THE NATIONAL INSURANCE INSTITUTE
Research and Planning Administration

THE LONG-TERM CARE INSURANCE LAW:

Data from the First Two Years

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Preface

The National Insurance Institute is pleased to present this report describing Long-Term Care Insurance (LTCI) during its first two years of implementation. This law, legislated in 1986, created a new, innovative insurance branch as part of Israel's social security system. Implementation of LTCI took place in stages. During the first stage, which lasted two years, funds were transferred to the Ministry of Health and the Ministry of Labor and Social Affairs to expand services being provided in the community and in institutions. At this time, as part of the planning process, an experimental demonstration study was conducted in order to test various aspects of the law's implementation as well as to collect material for future evaluation of its impact.

Only in 1988, after much rigorous planning and testing, did the National Insurance Institute begin providing personal benefits to elderly on the basis of clearly defined eligibility criteria. The law is aimed at providing services to severely dependent elderly, enabling them to remain in their homes as long as possible and to share with families the heavy burden of caregiving.

The operation of LTCI is based on a high degree of interagency cooperation, many efforts having been made to utilize existing bodies in order to prevent the creation of unnecessary administrative structures and expenses. It is gratifying to point out that during its first years of administration, the effective and fruitful cooperation between the National Insurance Institute, the Ministry of Labor and Social Affairs, the Ministry of Health, the Sick Funds, and the local authorities responsible for providing social services, has contributed much to the law's achievements. These achievements can be measured especially in terms of the fact that today 5% of Israel's elderly population receive personal care services, compared to 1.5% prior to the law's implementation. This expansion in coverage was effected

with a minimal increase in manpower thanks to the dedication and efforts of many public officials responsible for implementing the law.

There is no doubt that LTCI constitutes an important achievement for Israel, which is indicative of its concern to protect the rights and meet the needs of its dependent elderly.

I would like to thank the Long-Term Care Insurance Branch involved in planning and responsibility for implementing the law. Our thanks also to the public health nurses, social workers in local authorities, nurses from the Sick Funds, and claims officers from the National Insurance Institute, all of whom made possible the smooth and efficient implementation of this law. Finally, I thank the staff of the Research and Planning Administration of the Institute which has played an integral role since the earliest stages of planning, and which continues to closely monitor the implementation of LTCI.

Mordechai Zipori

Director General

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Long-Term Care Insurance: General Principles

In April 1986 the Israeli Knesset (Parliament) completed the enactment of a law which created the Long-Term Care Insurance branch (LTCI) within the framework of Israel's social security system. The law was enacted in response to the convergence of a multiplicity of factors: demographic trends, the inadequacy of existing programmes in meeting needs, the growing burden of care of the elderly to their families, threatened cutbacks in services to the elderly during severe economic periods and the concomitant desire on the part of legislators to protect the most basic required services. In addition to specifically defined personal care and home-help services provided on the basis of personal entitlement, the law provides funds for service development in the community and in institutional settings, and for some additional beds in nursing homes.

LTCI in Israel should be viewed as a logical continuation and expansion of social policy for the aged under social insurance. Whereas for the past 15 to 20 years, comprehensive measures for income maintenance for the elderly have been developed and refined, this next step in social policy reflects a shift in focus toward a statutory allocation of resources for the functionally dependent elderly.

In effect, the primary aim of the law is to define formally the State's statutory obligation to provide long-term care services to the seriously disabled among the elderly, on the basis of personal entitlement and clearly defined eligibility criteria, thus meeting individual needs of the eligible elderly and enhancing the family's role as primary care-giver. LTCI therefore has two target populations: severely dependent elderly persons and their informal care-givers, where the latter exist. These specifically defined services and benefits were intended to supplement the discretionary, selective services previously being provided via the Health and Social Affairs Ministries and by the Sick Funds, but which were unable to respond adequately to the

increasing need and cost of service provision.

An important consequence of the emergence of LTCI in Israel is that it brought to public debate and resolution, in the form of legislation, many issues that had previously been considered solely in the province of professional literature: issues regarding the role of the family in providing care, and links between informal care provision and formal service structures; community versus institutional care; cash versus benefits in kind; centralisation versus decentralisation in implementation; roles of private and public agencies in service development and provision; and, in Israel, the drawbacks, benefits and cost considerations of a social insurance-based programme as opposed to existing public programmes based on more selective and discretionary modes of resource allocation. Some of these issues have now been resolved in the law; the debate on others is still going on and will continue in the context of future research and evaluation.

The basic principles underlying LTCI are:

- Personal entitlement to services and benefits in a social insurance programme, paid for by contributions from the working population. The aim of the personal benefit is to enable dependent persons to remain at home for as long as possible and to strengthen family care-givers by providing services. In fact, under this law the target population is the dependent older person as well as his or her family. The emphasis is on providing home and community services, not institutional care. Under the law, an individual is eligible for benefits only if he or she does not reside in a nursing home or nursing ward. However, it should be emphasised that the role of benefits is not to replace family functions and responsibilities. The family continues to have primary responsibility for the care and welfare of the individual, since the benefit provides only part of the services required.

- Continued expansion of the network of available services by allocating funds for service development in the community and in institutions. Increasing the availability and accessibility of quality services in the community, as well as of trained staff for providing care at home and in day care centres for the elderly, is viewed as essential to enable effective use of benefits to provide services in kind to eligible individuals.

- Creation of a programme which is based on a clear division between assessment for eligibility, on the one hand, and service provision, on the other. Service provision and case coordination are decentralised functions, while eligibility determination and monitoring based on uniform guidelines and instruments are centralised so as to ensure maximum equity under law and maximum control over targeting and costs.

Some of the main measures and provisions of long-term care insurance are:

- Responsibility for determining eligibility is solely that of the National Insurance Institute (NII). Men over age 65 and women over age 60, who are severely functionally disabled in activities of daily living or who require constant attendance due to the danger of harming themselves or their envrironment, are eligible for services or cash benefits.[1] (Functionally disabled individuals below this age are currently eligible for a cash attendance allowance under General Disability Insurance.) Eligibility level is defined in terms of the degree of functional dependency, i.e. the degree to which the individual is dependent on the help of

[1] The statutory differential age requirement by sex conforms with those for old-age pensions from the National Insurance Institute.

others in basic daily functions including mobility in the home, eating, dressing, washing, continence control, and the need for personal attendance or supervision. It does not take into account social and situational factors, met or unmet needs, etc. There are two levels of eligibility, according to the degree of dependency, as assessed by a public health nurse from the Ministry of Health in the home of the elderly person, using a uniform, objective assessment instrument for measuring activities of daily living (ADL). Each person receives a score based on the home visit. Additional points are awarded to persons living alone who have accrued at least two points in ADL dependency and to those requiring constant personal attendance. Total scores are translated into the two basic eligibility levels.

- The benefit is intended for elderly persons living at home, in the community. Thus, only persons living outside nursing homes and nursing wards may apply for a benefit. Persons residing in sheltered housing or old-age homes that are not publicly financed may also apply. For those elderly receiving a benefit while living at home, if a decision is made to enter a nursing home, the benefit is halted upon entry into the institution.

- Eligibility for benefits is income-tested. Income taken into consideration includes that of the elderly person and spouse. For a single person, income above 1.5 times the national average wage renders him non-eligible while an income equal to the average wage cuts the benefit by half. Increments are allowed for dependents (see Appendix B). In cases where the benefit will have to be provided in cash (see below), the income test considers income of a son or daughter who resides with the elderly person and is defined as the care-giver. In such cases, only high income (that above three time the average wage) is considered. Data for

the first two years of implementation shows that less than 1% of applicants were ineligible due to income level.

- There are two benefit levels, parallel to the two eligibility levels, one equal to the National Insurance basic disability benefit for a single person (equal to 25% of the national average wage) and the second at 150% of the basic disability benefit. (These two basic levels are again set pro rata according to the income test so that, in fact, there are four possible benefit rates.) The emphasis is on services in kind, not on cash benefits. Only in specifically defined instances where services are unavailable and the eligible person is being cared for by a relative living with him or her is it possible to receive a cash benefit, until services become available. Cash benefits are provided at a rate of 80 per cent of the benefit level, reduced by what has been calculated as approximately 20 per cent administrative costs of providing benfits in kind. Out of a total of approximately 28,000 beneficiaries in May 1991, approximately 150 received cash benefits.

- The kinds of services which can be provided under LTCI are carefully delineated in a "basket of services". These services derive directly from the definition of eligibility in terms of dependency in activities of daily living, and are closely related to direct caring functions. They therefore include personal assistance in the home or in organised community facilities (such as day care centres), home help (with light basic household chores), personal attendance, laundry, meal preparation and delivery, and supply of absorbent undergarments for the incontinent. Medical, paramedical and social support services are not covered under LTCI and remain the sole responsibility of other agencies, which, it is hoped, will complement LTCI

care plans when necessary.

