4. Long-Term Care Insurance

A. General

The long-term care program was approved by the Knesset in 1980 as part of the National Insurance Law, and it began operating in April 1988. Long-term care insurance is designed to enable elders to continue living in a community framework for as long as possible, through the provision of personal care to those who require supervision or assistance in day-to-day functioning,, and thus to assist the families caring for them. The law applies to anyone who is insured with Old Age and Survivors insurance, homemakers (married women who do not work outside of the home), and new immigrants who are not insured with Old Age and Survivors insurance.

Any elder who is a resident of Israel living in the community (at home, that of a relative, or assisted living) is entitled to receive the long-term care benefit if he/she is impaired physically or cognitively, and satisfies the requirements of a means test[1] in accordance with the law. An individual living in a long-term care facility, or in the long-term care ward of a nursing home is not entitled to the benefit. The means test examines only the income of the elder and spouse. The law distinguishes between those who receive the benefit in cash within the framework of the experimental program (see below, Section H), and those who receive the benefit in cash due to the impossibility of providing them a service (benefit in kind). The first group undergoes a means test with identical rules to that conducted for recipients of the benefit in kind. For the latter group, as a condition of benefit receipt, the income of the caregiving relative living with him/her is examined.

The long-term care benefit is not paid in cash, but is provided to individuals entitled to services through organizations that the NII pays for these services (benefits in kind): personal care or supervision at home, transportation to and from and personal treatment at a day center, provision of absorbent products, laundry services and personal alarm units. A cash benefit is granted to entitled individuals for whom there are no available services or these cannot be provided within the hours specified by law, and for entitled individuals within the framework of the experimental program being run in a few branches of the NII.

The Minister of Welfare and Social Services is responsible for appointing local professional committees, which include a social worker from the local municipality, a health-fund nurse, and an NII representative. The committee is authorized to determine the treatment program – which services should be provided to the elder and who should provide them, as well as for making sure that the services are indeed provided, or for issuing an explicit decision that there are no services available.

1 The means test examines only the income of the elder and his/her spouse. The law distinguishes between those who receive the benefit in cash within the framework of the experimental program, and those who receive it in kind. The first group undergoes an income test with identical rules to that conducted for recipients of the benefit in kind. As a condition of receipt of the benefit in cash, the income of the caregiving relative living with the elder is also examined.

B. Dependency Test

The dependency test (ADL) assesses the degree to which assistance from others is needed in performance of the basic activities of daily living: washing, dressing, mobility (movement in the home and avoidance of falls), toileting, and eating (including the ability to heat up food and drink). The dependency test also assesses the need for supervision due to impairment of cognitive ability, deterioration of mental health, or a physical medical condition. The dependency test is performed by professionals – nurses, occupational and physical therapists, who undergo suitable training.

Those who have reached 90 years of age may be examined for the dependency test by a geriatric specialist physician at a hospital, clinic or in certain localities at a public facility. From October 2013 to July 2014, those aged 80-89 were able to choose, as part of an experimental program in six branches of the NII, to be examined by a geriatric specialist physician. (See Box 1 below).

C. Benefit Levels

In January 2007, **three levels of long-term care benefit** were determined, adjusted for three levels of dependency: a benefit at a rate of 91% of the full disability pension for an individual – to finance 9.75 hours of home care per week, 150% for 16 hours, and 168% for 18 hours of weekly home care.

Claimants are entitled to a full long-term care benefit in accordance with their determined level of dependency, if their income is not greater than the average income (NIS 9089 in 2014), to half of the benefit – if their income is higher than the average salary and up to 1.5 times the average salary. If their income is higher than 1.5 times the average, they are not entitled to the benefit.

For a claimant with a spouse, the claimant is entitled to a full benefit when the couple's joint income is not greater than 1.5 times the average salary, to half the benefit if their income is higher than 1.5 times the average salary and up to 2.25 times the average salary. A couple whose income is more than 2.25 times the average salary is not entitled to the long-term care benefit. When both members of the couple submit a claim for the benefit, their joint income is divided in two, and the means test is performed as if each was an individual.

In January 2014, the long-term care benefit was updated by a rate of 1.9% in line with the rise in CPI in 2013. In January 2015, the rate was not increased (due to the static CPI in 2014).

