of the Ministry of Health. According to the availability of beds, eligibility is determined by a carefully administered test of functional ability and social assessment of family situation. Level of funding is determined on the basis of an income test of the older person's and his children's income.

Application for entry into a non-medical residential facility is made either directly to a private facility or via the municipal welfare office, if public funding is requested. Eligibility is determined according to functional ability, living arrangements and assessment of finacial resources (the elderly person and children).

11. Financing of Residential Facility[5]

There are several ways in which long-term stays in residential facilities are financed:

a. Individual, private funding, in cases where elderly personally apply to the residential facility;

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5. Source of data: Factor H., M. Guttman and A. Shmueli, "Mapping of the Long-Term Care System for the Aged in Israel", Brookdale Institute of Gerontology and National Insurance Institute, Jerusalem, October 1982, pp. 23-24.

b. Shared financing by the elderly and voluntary organization

This type of shared financing is foud in non-government residential facilities owned and operated by voluntary organizations which are subsidized at a rate of approximately 30% of cost by the General Labour Federation or in immigrant organization facilities which cover part of operation. Residence in such facilities often entitles the elderly to financial assistance from sick funds.

c. Global financing by the Ministry of Health

The Ministry of Health finances up to 50% of costs for elderly in voluntary and immigrant organizations.

d. Shared financing by government, municipal authority, the elderly and the family

This is the most prevalent type of financing when the person is referred to a facility by the District Health and Welfare offices, and applies to 49% of the aged in all institutions and 73% of the aged in nursing homes.

e. Home and community services

Home and community services are variously paid for either by the individual (after according to a means test), or via the partial or total funding by municipal, government or public organizations, which may pay directly to the service provider or reimburse the family.

12. Financial assistance for long-term care

Today there are no insurance provisions for direct financial assistance to the elderly requiring long-term care. Only if an individual was severely disabled prior to reaching retirement age (65 for men and 60 for women) and received an attendance allowance for personal care under General Disability Insurance, he continues to receive the allowance after retirement age.

A bill has been submitted to the Israeli Parliament which would legislate Long-Term Care Insurance in Israel, under which severely dependent elderly in need of long-term care and their families would be eligible for benefits in cash or kind, based on the principle of personal entitlement.

13. Problems related to the co-ordination of long-term care services for the elderly

Fragmentation of services and the lack of coordination of service provision, and case-management in terms of need assessment, determining treatment plans and monitoring, are of major concern to professionals involved in long-term care in Israel. One of the problems stems from the often unsuitable division of responsibility between the sick funds and municipal welfare offices responsible for frail elderly on the one hand, and the Ministry of Health's responsibility for chronically ill, "nursing" elderly. Problems also arise from the lack of a case-management approach to long-term care and care for the elderly in the community which would provide

a continuum of care according to individual need, from care in the home, to organized community care and would include referrals for institutionalization when necessary.

Several demonstration projects exist in Israel for examining a more unified, comprehensive approach to long-term care in the community and in institutional settings. Provisions under the proposed long-term insurance would also provide greater incentives for coordinating and managing long-term care in the framework of multi-disciplinary local committees.

14. Assuring and regulating the quality of long-term care services for the elderly

Quality of care in residential facilities for long-term care is the responsibility of the Ministry of Health (nursing homes and departments for nursing patients and for the mentally infirm in residential homes) and the Ministry of Labour and Social Affairs (homes for frail and independent elderly). These ministries periodically inspect and licence the residential facilities. However, there is a problem with maintaining the quality of care, given limited finances, old institutions, lack of sufficiently trained manpower, etc.

15. Philosophy in regard to public financing of long-term care services for the elderly

Israel's philosophy with regard to public financing of long-term

care services is that although the primary responsibility for care resides with the family, all effort must be made to increase availability of services to the home and in the community, to increase access and raise the quality of care, so as to alleviate the burden on the family. Public financing of care on the basis of a means test is important to encourage continued family care and responsibility and to enable the individual to remain at home as long as possible. Income-tested public financing and regulation of institutions is considered essential to help the elderly and his family meet the rising costs of institutional care and to provide an adequate level of quality of care for those elderly who must enter an institution.

16. Major trends in long-term care policy

Major trends in long-term care policy in Israel are:

a. Providing more funds for the development of community as well as institutional services; increasing the availability of and access to services.

b. Providing benefits and services directly to the family caregivers in order to assist and encourage the family, which is the primary resource in Israel responsible for the organization and direct provision of care. In other words, family caregivers are becoming in themselves a target population for service development and planning for the elderly.

c. Raising the quality of care in institutions while increasing the number of beds to meet real need.

d. Developing policy which would not serve as an incentive to institutionalization, but would rather serve as an incentive to postpone institutionalization. This policy would be based on some form of personal entitlement in a universal system which would provide cash transfers and in-kind services to eligible elderly.

e. Encouraging greater provision of long-term services by voluntary organizations and private enterprises.

f. Increasing the number and improving the quality of manpower in long-term care in the community and in institutions.

g. Creating multi-purpose service centers which would provide a variety of care, e.g. residential homes which provide day care and respite care as well as long-term beds.

h. Coordinating the provision and monitoring of long-term care by local interdisciplinary committees.

i. Coordinating existing procedures for need assessment, determining service plans and service provision, using a case-management approach.

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