- The National Insurance Institute has over-all responsibility for the law's operation and its monitoring. However, there is a sharing of responsibility in implementation between the Ministry of Health, the Ministry of Labor and Social Affairs, the General Sick Fund (Kupat Cholim), and the municipal authorities. Branches of the National Insurance Institute, which have sole responsibility for determining eligibility on the basis of functional disability in ADL, operate in conjunction with local professional committees, which are defined by law and which have responsibility for determining care plans, providing services, monitoring changes and reporting. Although the committee is an organ of the National Insurance Institute, each committee is staffed by a senior social worker from the municipal authority, who is also the committee coordinator, by a nurse from Kupat Cholim Clalit, Israel's largest Sick Fund, and by a clerk from the local branch of the National Insurance Institute. The committees operate via field professionals in the community - social workers from municipal welfare departments and nurses from sick fund clinics - who are in direct contact with eligible individuals and their families, submit care plan proposals to the committee and provide case management and coordination functions as required. This type of arrangement ensures that eligibility for benefits will be determined using uniform instruments and guidelines under the responsibility of a central agency, the National Insurance Institute (NII), thus ensuring an optimal measure of personal and regional equity in resource allocation. At the same time, it decentralises the most important professional functions at the level of case management and service provision, recognising that these are best understood and dealt with at the local professional level. Most importantly, this arrangement requires a very close

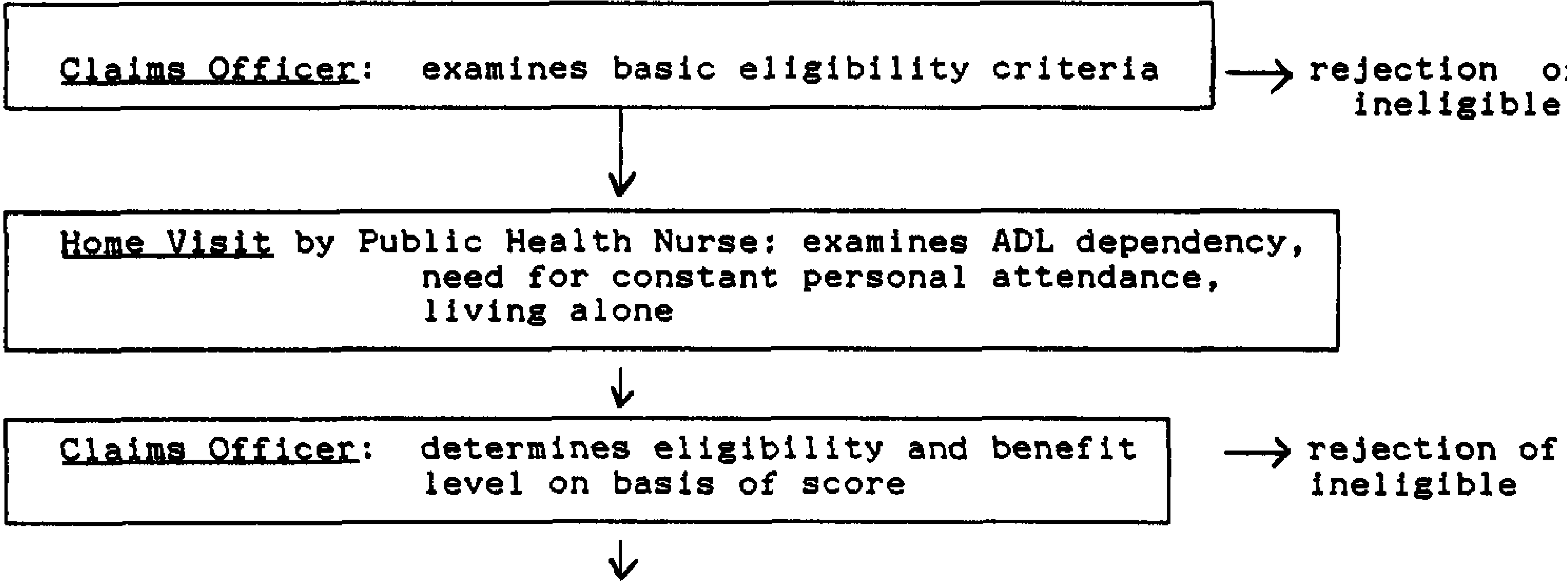
degree of interagency cooperation, defined under the law.

- In addition to stipulating required services, the care plan indicates which agencies will provide these services. The programme operates strictly on a sub-contracting basis, raising important requirements of licensing, regulation and monitoring. The payment for services is transferred directly from the National Insurance Institute's central office to the service provider agency, after authorization each month by the committee coordinator. Cash benefits are paid to the eligible person. Only certified agencies having legal status and approved by the Ministry of Labour and Social Affairs can be contracted with to provide services. Benefits cannot be transferred to private persons providing care.

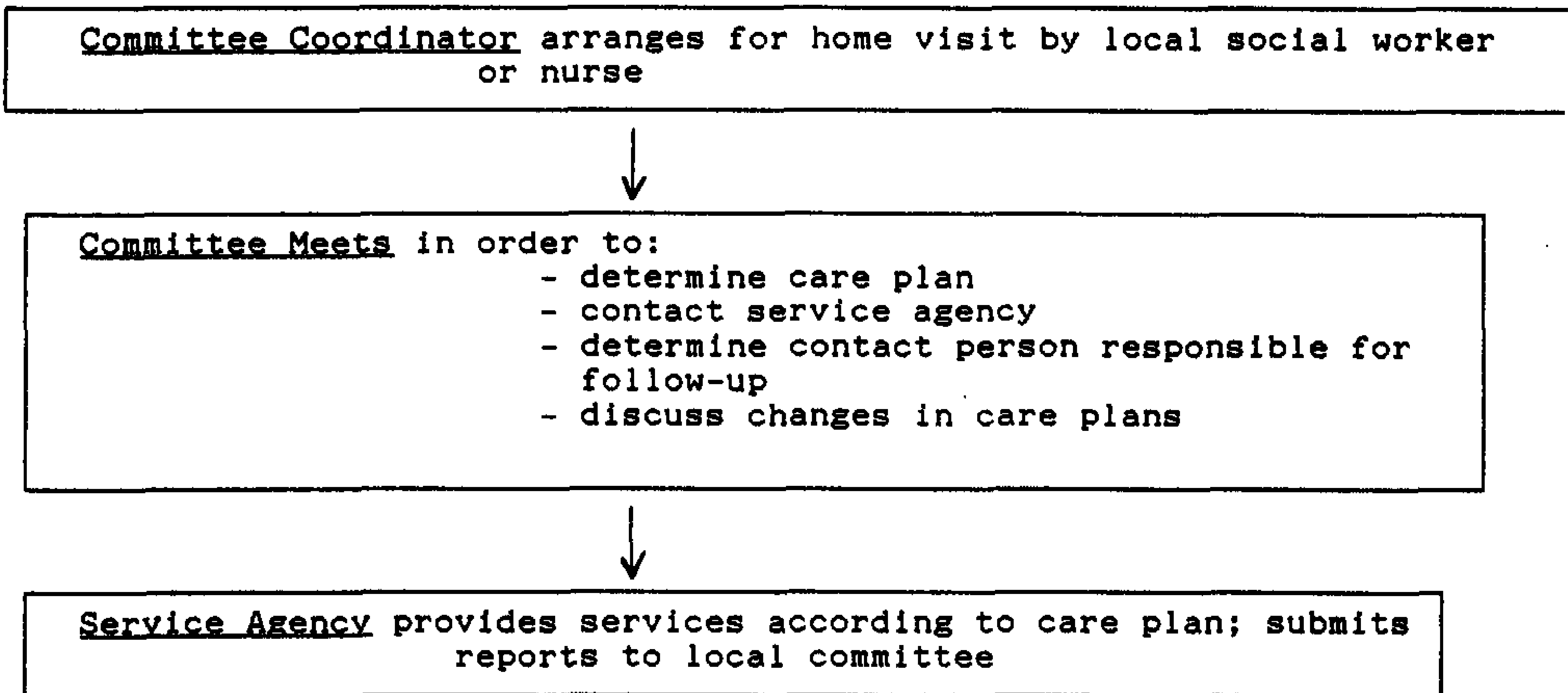
DIAGRAM 1

Procedure for Determining Eligibility and Providing Services under LTCI

I APPLICATION TO NATIONAL INSURANCE INSTITUTE BRANCH OFFICE



II LOCAL INTERDISCIPLINARY COMMITTEE: SOCIAL WORKER, NURSE FROM SICK FUND AND CLAIMS OFFICER



Applications for Long-Term Care and Eligibility

Since its inception in April 1988 till March 1990, 61,000 elderly submitted 71,494 applications for long-term care benefit (including reapplications). During the second year, there were 26% fewer applications overall than in the first year. After the first six months of operation, during which an unusually large number of applications were processed, the average application rate tapered off to a stable 2,550 per month (Table 1, Diagram 2).

TABLE 1

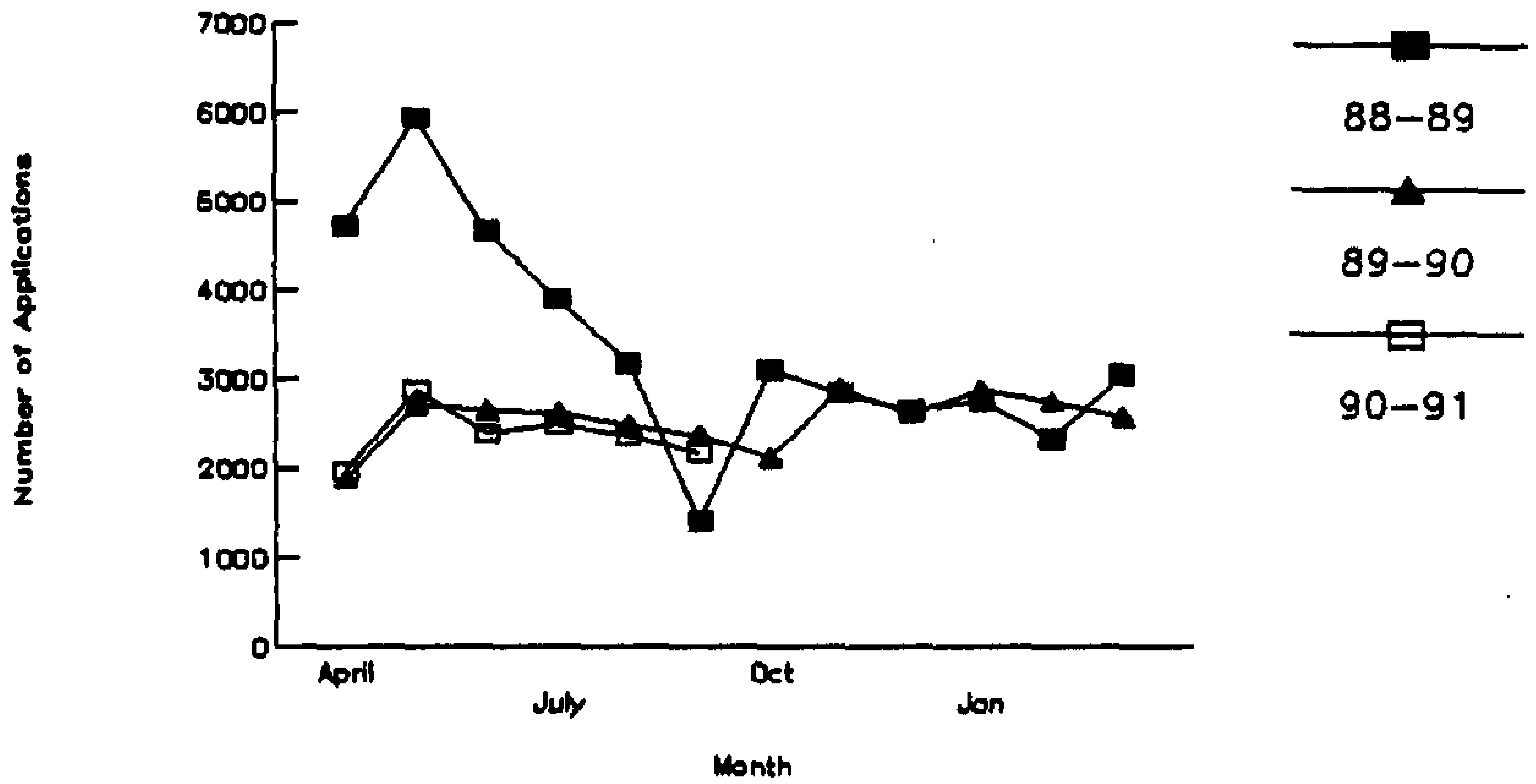
Applications, Eligibility and Reapplication Rates and Deaths, 1988, 1989