Recipients of long-term care benefits on the two highest levels who employ only an Israeli and not a migrant worker (neither in the framework of the long-term care benefit nor otherwise) are entitled to extra weekly hours: three hours for benefit recipients at

a rate of 150%, and four hours for those receiving the benefit at a rate of 168%. Those entitled to half of the benefit due to income are entitled to half the additional hours depending on the determined level of dependency.[2]

D. Legislative and Administrative Changes

- **Payment of benefit in cash:** On 31.7.2013, an amendment to the law was approved, according to which those entitled to a long-term care benefit who employ a caregiver who is not a relative, for at least six days a week for twelve hours per day, may receive the benefit in cash. The rates for the benefit in cash are– 80% of the rates for the long-term care benefit in kind[3]. The amendment does not limit receipt of the benefit in cash based on level of benefit, type of caregiver (Israeli or foreign), or regions of the country.

  An additional amendment to the law mandates that entitled individuals can receive additional long-term care services, with their cost being deducted from the full benefit value. Also, 20% will be deducted from the difference – (such that the value of the benefit in cash will be 80% of the value of the benefit in kind). This change came into effect on 1.3.2014.

  The law was passed as a temporary measure from the publication of regulations to the implementation of its provisions until 1.12.2014. Due to the early elections, the measure was extended till the end of June 2015. During this period, the NII is responsible for tracking its implementation and consequences through research.

  On 6.2.2014, regulations were published according to which those beginning to employ a foreign caregiver or renewing a suspended permit for one, will be asked to choose whether to receive the benefit in kind or in cash. For those choosing to transfer from a benefit in kind to one in cash – the change will take effect after five business days from the date of receipt of the request. For those choosing to transfer from a cash benefit to one in kind – the change will take effect on the first of the month following the date of receipt of the request.

  Those receiving the benefit in cash and employing a foreign caregiver, may request the NII to deduct 12% of the minimum wage for a provident fund for an allowance for the caregiver, and should they do this, they will be regarded as having fulfilled their obligation to set aside funds for deposit in accordance with the Foreign Workers Law.

2 From March to September 2009, this supplement was funded through an agreement with the Ministry of Finance, which paid for it. From October 2009, in accordance with the Economic Optimisation Law for the years 2009-2010, the addition was financed in accordance with the National Insurance Law.

3 The gap between the long-term care benefit values in kind and in cash stems from the additional costs of long-term care companies, which individuals are not required to pay for: payment of VAT and the employment costs of professionals such as social workers.

Due to sanctions in branches of the NII, the option of choosing a cash benefit where in previous years this was not offered, took effect only in June 2014.

- **Dependency assessment for people aged 80-89**: 31.7.2014 marked the end of an experimental program that had allowed people aged 80-89 served by NII branches in the cities of Be'er Sheva, Tiberias, Jerusalem, Nahariya, Petah Tikva, and Ramat Gan to be examined for a dependency test by a specialist geriatric physician[4]. The dependency assessment must be performed in the claimant's home and not in the physician's clinic, by a physician within the framework of his/her work in a publicly owned medical institution. Claimants are not required to pay for the assessment, other than the deductible in accordance with the rules of the National Health Insurance Law. They may also choose assessors from the NII to perform the dependency assessment, as in the past. (For elaboration see Box 1).
- **Benefits for Holocaust survivors**[5]: As of July 2014, the means test does not include Holocaust survivor pensions from the Holocaust Survivor Authority in the Ministry of Finance (from August 2011, the test did not include Holocaust survivor pensions from foreign countries).
- **Changes in the dependency test**: From 5.8.2014, in the wake of the Ben-Yehuda Commission[6] (a public commission headed by professor Aryeh Ben-Yehuda from the Hadassah Ein Kerem Hospital), the following changes have been in effect:
  - A person found to be absolutely dependent for all routine daily functions due to severe mobility impairment, including assistance in toileting, is entitled to a benefit at a rate of 150% (if he/she is not single), and to a benefit at a rate of 168% (if he/she is single) without the need to accrue points from other areas.
  - One who needs constant supervision is entitled to a benefit at a rate of 168% without the need to accrue points from other areas, in other words no dependency test (ADL) will be conducted. The section of the test checking the need for supervision was reformulated, so that the decision regarding the need for supervision is based on a number of points that the claimant accrues in this part.
  - Change of entitlement for a blind person: Based on a certificate of blindness, or document from an ophthalmologist attesting to blindness, a blind person may receive an additional 0.5 points in the eating section. A single person may receive a benefit at a rate of 91%, unless he/she is found dependent to a degree that entitles to a benefit at a higher rate.

4 According to section 224(c)(2) of the National Insurance Law (Consolidated Version) 1995, as of August 2008 individuals age 90 and older may choose a specialist geriatric physician to perform the dependency test instead of an NII assessor.
5 Amendment No. 5, 2014.
6 See the NII website: Dependency test – Ben-Yehuda Commission, letter 283, 3rd July 2014; Dependency assessment form (BL 2610, 7/2014 version), general circular 12/2014 Long-term care 1431, 3rd October 2014.