	Year	
	4/88 - 3/89	4/89 - 3/90
Total Number of Applications*	41,019	30,475
Percent Reapplication	8.8%	23.4%
Percent Eligibility	56.8%	48.3%
Number of Deaths	4,460	6,655
<u>Reasons for Rejection</u>		
(percentage of total rejections)		
Basic Eligibility Requirements	8.7	8.5
Income Test	1.0	1.0
ADL Assessment	90.3	90.5

Includes reapplications of elderly who have been determined ineligible.

Diagram 2 — Number of Applications

Per Month, 1988—1990



Compared to 57% in 1988, in 1989 the average eligibility rate was 48%, a reduction of 9%. This datum reflects the fact that during the first year of implementation, LTCI absorbed a relatively higher proportion of elderly who had been disabled for years, while by the second year the new applicant population was somewhat less severely disabled. Interestingly, the eligibility rate is still on the decline and by June-July of 1990 it was 44% of applications in these months. Reasons for rejection were similar in both years: 90% of the applications were rejected after applicants did not accrue sufficient points in the ADL assessment, 9% on the basis of not meeting basic eligibility requirements such as age, residence, etc., and only 1% due to high income level. 74% of the eligible population were found eligible for the standard benefit and 26% for the increased benefit.

An interesting trend is the steady increase in the number and rate of reapplication. According to LTCI a person may reapply if his condition deteriorates, no waiting period being required. If we consider only reapplications of those who were previously rejected, the percent out of the total number of applications increased sharply, from only 8.8% during 1988 to an average of 23.4% in 1989, and is still rising. This trend suggests that it will be unrealistic to expect an easing off in the administrative load, since processing reapplications requires the same administrative and professional effort in terms of procedures and resources as do new applications.

Application and Eligibility Rates in Comparison to the Total Elderly Population

As noted above, men aged 65+ and women aged 60+ may apply for a benefit. Eight per cent of this relevant elderly population applied for a benefit during the first year of implementation and six per cent during the second year (see Tables 2 and 3). The eligibility rates in the corresponding

years were four and five per cent, respectively. Eligibility rates were derived from the year-end number of eligibles.

During the first year, 30% of those aged 85 and over applied for a benefit. This pattern resulted in the applicant population being relatively older than the general aged population. For example, whereas the 75+ group constituted less than 35% of total elderly population, they were approximately 66% of the applicant population and almost three-quarters of the eligible. Even greater differences were found for the group aged 80 and over.

Whereas the overall eligibility rate showed only a slight change in the second year, the older age groups had more marked increases, for both men and women. In the first year of implementation, the age groups 80-84 and 85+ had eligibility rates of 9% and 17%, respectively. In the second year, these figures jumped to 13% and 23%.

Of the total number of applicants in 1989-90, almost two-thirds were women and one-third men. In the general elderly population, 62% were women. The higher proportion of women out of the total elderly population applying for benefits was found in all age groups except those aged 85+, where similar rates of application were found for men and women.

TABLE 2

Applicants and Eligible by Age and Sex, 1988/89

Age	Total Elderly Population*	Applicants		Eligible**	
		% of Total Population	% of All Applicants	% of Total Population	% of Eligible
Total No.	472,700	8	37,544	4	17,064
Total %	100.0	-	100.0	-	100.0
60-64	18	2	6	1	4
65-69	26	4	12	1	10
70-74	23	6	17	2	15
75-79	19	11	25	5	25
80-84	9	19	21	9	23
85+	5	30	19	17	24
			Men		
Total No.	179,400	7	12,518	3	5,762
Total %	100.0	-	100.0	-	100.0
65-69	33	2	11	1	9
70-74	27	4	15	2	14
75-79	23	18	26	3	24
80-84	12	14	25	7	25
85+	6	27	23	15	28
			Women		
Total No.	293,300	9	25,026	4	11,302
Total %	100.0	-	100.0	-	100.0
60-64	29	3	8	1	6
65-69	23	5	13	2	11
70-74	20	7	17	3	15
75-79	16	13	25	6	25
80-84	8	21	20	10	22
85+	5	30	17	18	22

* Israel Statistical Yearbook, 1988, population of 1987.
** Eligible for services, March 1989.

TABLE 3

Applicants and Eligible by Age and Sex, 1989/90

Age	Total Elderly Population*	Applicants		Eligible**	
		% of Total Population	% of All Applicants	% of Total Population	% of Eligible
Total No.	479,400	6	27,870	5	23,928
Total %	100.0	-	100.0	-	100.0
60-64	17	2	5	1	3
65-69	28	2	13	2	10
70-74	21	4	16	4	15
75-79	20	7	23	6	23
80-84	10	14	25	13	25
85+	5	21	18	23	24
Men					
Total No.	182,200	5	8,889	4	7,746
Total %	100.0	-	100.0	-	100.0
65-69	34	1	10	1	8
70-74	25	3	14	2	14
75-79	23	5	23	4	23
80-84	12	11	27	9	27
85+	6	21	26	20	29
Women					
Total No.	297,200	6	18,980	5	16,182
Total %	100.0	-	100.0	-	100.0
60-64	28	2	8	1	5
65-69	24	4	13	2	11
70-74	18	6	17	5	15
75-79	16	9	23	8	23
80-84	8	17	20	16	24
85+	5	21	17	26	22

* Israel Statistical Yearbook, 1989, population of 1988.
** Eligible for services, March 1990.

Elderly individuals who reported living alone constituted a surprisingly high proportion of the applicant and eligible populations, compared to the general elderly population (see Table 4). The proportion of this group increases with age and is twice as high among female applicants and beneficiaries as among males.

To summarize, the applicant group is not demographically representative of Israel's elderly population. Among applicants, the oldest groups and those who live alone (primarily females) are over-represented, these two characteristics being correlated in the population of elderly.

TABLE 4

Comparison of Groups by Household Composition, 1989/90
(percentages)

Elderly Population	Total	Alone	With Spouse	Other
Total	100	27	50	23
Applicants	100	44*	43	11
Eligible	100	41*	42	13

* These figures may be somewhat overestimated. The proportion of eligible individuals who received additional points in ADL for living alone was lower, but may not be fully documented for severe cases in which the added points in ADL made no difference in eligibility level.

Approval Rates

In the first two years of the implementation of the LTCI, significant differences were found in the approval rates according to age, sex and household composition (Table 5). Approval rates are based on the number of eligible out of the number of applicants. The older the age group, the higher was the approval rate. Men had a significantly higher rate than women, especially those men living with a spouse (62%).

TABLE 5

Approval Rates According to Demographic Parameters*

Parameter	Approval Rate
Total	53.0%
<u>Sex</u>	
Female	50.6%
Male	58.2%
<u>Age</u>	
60-64**	41.4%
65-69	46.8%
70-74	50.8%
75-79	52.1%
80-84	55.0%
85+	62.4%
<u>Household Composition</u>	
Alone - Total	49.3%
Female	49.4%
Male	49.2%
With Spouse - Total	54.6%
Female	48.0%
Male	62.0%
Other - Total	60.8%
Female	60.6%
Male	62.0%

* From April 1988 to March 1990.
** Includes women only.

Level of Eligibility

The proportion of recipients receiving lower and higher benefits were similar for both 1988 and 1989: after the first few months of implementation, when as many as 37-38% of recipients were eligible for the higher benefit, only one quarter were determined eligible for this higher benefit. As seen from Table 6, for only 2% of the eligible population was the benefit reduced by half due to income (see introduction for income test).

TABLE 6

Eligible Population by Benefit Level

Year	Total Eligible	Benefit Level			
		50%*	75%*	100%	150%
88/89	100%	1.2	0.7	71.1	27.2
89/90	100%	1.2	0.9	72.3	25.6

* Eligible whose benefit level was reduced by 50% due to income.

Further comparison of level of eligibility by age and sex for the population of applicants in the first two years shows the following differences (see Table 7):

1. The increase in rate of eligibility for the higher benefit by age is found particularly among women applicants, while being more stable for men.

2. At all ages, excepting 85+, men are more likely than women to be eligible for a higher benifit.

In spite of the fact that there are relatively more dependent women than men in the community, these differences suggest that not only are men who apply more likely to be dependent, but that their level of dependency tends also to be more severe in comparison to elderly women. Interestingly, these differences are more pronounced among younger age groups.

TABLE 7

Eligibility Levels by Age and Sex, 1988/90#
(percentages)

Age	Eligibility Level*			
	Total	0	100%**	150%**
Total Applicants	100	43	42	15
60-64	100	50	39	11
65-69	100	46	42	13
70-74	100	41	44	15
75-79	100	40	44	16
80-84	100	35	49	13
85+	100	28	49	23
Women	100	41	44	15
60-64	100	50	39	11
65-69	100	49	40	11
70-74	100	44	42	14
75-79	100	42	43	15
80-84	100	37	47	17
85+	100	29	49	22
Men	100	36	44	20
65-69	100	39	45	17
70-74	100	37	45	18
75-79	100	38	43	20
80-84	100	36	43	21
85+	100	30	48	22

Population of those applying in first two years.
* A level of '0' signifies ineligibility.
** Includes recipients of reduced benefits.

Criteria for Determining Eligibility

The decision to accept or reject an individual's claim for a long-term care benefit is made in a two-stage process.

During the first stage, a review is made of basic conditions of eligibility specified under the law's provisions: age, residency status and income. The procedures in this stage are carried out by claims officers at branch offices of the National Insurance Institute where claims are submitted. The second stage of eligibility determination is based on an assessment of dependency performed by a public health nurse (from the Ministry of Health) in the home of the elderly. The assessment of dependency is comprised of three components: an ADL assessment, the need for constant personal attendance and whether the person lives alone. On the basis of the score accrued in these items, entitlement and level of benefit are determined.

ADL Assessment

Using a cumulative point system the ADL assessment instrument (see appendix) measures the degree to which the claimant requires the assistance of others in the performance of the following basic ADL functions: mobility in the home, dressing, bathing, feeding and continence control. Each ADL item measures several levels of dependency, from total independence to total dependence on the help of others. The maximum points that can be accrued in ADL is 8.0. Claimants who live alone and who score at least 2.0 points in ADL receive an additional 2.0 points.

The Need for Constant Personal Attendance

In addition to assessing ADL dependency, the public health nurse also determines whether the claimant requires the constant presence of another individual at home in order to prevent his

harming himself or his surroundings. This is assessed on the basis of the elderly person's awareness of his surroundings, his judgmental ability, memory and history of accidents. Included are any exceptional behavioral incidents, as well as other risk factors in the home. Based on first hand impressions, the claimant's response to a series of simple questions, and in accordance with the reports of family care-givers, the nurse determines the need for constant personal attendance, and allocates and additional 6.5 points to the ADL score. No additional points are given for partial attendance requirements, these having already been incorporated in the scoring for basic ADL items.

Eligibility Routes

Level of eligibility is determined as follows:

0 - 2.0 points	- rejection
2.5 - 6.0 points	- eligibility for lower benefit
6.5 + points	- eligibility for higher benefit

As stated, a claimant becomes eligible if he exceeds the eligibility threshold, that is, scores at least 2.5 points, in accordance with any of the following possible combinations:

a. ADL score of at least 2.5; constant personal attendance not required (total score 2.5 - 8.0).
b. ADL score of only 2.0; lives alone and is therefore entitled to an additional 2.0 points; constant personal attendance not required (total score 4.0).
c. ADL score of at least 2.5; constant personal attendance required: 6.5 points (total score 9.0+).
d. ADL score of less than 2.5; personal attendance required: 6.5 points (total score 6.5 - 8.5).

TABLE 8

Distribution of Beneficiaries by Possible Score Combinations for Eligibility 1988, 1989
(percent of total)

Year	Total Eligible	ADL(2.5+)	ADL(2) Lives Alone (2)	ADL(2.5+) Attendance (6.5)*	ADL(-2.5) Attendance (6.5)*
1988/89	100	75	7	14	4
1989/90	100	79	9	9	3

* The two points awarded for living alone is disregarded in these categories

Table 8 shows that, of the total number of beneficiaries in 1988/89 and 1989/90, 75% and 79% respectively, derived their eligibility solely from their ADL score. Less than 10% were eligible solely because they lived alone and were therefore allocated an additional 2 points to their ADL score of 2.0. An additional 3-4% scored less than 2.5 on their ADL but were judged eligible (for a higher benefit) solely due to their need for constant personal attendance. The total proportion of beneficiaries receiving a score for constant personal attendance decreased from 18% in 1988 to 12% in 1989, possibly due to the relatively physically "better" condition of applicants in the second year, in terms of functional ability.

Taking a closer look at this group (Table 9), we found that the percentage of both applicants and eligible elderly requiring constant personal attendance was slightly higher among men than women, and increased steadily with age for women while remaining relatively constant for men up to age 80, after which we find a slight drop in this rate. Men living with others were the most likely to require attendance, when examined by family composition. The reasons for this are unclear and deserve further attention. There was a sharp decrease from the first to second year in the rate of those requiring constant personal

attention. The steepest decline was among women in the age range 60-75. These figures further indicate that the most severely disabled elderly applied to receive long-term care in the program's initial year.

TABLE 9

The Proportion of Applicants and Eligible Requiring Constant Personal Attendance by Age and Sex, 1988, 1990

Age	Percent Applicants Requiring Attendance*		Percent Eligible Requiring Attendance**	
	89/90	88/89	89/90	88/89
Total	6	11	13	18
60-64	3	8	9	15
65-69	3	9	10	15
70-74	5	10	11	17
75-79	6	11	14	19
80-84	6	13	13	20
85+	7	14	14	19
		Men		
Total	7	14	14	21
65-69	5	11	12	18
70-74	7	12	14	19
75-79	6	14	15	22
80-84	7	15	14	22
85+	7	14	13	20
		Women		
Total	5	10	12	17
60-64	3	8	9	15
65-69	3	7	9	14
70-74	4	9	9	16
75-79	6	10	13	17
80-84	6	12	12	18
85+	8	14	14	19

Proportion of total number of applicants in each age group.
* Proportion of total number of eligible applicants in each age group.

Examining the distribution of applicants according to detailed ADL and total scores (see Table 10) reveals what might be a slight tendency to accord points which place the applicant just above the eligibility threshold. Unusually high proportions are clustered around the eligibility thresholds. We find a sharp increase in total scores from 3% receiving a sub-eligibility threshold score of 2.0 to 8.4% receiving a 2.5 score. Similarly, among those living alone, an unusually high 13.4% of total applicants received an ADL score of 2.0, which automatically raises their total score to eligibility level, as a result 12.2% received a total score of exactly 4 points.

Aside from the tendency for scores to cluster around the eligibility threshold, we do find a distribution over the entire score range. In fact, while there were some applicants who became eligible for the lower benefit on the basis of a 2.5 score, a significant number were eligible for the same benefit level with a score of 5-6.0. There is therefore a wide disparity of scores among those eligible for the lower benefit. It is clear therefore that not all recipients of the lower benefit have similar levels of functioning. Similarly, we find severely disabled individuals with a range of high scores. A policy issue for consideration might consider possibilities for expanding the current format of two benefit levels to allow for intermediate levels, perhaps changing the score ranges to permit those having higher dependency scores to receive an even higher benefit while those having low scores to be eligible for a reduced benefit. This might achieve a better "fit" between benefit level and service needs.

TABLE 10

Distribution of Applicants by ADL Points and Total Dependency Score, 1989/90

Score	All Applicants		Living Alone	
	ADL Only*	Total Score**	ADL Only	Total Score**
Total	100.0	100.0	100.0	100.0
0.0	16.0	15.0	18.0	17.7
0.5	10.3	10.0	11.3	11.0
1.0	9.2	8.8	9.8	9.4
1.5	7.3	6.7	7.3	6.7
2.0	9.0	3.0	13.4	1.5***
2.5	13.3	8.4	13.6	4.1
3.0	7.9	5.2	7.1	2.2
3.5	6.2	4.4	4.9	1.0
4.0	4.0	8.4	2.5	12.2
4.5	4.2	7.1	3.2	10.0
5.0	3.2	4.5	2.2	5.2
5.5	2.2	2.9	1.5	3.2
6.0	1.4	1.5	1.1	1.6
6.5	1.8	2.2	1.1	2.3
7.0	1.3	1.7	0.9	1.7
7.5	1.1	1.3	0.7	1.0
8.0	1.5	1.7	0.9	1.2
8.5		0.6		0.6
9.0		0.6		0.5
9.5		0.7		0.5
10.0		0.6		0.6
10.5		0.5		0.5
11.0		0.6		0.4
11.5		0.5		0.2
12.0		0.4		0.4
12.5		0.4		0.2
13.0		0.4		0.2
13.5		0.2		0.2
14.0		0.3		-
14.5		0.3		-
15.0		-		-
15.5		-		-
16.0		-		-
16.5		-		-

* ADL does not include additional points for living alone and constant attendance.

** Includes scoring for individuals reported living alone and for constant personal attendance.

*** This group includes applicants who reported that they were living alone but who were not recognized as such in accordance with NII regulations.

Reassessment of Dependency Level

Reassessment of dependency is conducted by a public health nurse in the following situations:

- reapplication after previous rejection;
- reapplication for the higher benefit;
- re-examination of eligibility at the initiative of the National Insurance Institute due to new information regarding improvement in functional ability (or as part of periodic monitoring).

As mentioned, 23% of all applications in 1989/90 were in fact reapplications. (Some individuals applied as many as eight times.) In addition regulations require reassessment after six months of eligibility (see Law, Appendix D) in those cases where there is an indication of possible improvement in the dependency status of the individual.

Table 11 shows the results of all reassessments of dependency, most of these being the result of reapplication. In 42%, there was no change in eligibility status, 38% became eligible, and 17% increased their benefit level. In only 3% of the cases was the benefit reduced or eligibility cancelled. This reflects the difficulty involved in moving people out of the system, in spite of a certain, although unknown, proportion of elderly whose condition might be improving, especially among younger beneficiaries who became eligible after surgery, hospitalization, etc. With regard to reapplications after eligibility had been denied, a total of 51% of reapplications were submitted within three months of the first rejection: 18% were submitted after less than one month had passed since the last assessment, 18% were submitted within two months and 15% in the third month. This pattern, which is placing an incredibly heavy load on the administrative system, deserves further study in order to limit reapplication to those in real need.