Box 1
Examinations for Long-Term Care Benefit Performed by Geriatric Specialist Physicians – The Experimental Program for Persons Aged 80-89[1]

In May 2012-April 2013, the option was given to claimants of the long-term care benefit aged 80-89[2] who lived in areas served by the Tiberias, Jerusalem and Petah Tikva NII branches, to choose a geriatric specialist physician to perform the dependency test instead of an NII assessor (hereafter: the first wave[3]). In October 2013 the program was extended until July 2014, to areas also served by the Be'er Sheva, Nahariya, and Ramat Gan branches (hereafter: the second wave). These cities were selected due to their geographical, social, and socioeconomic diversity, as well as different levels of physician availability. In this way, a greater amount of data was collected to assist the decision to implement the option of choosing a physician for all claimants aged 80-89 in the entire country.

According to the program's rules, physician examinations for those aged 80-89 are conducted in the home, in the framework of the physicians' employment at public medical institutions, and no payment may be collected for the examination (other than the deductible in accordance with the National Health Insurance Law). The NII pays these institutions for the examinations (the level of payment is determined between the physician and the employing institution). The physician is required to fill out a dependency assessment form concerning various areas of functioning (dressing, washing, eating, toileting, movement in the home, falls, and need for supervision), and must explain the decisions.

The follow-up report for the first wave of the program indicated low rates of claimants requesting to be examined by physicians, and difficulties in exercising this option in the periphery, and even in several of the large cities, due to the small number of geriatric specialist physicians employed in public medical institutions. The report raised the concern that, essentially two different sets of rules had been created for dependency assessment: the assessors (generally nurses) and the physicians examine dependency from different professional points of view (and even their examination

1 This box is an abridged version of the article: S. Asiskovitz (2015), **"Examinations for Long-Term Care Benefit Performed by Geriatric Specialist Physicians for Persons Aged 80-89 – The Second Wave of the Experimental Program"** (appearing on the NII website).

2 As of August 2008, long-term care benefit claimants age 90 and up were able to choose a geriatric specialist physician for the dependency test.

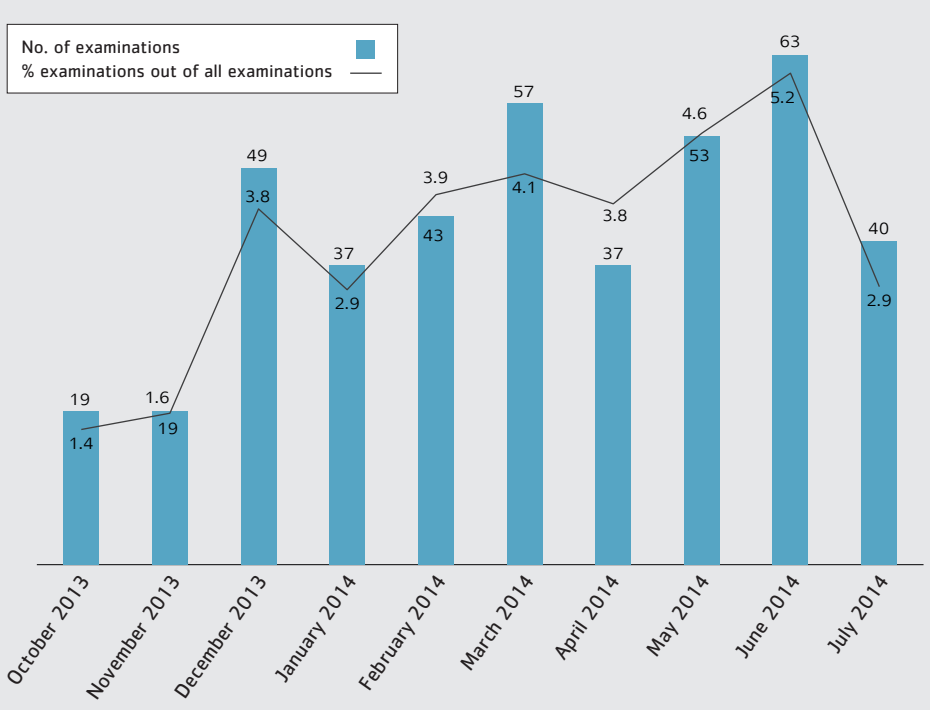
3 Findings from the first wave of the program appear in the article: S. Asiskovitz (2013), **"Experimental Program for Choosing Geriatric Specialist Physician for Performance of Dependency Assessment As a Condition for Long-Term Care Benefits for Individuals Aged 80-89: Findings from Implementation of the Program May 2012-April 2013"** (appears on the NII website).

forms are different). Nevertheless, the report did not determine whether the doctors' tendency to determine higher levels of benefit stems from characteristics of those seeking the examination (older individuals, and thus the dependency level of the second wave, or need for supervision, was higher), or from their different methods of assessment.