TABLE 11

Results of Re-examination, 1989/90

Situation Description	Percentage
Total Reassessments	100
No change in eligibility	
Remained rejected	21
Remained eligible	21
Positive Change in eligibility	
Previously rejected, became eligible	38
Previously eligible, benefit level increased	17
Negative Change in eligibility	
Previously eligible, rejected after reassessment	2
Previously eligible, benefit level reduced	1

Form of Service Provision

At the end of the second year of implementation (March 1990), the number of eligible individuals was 23,928, an increase of 40% over the previous year. (Only 22,799 in fact received services during this month; see discussion below on service refusers.) In 95% of these cases in-kind services were designated in the care plan, reflecting the success of local committees in identifying needs, locating appropriate service agencies and getting care into the home of the eligible. This was true for all localities in Israel. Individuals eligible for a cash allowance, due to the fact that services were unavailable in the community, remained a negligible 1% of total number of eligible. A total of 4% of the eligible declined to receive services offered by the local committees and thus received no benefit. (See separate discussion of this group below).

Service Mix

During the first two years, the majority of recipients received personal care at home as the sole benefit, while 13% received additional services in the home as well, these being primarily disposable paper undergarments, laundry service, and meals-on-wheels (see Table 12). An additional 6% of the elderly were in day care centers as part of their care plan, an increase from 4% in the previous year. This growth is perhaps indicative of a slowly increasing utilization of this important service as a result of LTCI. Those receiving the higher benefit had the highest proportion (28%) receiving additional services to basic home care. Relatively more of this group were also receiving services in a day care center, in comparison to those eligible for the lower benefit. Clearly, the range of services received is related to the benefit level.

TABLE 12

Eligible by Benefit Level and Care Plan
(April 1989 - March 1990)

Care Plan	Total	100%	150%
Total (%)	100	100	100
Benefit - Care at Home Only	79	86	62
Benefit - Day Care Center Only	2	2	4
Benefit - Home & Day Care Center	4	4	3
Benefit - In Home and Other Care	13	8	28
Other	2	1	3

It is important to point out that there is some discrepancy between the number of eligible individuals for whom care plans have been approved and the number of service recipients, due to an inevitable delay between the committee's decision and the date on which service provision begins for some recipients. Moreover, especially during the first year, a gap was sometimes found between the benefit level and the number of monthly care hours actually provided, for the following reasons:

- hospitalization or death of recipient; services were terminated before the end of the month;
- services began in the middle of the month or, for various reasons, at a later date than that set by the committee;
- partial delivery of services because of a change in homemaker.

These discrepancies, although much reduced in the second year of operation, must be taken into consideration in the examination of total and per capita expenditures.

The following table presents recipients at selected periods during the first two fiscal years, by type of service, average number of hours provided and average per capita costs per service (in constant shekels and U.S. dollars).

TABLE 13

Recipients, Hours of Care and Costs
Selected Months 1988, 1989

Month and Service	Recipients Total	Total Monthly Hours of Service	Average Monthly Cost Per Recipient		Average Monthly Hours @ Recipient	Average Cost of Service Hour	
			(NIS)#	($)		(NIS)#	($)
November 1988							
Personal Care	9,762	452,234	535	270	46.33	11.6	[illegible]
Day Center**	430	-	355	179	-		-
Disposable Undergarments**	931	-	183	92	-		-
Laundry, Others**	47	-	69	35	-		-
March 1989							
Personal Care	13,734	629,529	538	256	45.80	11.7	[illegible]
Day Center**	649	-	370	176	-		-
Disposable Undergarments**	1,186	-	185	88	-		-
Laundry, Others**	132	-	58	28	-		-
October 1989							
Personal Care	18,517	843,737	554	263	45.53	12.2	[illegible]
Day Center**	965	-	365	173	-		-
Disposable Undergarments**	1,619	-	171	81	-		-
Laundry, Others**	264	-	50	24	-		-
March 1990							
Personal Care	20,698	919,029	549	273	44.4	12.4	[illegible]
Day Center**	1,116	-	389	193	-		-
Disposable Undergarments**	1,753	-	162	81	-		-
Laundry, Others**	343	-	50	25	-		-

At constant March 1990 New Israel Shekels (NIS).
* Recipients can receive more than one service.
** No reliable date available for provision and cost per service unit for these services.

We find the number of personal care recipients, for example, steadily increasing from 13,734 in March 1989, to 20,698 at the end of the second fiscal year, with the average number of hours provided monthly decreasing slightly and the average per capita monthly and hourly costs slowing a gradual increase. The increase in total monthly expenditures on personal home care increased by 54% while the number of recipients increased by 51%. This is explained mainly by the slow, steady increase in the average cost per service hour, adjusted over the year according to changes in the national average wage. Over the two-year period, the average number of hours received monthly decreased slightly, by almost two hours. There has also been a steady increase in the size of total and per capita monthly expenditure on day-care centers, reflecting the growing use of this form of care.

Day-Care Centers

Adult day-care centers were the mode of delivery of personal care services for 6% of recipients in March 1990. Of these, 57% also received some personal care services at home. The decision to choose day-care centers is based not only on suitability but also availability of day-care in specific localities. This is reflected in different utilization rates of day-care centers by NII region. In the highest utilizer, the Netanya region, 15% of all recipients received either total or partial personal care from a day-care center. In contrast, some regions had almost no recipients attending day-care centers, these areas also having few day-care facilities.

Almost two-thirds of recipients receiving care at day-care centers received the standard benefit, and a third received the higher benefit. In comparison with those recipients receiving home-based care only, a higher proportion of day-care recipients received the higher benefit (35% versus 24% in the former group), due primarily to the higher proportion of day-care center attendees certified as being in need of constant personal

attendance, 30%, versus 15% among home care recipients. It would seem that the care programs which at least partially include the utilization of day-care centers are more likely to be preferred by the recipients requiring personal attendance, thus providing an important relief service for the family.

Recipients who attend only day-care centers have considerably greater access to personal care than do home-based recipients. For examples, instead of 10 weekly hours of personal care which home-based recipients usually receive (at the lower benefit level), the day-care center attendees receive 5 days of care (5-7 hours per day). Partial day-care center attendees have their benefits adjusted pro rata.

An analysis of day-care center attendees by sex shows that 45% are males and 55% are females. This represents a considerably larger proportion of males than in the total recipient population (34%). Attendees are also a relatively younger group than the general recipient population.

Service Providers

Services provided under LTCI are supplied under a sub-contracting arrangement through agencies authorized by the Ministry of Labor and Social Affairs, the conditions of service delivery being determined by a contract between the NII and the agency. These agencies include non-profit organizations as well as private, for-profit agencies. Under the law's provisions a kibbutz or a moshav (rural settlements having different modes of collective ownership) are considered service providers.

In spite of the fact that there was very little provision of home care by the private market prior to LTCI, the breakdown of recipients by service agencies shows the dramatic increase in the role of the private sector immediately following its implementation.

During both years, service provision was divided almost equally between non-profit and private agencies, both in terms of number of clients and service hours, with the private sector having a somewhat smaller share of the market in terms of payment (see Table 14). Israel's largest non-profit homemaker service, Matav, provided care to about one-third of LTCI recipients. Interestingly, the burden of service provision was shared equally by private and non-private agencies also in terms of the number of highly dependent recipients receiving the increased benefit, these generally being more difficult to care for in the home. This finding would seem to indicate that no preference was shown toward either sector even in the most serious cases. Note that the proportion of severe cases was especially high among kibbutz and moshav residents, suggesting either the relatively high proportion of severe dependency of elderly in these communities, or the establishment of support systems which serve as alternatives to institutionalization.

TABLE 14

Recipients: Service Hours and Expenditures by Type of Service Agency*
April 1989 - March 1990

Agency	Recipients	Hours / Month	Expenditures	% Receiving Increased Benefi
Total (Percent)	100	100	100	28
Matav-Non Profit	30	32	32	26
Other Non-Profit**	14	12	14	25
Private	49	49	46	28
Kibbutz, Moshav	3	3	4	46
Cooperative	4	4	4	25

* Individuals receiving services from more than one agency are counted twice

** Includes small community non-profit organizations and day care centers.

Refusal to Receive Services

Eligible individuals who decide to decline services offered them under LTCI are categorized as "service refusers." According to existing procedures, after a person is determined eligible, the local social worker is responsible for designing a care plan together with the elderly and his family, according to their specific requirements. This plan is then submitted to the local committee for discussion and approval. If in spite of all attempts, the individual persists in refusing services offered, a brief report explaining reasons for the refusal is submitted to the committee coordinator. The eligible individual then receives notification from a NII claims officer that he has the right to reverse his decision and receive services.

In the course of the law's first year of implementation, 922 eligible persons declined to receive the services offered, although some subsequently changed their minds and decided to accept the services. Thus, by the end of the first year there were 669 and by the end of the second year 732 persons who declined services. An examination of changes that took place in the status of this group during the first year showed that approximately one-half of those who declined to receive services persisted in their refusal, one-quarter reversed their position and began to receive services and one-quarter had originally received services but subsequently changed their mind (see Table 15).

TABLE 15

Change in the Status of Individuals who Declined Services, 1988/89

	Total	Steady Refusal	Service Provision Followed by Refusal	Refusal Followed by Provision	Death
Numbers	922	448	221	229	24
Percentage	100	49	24	25	2

A comparison of all eligible persons to those who declined services indicated that these were generally less functionally disabled, although 17% were, in fact, eligible for an increased benefit (see Table 16). No differences were found by age, sex or household composition, although it might have been expected, for example, that those declining services would be more likely to have immediate access to informal care, such as from spouses or children living in the household.

It was surprising, therefore, that 37% of all service refusers consisted of persons living alone, a group generally considered an important target for service delivery, and who would, it would seem, welcome personal care in the home. Some of this latter group, it should be mentioned, had only minor dependency levels and became eligible due to the two additional points accrued for living alone.

A comparison between all those who declined services and those who consequently reversed their initial refusal showed that individuals in the latter group were more likely to be males, to live with a spouse, and to have significantly higher dependency levels. It is not clear why household composition might affect the decision to reverse a previous refusal of services.

TABLE 16

Individuals Who Declined Services by Dependency Score, 1988/89

	Total		Dependency Level			
	Numbers	%	2.5-4.0	4.5-6.0	6.5-9.0	9.5+
Total Eligible	20,966	100.0	41.9	28.7	15.4	14.0
Total Refusers	669	100.0	55.0	28.4	8.7	7.9
Refusers who Consequently Received Service	268	100.0	44.8	28.0	11.5	15.7

In order to examine more closely the reasons for eligible persons declining services, a detailed study was conducted in several NII branch offices. In most cases the information was found in the files containing reports by the local social worker and the committee coodinator.

The most frequently given reason for declining services (40%) was the demand for a cash allowance in lieu of services, either on the part of the eligible elderly or his family. In some cases the demand for cash allowance was specified for housekeeping help or for institutionalization. In other cases it was requested as compensation for a relative who was already providing care to the elderly. The second most frequent reason (21%) was the elderly person's opposition to a non-relative providing personal care sometimes because a relative was already providing care. This was often due to specific cultural or religious attitudes which frown upon the idea of a stranger entering the home and providing care to the elderly. Other reasons for refusing services include: a refusal on the part of a home helper who already worked in the household to register with a recognized service agency (concomitant with the elderly's refusal to accept a different or additional homemaker) (25%), the

demand for household help only rather than for personal care (11%), or the general lack of interest in formal care (8%). In some cases the applicant's functional condition had improved by the time the social worker visited the home and there was no real need for the kinds of services being offered. On the other hand, in other cases the number of care hours offered was felt to be inadequate or the family requested that service delivery be postponed to a later, more convenient date.

Income of Long-Term Care Recipients

This section presents a preliminary analysis on the income sources and income level of those eligible for the long-term care benefit. It was previously noted that an income test is required for all long-term care applicants, in addition to other eligibility preconditions which must be met. The percent of elderly denied a long-term benefit because of high income is very small, 1% of applicants. Data on the income patterns of the elderly in Israel is drawn from the 1985 Survey of the Elderly. To give a general measure of the income of the entire elderly population, the median household income was only 38% of the average wage. Approximately 3% of all elderly households have an income higher than the income test set for long-term care eligibility, according to the 1985 survey. There is reason to assume that the proportion of those having high incomes among the recipient population is considerably lower than that among the general population (see below). It would appear, then, that the applicants rejected on the basis of the income test are only a segment of potential applicants who have practiced self-selection. Recognizing that they would be rejected on the basis of income, many elderly may have been discouraged from applying for long-term care.

By income source, 95% of long-term care recipient households receive Old-Age/Survivors Pension from the National Insurance Institute, and a quarter have income from an occupationally-based pension plan (see Table 17). These proportions are to be compared with the households among the general population, where slightly less receive Old Age/Survivors Pension (91%) and considerably more have an occupationally-based pension income (38%). In general, the recipient population has fewer financial resources than does the general elderly population.

TABLE 17

Comparison of Income Sources Between Recipient Households of Long-Term Care and the General Elderly Population

Population Group	Number of Households (000)	Income Sources (Percentage)			
		NII*	Pension	Work	Other
Total **	273.1	91.0	38.4	21.5	25.4
Recipients#	16.5	95.0	24.5	2.7	10.1

* Includes Old-Age/Survivor and other benefits of the National Insurance Institute.
** See A. Zipkin and B. Morginstin, Income Patterns of the Elderly, Publicati No. 63, Department of Research and Planning. The National Insurance Institute, 1989.
# As of March, 1989.

The disparity between income sources finds clearer expression in the distribution of income level. Table 18 shows that seven out of ten recipient households have an income less than or equal to half the average wage, while 57% of the general elderly population has a similar income level. Moreover, proportionately twice as many households in the general elderly population than in the recipient population have an income exceeding the average wage.

The recipient population is clearly less financially secure than is the general elderly population, which itself has an average income level lower than the population at large. This lack of resources is a serious constraint on maintaining quality of life and on the purchase of needed ancillary services, beyond what LTCI provides.

TABLE 18

Comparison of Household Income Levels Between the General Elderly and Recipient Population#

Population Group	Number of Households (000)	Income Level (Percent) As Proportion of Average Wage*		
		Up to 50%	50%-100%	>100%
Total**	273.1	57.4	26.3	16.3
Recipients*	16.5	69.6	12.7	7.7

* Adjusted to average wage, March 1990 - 2,191 NIS/monthly.
** Source, see above Table 18 .
\# As of March 1989.

Financing the Long-Term Care Law

Being a social insurance program since 1980, LTCI has been financed by payroll contributions. It is currently financed through contributions from three sectors: government, employees, and employers. From the initial year of collections in 1980, the contribution rate has been a constant 0.2 percent of employee wages. The division between these three sources of contribution has changed since 1980, however, due to changes in the government's economic policy to ease the tax burden on employers and reduce the cost of labor. In 1980 the contribution rate was divided equally between employers and employed, 0.1 percent each, with no government contribution. By April 1, 1990, this distribution had changed significantly for employers, to 0.04 percent of employees' wages. The government then began to pay 0.06 percent, and the employees' contribution rate went unchanged.

The collection of contributions began in 1982, while the first year of expenditures was not until 1986. The program was thus able to accumulate a considerable reserve fund.

Expenditure by Program

The Long-Term Care Law funds more than direct assistance to recipients, although this comprises the bulk of expenditures. Provisions of the law stipulate that a significant proportion of contributions be allocated to the Ministry of Labor and Social Affairs and the Ministry of Health for the purposes of development of community services and supplemental nursing home beds. Nursing home beds are funded for both the independent and the frail elderly. In addition, the law also provides for the funding of non-governmental institutions which develop either community services for the elderly or nursing home services. The following table shows the expenditures of funds by program for the budget years 1988 and 1989. Expenditures are in nominal new shekels.

TABLE 19

Expenditures under the Long-Term Care Law, 1988-1989 (000 NIS)

Year	Total	Direct Benefits	Nursing Beds*	Community Services*	Service Development*	Other
1988#	55,600	29,570	14,300	4,120	2,670	3,840
1989##	142,400	112,000	16,620	3,250	5,500	4,950

* Includes the Ministries of Health and of Labor and Social Affairs only.

$1 = 1.6 NIS ## $1 = 2.0 NIS

The table demonstrates the changing pattern of expenditures from 1988 to 1989, reflecting the increased emphasis on direct benefits in 1989 as a result of the expanding eligible population. Direct benefits to recipients commenced in April 1988. Not included in the table are costs on the part of the National Insurance Institute to administer the law. These include the employment of a considerable number of clerks, data processing and so forth. The expenditure category of 'other'

refers to transfer payments to nurses and social workers outside of the National Insurance Institute who administer the dependency tests, serve on the local committees, and maintain regular contact with recipients.

Length of Time to Process Application

The processing of an application for long-term care consists of a number of stages, each of which is governed by specific regulations. The first stage consists only of the submission of all necessary information to establish eligibility, including the administration of the dependency test in the home of the elderly. It does not include the official determination of eligibility by a NII claims officer. In the second year of the full administration of the law, the average length of time to complete this first stage was 15 days (see Table 20). More than four out of five applicants had completed this stage within 20 days, and the remainder within a month. Some applicants, 6% of the total, were not dealt with because of the temporary suspension of their application. This was due to either hospitalization of the applicant, or failure to locate the given address for ADL assessment.

From the day the application is submitted in the NII branch offices until eligibility to receive the benefit is officially determined by a claims officer took on average 28 days in 1989/90, an improvement from the average of 37 days the previous year. In almost nine of ten cases, eligibility was determined within 45 days of submission of the application. The third stage of processing consists of the decision in the local committee to approve a program of home care. The time elapsed between application approval and approval of a home care program was on the average 26 days in 1989/90. For almost six of ten eligible applicants, this period was within thirty days. During this time period, the NII administrator transfers the prerequisite material to the local committee coordinator and the results and recommendations of a home visit by a community nurse and/or social worker are submitted to the committee for a final decision.

The law clearly defines the parameters of time permitted in

processing applicants, the qualifying date being defined as thirty days from the first of the month in which the application was submitted. The law specifies that no more than 60 days elapse between the qualifying date and the commencement of services to recipients. In 1989/90, services commenced for 97% of recipients within the 60 days prescribed by law. The remaining cases did not receive services within 60 days for a variety of reasons: suspension of the process due to hospitalization, missing data, lack of availability of services, etc.

TABLE 20

Average Number of Days in the Stages of LTCI
April 1988 - March 1990

Period	From Submission of Application to:		From Eligibility Determination to Local Committee Decision
	Administration of Dependency Test	Eligibility Determination	
1st year	24	37	27
2nd year	15	28	26

Summary

This report has reviewed the data of the first two years of implementation of the Long-Term Care Insurance law. The first year was characterized by tremendous efforts to cope with the flood of applications, the organization of local committees, and the development of a network of service providers. In contrast, the second year witnessed the stabilizing of tested procedures for processing applicants and beneficiaries, a greater focusing of attention on issues of quality of services provided to beneficiaries, and the gradual improvement of regulation and control mechanisms for both the quantitative and qualitative aspects of the law's implementation.

Approximately 30,500 applications were submitted in the second year, a reduction of 26% from the first year. There has been a significant change in the nature of the applicants, with approximately one quarter of the applications in the second year submitted by previously rejected applicants. The total number of applicants in the second year represents approximately 6% of the eligible population (males 65 and over, and females 60 and over). This was down from 8% of the population in the first year of implementation. The number of beneficiaries at the end of the first year was about 4% of the eligible population and reached 5% by the end of the second year. Females comprise two-thirds of all beneficiaries. It is expected that the number of beneficiaries as a proportion of the elderly population will grow. No significant reduction in administrative load can be foreseen, since reapplication is identical to first applications in terms of administrative procedures.

The eligibility rate for male applicants is higher than that for female applicants in all age groups. However, there is a disproportionate number of female beneficiaries, due to their disproportionate number of applications. There is some overrepresentation of elderly living alone who apply for long-

term care assistance, most of these being women.

The eligibility rate decreased from the first to the second years of implementation, from 56% of all applications to 48%. This downward trend continues into the third year of implementation.

Of the reasons for application rejection, the overwhelming majority (91%) in the first two years were for failure to obtain the necessary minimal score in the dependency assessment. Another eight percent were rejected because of failure to meet the eligibility preconditions - age, residency in Israel, and non-residence in an institution. Finally, one percent were rejected because of the income test.

Of the 16,500 elderly found eligible for long-term care in the second year of the program, three-quarters received the standard level benefit and one-quarter the higher benefit. This distribution was little changed from the first year of implementation, although the proportion of those elderly qualifying for constant personal attention declined sharply from the first to second year.

A major issue concerning eligibility benefits, already raised in the first year of implementation, has been the desirability of adding intermediate benefit levels. The wide distribution of scores at the standard benefit level (100%) has led to some concern at the inequity of the same package of services being offered for disparate levels of need. Creating additional benefit levels (particularly among those presently receiving the standard benefit) would ensure a better match between services and disability levels.

Appendix A

Examination of the Need for Help from Others in Care of the Elderly

Please indicate only one option in each function.
The nurse will note the functional level in the appropriate box. Points will be coded and added up by the claims official.

a. Mobility in the home

__ Bedbound; unable to get out of bed on his own or to take a few steps.

__ Uses wheel-chair and needs help in transferring to and from wheel-chair or in manipulating chair.

__ Uses wheel-chair but transfers and manipulates chair independently.

__ Mobile with or without mechanical aid, but needs help or another person in walking or in getting up.

__ Independent with mechanical aid (walker, cane).

__ Walks freely.

Description of functional ability and help needed: (indicate who helps and if no help is available)

____

____

b. Dressing

__ Needs full or extensive help in dressing

__ Needs some help (shoes, socks, buttoning, lacing, attaching orthopedic applications)

__ Dresses without help

Description of functional ability and help needed:
(include who helps and if no help is available)

____

____

c. Washing

__ Needs full assistance in washing,
in bed, bath, or shower

____

__ Needs active help in some washing
activities

____

__ Needs help in shaving/washing hair

__ Needs encouragement/presence in
bathroom, but not active
assistance

____

__ Washes without help

Description of functional ability and help needed:
(indicate who helps and if no help is available)

____

____

d. Feeding and Drinking

__ Needs full feeding (including liquids and feeding-tube)

__ Needs partial help in eating or drinking

__ Needs help in eating, cannot even help himself to bread, hot or cold drink, cannot warm up his own food, forgets to eat if he isn't reminded

__ Complete blindness (if not included in any of the above items)

__ Eats and drinks without help

Description of functional ability and help needed:
(indicate who helps and if no help is available)

____

____

e. Continence

__ Incontinence both in fecal and urinary functions, does not care for himself, is total dependent on others ______________________

__ Incontinent in either the fecal or urinary functions during day and night hours, does not care for himself, is totally dependent on others

____

__ Uses bathroom but needs extensive help (in mobility, dressing, personal hygiene after use)

____

__ Uses bathroom or pan/bottle, but needs help

____

__ Is partially incontinent and does not care for himself

____

__ Continent, or independent in using bathroom or aids (changes his own bag, etc.)

Description of functional ability and help needed: (indicate who helps and if no help is available)

____

____

f. The need for attendance at home:

1. Understanding orientation of the elderly: nurse is requested to indirectly determine during interview whether person knows where he lives, birth date, father's name, doctor's name, etc. In addition, nurse is asked to examine during the interview whether the person understands basic ADL activities and find his way around the house (bathroom, kitchen, etc.).

____

____

2. Description of behavior during visit (cooperative, passive, quiet, aggressive, etc.).

____

____

3. Report incidents or accidents during past three months (kind of accident, and source of information).

____

____

4. Actual provision of attendance (reported on basis of description of daily routine or other sources).

____

____

g. Nurses decision of attendance:

__ Person endangers himself or his environment when left alone
Constant attendance of another person at home is required

__ Does not endanger himself or others when left alone

Appendix B

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 average wage

Note: In March 1990 the average monthly wage of employees was 2,236 New Israeli Shekels, or $1,112.

Appendix C

Pre-Existing Support Systems and the Transition to LTCI

Before the implementation of LTCI, elderly individuals requiring personal care were entitled to apply for assistance to their sick fund, primarily Israel's largest sick fund, Kupat Cholim Clalit, which provides health care to 95% of the elderly (see introduction). When the law's full-scale implementation began in April 1988, Kupat Cholim Clalit made plans to cease its funding of personal care services. As a result, many individuals would have been left without any assistance until the application to LTCI could be processed and approved. In order to prevent this contingency, Kupat Cholim and the NII signed an agreement according to which Kupat Cholim would continue to provide services while the NII would compensate retroactively for the interim period of all those applicants determined eligible for a benefit. Out of the approximately 5000 individuals who had received care from Kupat Cholim, 79% submitted applications for benefits and 75% of these were in fact determined eligible. This relatively high eligibility rate supports the importance of the arrangements for individuals who would otherwise have been deprived of urgently needed services.

A question facing policymakers during the first year's operation of LTCI related to the nature of the increase in coverage under law, which more than tripled the number of elderly receiving personal care. How was the new population different from those who had previously been receiving services through the sick funds? A comparison between members of Kupat Cholim who had received services before the law and those who had not but were subsequently determined eligible for a benefit highlights several points. Firstly, while there were no differences between the two groups by age, sex and household composition, the former group was significantly more disabled, 76% of them being eligible for a

benefit, and 38% being eligible for the higher benefit. What is important, however, is the fact that of the population that had previously not been covered by Kupat Cholim, as many as 53% were in fact eligible for a benefit under LTCI and even 25% for a benefit at the higher level. This finding identifies clearly what was previously a severe unmet need among disabled elderly which was covered upon the implementation of LTCI.

Former Recipients and Non-Recipients of Care from Kupat Cholim by Eligibility for LTCI and % Eligible for Higher Benefit

	Former Recipients	Non-recipients*
% Eligible for LTCI	75%	53%
% Eligible for Higher Benefit	38%	25%

* Of the total number of persons eligible for LTCI.

Appendix D

The Long-Term Care Insurance Law

The following text is a verbatim English translation of the National Insurance Law (Amendment No. 61) 5746-1986, which was passed by the Knesset (Israel's parliament) on April 7, 1986 and published in Sefer Hachukkim 1178, April 25, 1986, page 154.

It should be emphasized that under Israel administrative and legal practice no translation of Israel legal measures is binding.

The following is not an official translation authorized by the Israeli Ministry of Justice. The National Insurance Institute is therefore not responsible for its contents nor for any damage that may be caused by relying on them.

NATIONAL INSURANCE LAW
(AMENDMENT NO. 61) 5746--1986

1. Replace Chapter 6 "E" of the National Insurance Law (Consolidated Version) 5728-1968 (hereinafter: the main law) with the following:

Chapter Six "E": Long-term Care Insurance

Article One: Definitions

Definitions
127EEEE, In this chapter --
"insured person" -- each of the following:
(1) a person insured under old age insurance and survivor's insurance;
(2) a housewife within the meaning of that term in section 8;
(3) a widow entitled to a pension, as said in section 9;
(4) An Israel resident who came to Israel under the Law of Return 5710-1950 and is not insured under old age insurance and survivors' insurance;
"deficiency" -- a physical, mental or emotional deficiency due to disease, accident or birth defect.
"daily activities" -- dressing, eating, control of urine and bowel movements, washing, mobility in the home.
"attendance" -- attendance on and supervision over the insured person, to prevent damage or danger to himself and to others;
"long-term care benefit" -- a monthly benefit paid under the provisions of this chapter as participation in the cost of long-term care services;
"nursing home" -- a nursing home or a long-term care department, in which people in need of long-term care, mentally incompetent and infirm people are cared for;

"single person's full pension" -- as defined in section 127 KK;
"local professional committee" -- a local professional committee for long-term care, under section 127 MMMM.

Article Two: Benefits

Long-term care benefit
127FFF(a)(1) An insured person who, because of a deficiency, has become largely dependent on the help of others for the performance of daily activities, or who requires attendance is entitled to a long-term care benefit at a rate equal to a single person's full pension;

(2) An insured person who, because of a deficiency, has become completely dependent on the help of others for the performance of daily activities, or who requires constant attendance is entitled to a long-term care benefit at a rate equal to 150% of a single person's full pension;

all subject to the provisions of subsection (c) and of section 127 GGG.

(b) A long-term care benefit paid as said in section 127 GGGG(c) shall be at the rate of 80% of the rates set in subsection (a).

(c) The examination of the degree of dependence on the help of others shall be performed by the Institute, according to arrangements made between the Institute and the health and welfare services.

(d) The entitlement to long-term care benefits and its rate shall be subject to income criteria prescribed by the Minister in regulations, with the agreement of the Minister of Finance and with the approval of the Knesset Labor and Social Welfare Committee; the rate of benefits in line with income criteria and rules for calculating that income, including criteria and rules for different categories of insured persons, shall be prescribed in those regulations. For the purposes of a benefit paid under section 127 GGGG(c), the income of the relative who takes care of the entitled person may also be taken into account, and that on conditions prescribed in regulations as aforesaid; for this purpose, "relative" -- the entitled person's son or daughter, whose income exceeds at least three times the average income.

Payment of long-term care benefit
127GGGG.(a) A person entitled to a benefit under this chapter shall be a person who, on the day the claim for a long-term care benefit was submitted, had reached the age of 65, for a man, and age 60, for a woman.

(b) Notwithstanding the provisions of sections 135, 136, and 136B, a long-term care benefit shall be paid, in whole or in part, to the person who provides the long-term care services, as determined by the local professional committee, and not the entitled person.

(c) A long-term care benefit shall be paid to the entitled

person only if the local professional committee determines that he lives with a relative who takes care of him and that no long-term care services are available for him or that no long-term care services were provided for him within 60 days of the day on which entitlement to long-term care benefits arose; if long-term care services were available, but the entitled person refused to accept them without reasonable cause, the long-term care services shall be deemed to have been provided.

(d) If an entitled person does not live with a relative or lives with a relative who does not take care of him and if the local professional committee determines that no long-term care services are available for him, or if no long-term care services were supplied within 30 days from the day on which entitlement to long-term care benefit arose, he shall be entitled to enter, under the customary rules, a nursing home of the State, or a nursing home in the support of whose inmates the State participates, provided that the cost of his maintenance be within the framework of approved budgets of the Ministry of Health and of the Ministry of Labor and Social Welfare.

Qualifying period

127 HHHH. The qualifying period for long-term care benefits is 12 consecutive months, immediately preceding the submission of a claim for a benefit.

Restriction of entitlement

127 IIII. An insured person who is in a nursing home or for whom the provisions of 137(a) hold true is not entitled to long-term care benefits.

Prevention of double payment

127 JJJJ. (a) A person entitled to a long-term care benefit and also to a special benefit under section 69, or to a benefit for special services as said in section 127 Y may opt for one of them.

(b) A person entitled to a longer term care benefit under this chapter and also to long-term care services from the State in cash or in kind, in accordance with laws and categories of payments prescribed in regulations approved by the Knesset Labor and Social Welfare Committee, may opt for one of them.

Beginning of entitlement

127 KKKK. Notwithstanding the provisions of section 128, entitlement to a long-term care benefit shall begin 30 days after the first of the month in which the claim for the benefit was submitted.

Reexamination

127 LLLL. The Institute may examine --

(1) whether the entitled person is cared for by a relative and whether he receives long-term care services of an extent and quality determined for him, as the case may be;

(2) the degree of the entitled person's dependence on the

help of others for the performance of daily activities, including a reexamination at the entitled person's request, all according to rules made by the Minister in regulations with the approval of the Knesset Labor and Social Welfare Committee.

Local professional committee

127 MMMM.(a) The Minister shall appoint local professional committees on long-term care and he shall determine the areas of their activity.

(b) The committee's members shall be a nurse from the health services, a social worker form the local welfare services and an Institute employee; the committee shall consult a physician.

(c) The nurse and the physician said in subsection (b) shall be chosen from a list to which the Minister and the Minister of Health have agreed.

(d) The Minister may, in consultation with the Minister of Health, prescribe the procedure of local professional committees by regulations, and as far as those have not been prescribed as aforesaid each local professional committee may determine its own procedure.

Functions of local professional committee

127 NNNN. (a) The Institute having determined that an insured person is entitled to long-term care benefits under section 127 FFFF, it shall so inform the local professional committee in whose area of activity the insured person lives.

(b) The local professional committee shall determine the long-term care services to be provided for the insured person; having so determined, it shall determine who shall provide the services, and it shall see to it that those services are provided or determine that there are no available services which can be provided; the committee may limit the validity of its findings in terms of time.

(c) The local professional committee shall inform the Institute of its decisions under subsection (b).

Appeals committee

127 OOOO. (a) Any person who considers himself aggrieved by a decision of a local professional committee may appeal against it before an appeals committee.

9b) The composition of an appeals committee, its powers, the times for the submission of appeals and its procedure shall be prescribed by regulations with the approval of the Knesset Labor and Social Welfare Committee.

(c) An appeals committee member who is a physician or nurse shall be chosen from a list to which the Minister and the Minister of Health have agreed.

Expansion of categories of entitled persons and of benefits
127 PPPP. The Minister may, by regulations with the agreement of the Minister of Finance and the approval of the Knesset Labor and Social Welfare Committee --

(a) make the entitlement to long-term care benefits applicable also to persons who have not reached age 65, for men, and age 60, for women;

(b) prescribe additional categories of benefits to be provided for persons restricted in their functions, as well as rules, conditions, criteria, rates and dates for their payment.

Article Three: National Committee

National committee on long-term care
127 QQQ. (a) The Minister shall appoint a national advisory committee on long-term care (hereinafter: national committee), and he shall appoint the committee's chairman from among the members appointed under subsection (b)(9) or (10).

(b) These shall be the national committee's members:

(1) two representatives of the Ministry of Labor and Social Welfare;

(2) two representatives of the Ministry of Health;

(3) a representative of the Ministry of Finance;

(4) a representative of the Ministry of Interior;

(5) two representatives of the Local Government Center;

(6) two representatives of the National Insurance Institute;

(7) two representatives of the General Sick Fund of the General Federation of Labor in Israel;

(8) a representative of all these sick funds:

(1) Kupat Holim Maccabi;

(2) National Workers' Sick Fund;

(3) Kupat Holim Meuhedet;

(9) three experts in the field of prolonged care of long-term care patients, to be appointed in consultation with the Minister of Health;

(10) an expert from among the directors of geriatric departments or from among experts in nursing homes, to be appointed in consultation with the Minister of Health;

(11) a representative of "Eshel", the Society for the Planning and Development of Services for the Aged in Israel;

(12) a representative of the Mishan Center in the General Federation of Labor in Israel;

(13) two representatives of the Pensioners' Association of Israel.

(c) the national committee's term of office shall be four years.

(d) The Institute shall supply to the national committee any administrative services required for its orderly functioning.

(c) The Minister may prescribe the committee's procedure by regulations, and to the extent that it has not been prescribed as aforesaid the committee may determine its own procedure.

Function of national committee
127 RRRR. The national committee shall advise the Institute on the financing of activities, as said in section 127 SSSS (hereinafter: development activities; for this purpose it shall - (1) examine plans for development activities submitted to it by public bodies, and it shall express its opinion on them;

(2) recommend national priorities for development activities;

(3) recommend the allocation of funds to finance development activities.

Article Four: Funding

Development and current maintenance of services
127 SSSS. (a) The Institute shall finance, in consultation with the Council, on the national committee's recommendation, with the Minister's approval and with the agreement of the Minister of Finance, activities aimed at the development of community services for persons restricted in their functions who require long-term care, and also for the development of services provided in nursing homes, and for the improvement of their quality, provided that the total annual allocation for these activities in fiscal 1986 through 1988 not exceed 20%, and in subsequent fiscal years 10% of the annual estimate of the collection of long-term care insurance contributions for that year; the Institute shall prescribe procedures and times for reports on the use of allocated funds.

(b) If, in any fiscal year, the Ministry of Labor and Social Welfare or the Ministry of Health increased the number of persons cared for in nursing homes, the Institute shall finance the current maintenance of the number of persons added in that fiscal year in the said homes, provided that the total allocation in any fiscal year for each of those Ministries not exceed 15% of the annual estimate of the collection of long-term care insurance contributions for that year; such financing shall be provided in amounts, at times and in ways agreed between the Institute and the Ministries, but from fiscal year 1987 on amounts for any years shall be paid after the receipt of a report on the utilization of funds allocated under this subsection in the preceding year.

(c) The provisions of this section shall be in effect in fiscal years 1986 to 1995.

Expansion of scope of entitlement
127 TTTT. (a) In fiscal years 1986 and 1987, the Institute shall allocate an amount of NIS 3 million a year each to the Ministry of Health and to the Ministry of Labor and Social Welfare, to cover their expenditure for the expansion of the scope of personal care services and housekeeping assistance.

(b) The amounts said in subsection (a) shall be transferred to the Ministries in installments, at times and in ways agreed between them and the Institute; each installment shall be increased at the rate of increase between the index established in March 1986

and the index last published before the day of that transfer.

(c) The Institute shall transfer the said funds for fiscal years 1986 and 1987 after the receipt of reports on the utilization of funds allocated under this section."

Amendment of section 143

2. In section 143 of the main law --

(1) insert after subsection (a);

" (a1) long-term care benefits shall not be deemed a pension for purposes of subsection (a)(1);"

(2) in subsection (d) insert after paragraph (3)

" (4) a long-term care benefit."

Amendment of section 159

3. In section 159 (b) of the main law, after "consultation with the Minister of Finance", insert "and for the purposes of long-term care insurance, with the agreement of the Minister of Finance".

Amendment of section 169

4. In section 169 of the main law, insert after subsection (Jewish):

" (k) a woman insured under Chapter Six "E" who is a housewife, within the meaning of that term in section 8, or who is a widow entitled to a pension as said in section 9, shall not pay insurance contributions under section 157(d5), as long as she is not insured under Chapter Two."

Amendment of section 181

5. In section 181(b) of the main law, replace "under Chapter Nine "B" or Chapter Six "D" with "under Chapters Nine "B", Six "D" and Six "E"".

Amendment of section 217

6. In section 217 of the main law, insert after subsection (1a):

" (a2) The Treasury shall recompense the Institute, at its request, for expenses incurred by it for long-term care benefits for an Israel resident under paragraph (4) of the definition of "insured person"."

Effect

7(a) Sections 127 EEEE and 127 QQQQ through 127 TTTT of the main law, added by this law, and sections 2 through 5 shall be in effect from 21 Adar 5746 (April 1, 1986) (hereinafter: date of effect).

(b) All the other sections of the main law added by this law and section 6 shall be in effect from the end of 24 months after the date of effect.

Publication

8. This law shall be published in Reshumot within 20 days from its adoption by the Knesset.

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Publications may be ordered from the Research and Planning Administration,
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