In the 10 months of the experiment, 417 out of 12,256 examinations (3.4%) were performed by physicians, an average of 42 examinations per month, with the monthly number ranging between 19 and 63 (Figure 1).

Similar to the first wave, in the second wave the percentage of examinations

Figure 1
Dependency Examinations Performed by Physicians, All Branches – Second Wave



performed by physicians out of total examinations was also low – 3.4% versus 4.8% in the first wave, and in the three veteran branches – 4.1% (Table 1).

Distribution of examinations by level of benefit was also similar in the two waves:

Table 1
Examinations in All Branches – Comparison of Waves

	Second wave (all branches)		First wave		Second wave (veteran branches)	
	Assessors	Physicians	Assessors	Physicians	Assessors	Physicians
Monthly average	1,184	42	575	29	601	26
%	96.6	3.4	95.2	4.8	95.9	4.1

Figure 2
Examinations Performed by Physicians by Branch – Second Wave

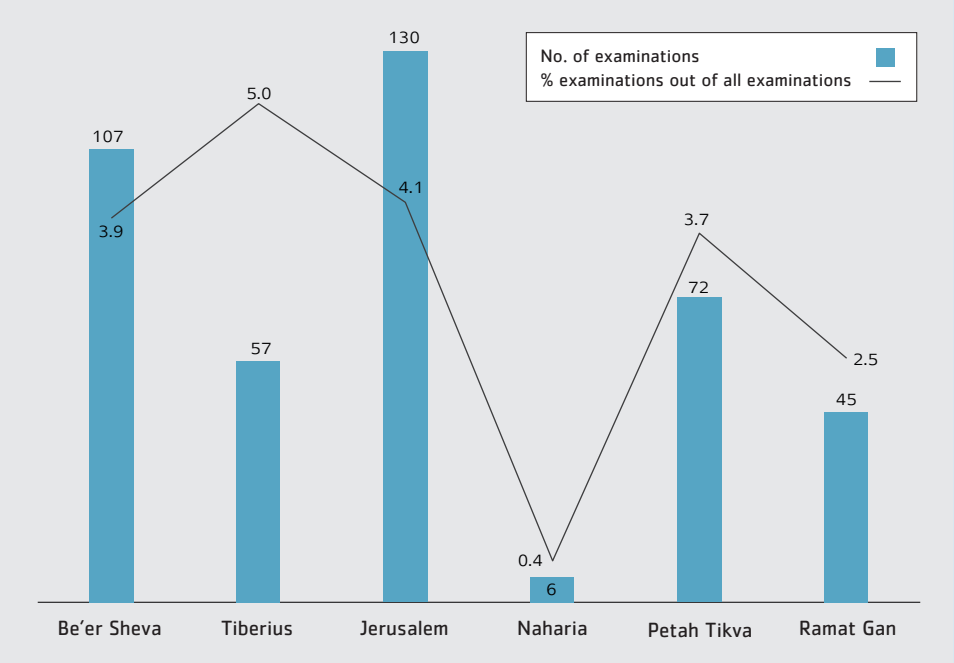


Table 2
Examinations by Branch – Comparison of Waves

	Second wave (all branches)				First wave			
	Assessors		Physicians		Assessors		Physicians	
	Monthly average	%	Monthly average	%	Monthly average	%	Monthly average	%
Be'er Sheva	265	96.1	11	3.9	-	-	-	-
Tiberias	107	95.0	6	5.0	106	98.9	1	1.1
Jerusalem	308	95.9	13	4.1	289	94.4	17	5.6
Nahariya	141	99.6	1	0.4	-	-	-	-
Petah Tikva	185	96.3	7	3.7	180	94.4	11	5.6
Ramat Gan	178	97.5	5	2.5	-	-	-	-

approximately 80% of physician examinations granted rights to one of the two highest benefit levels, versus about 30% for the assessor examinations. Approximately 1/5 of assessor examinations granted no benefit, versus approximately only 2% of physician examinations (Figure 3 and Table 3). The report was unable to definitively identify the reasons for this, but speculated: those examined by physicians were older than other examinees, and the professional outlooks of physicians and assessors, according to which they assess dependency and need for supervision – are different.

In the two program waves, information regarding number of examinations by

Figure 3
Levels of Benefit Determined by Type of Examiner

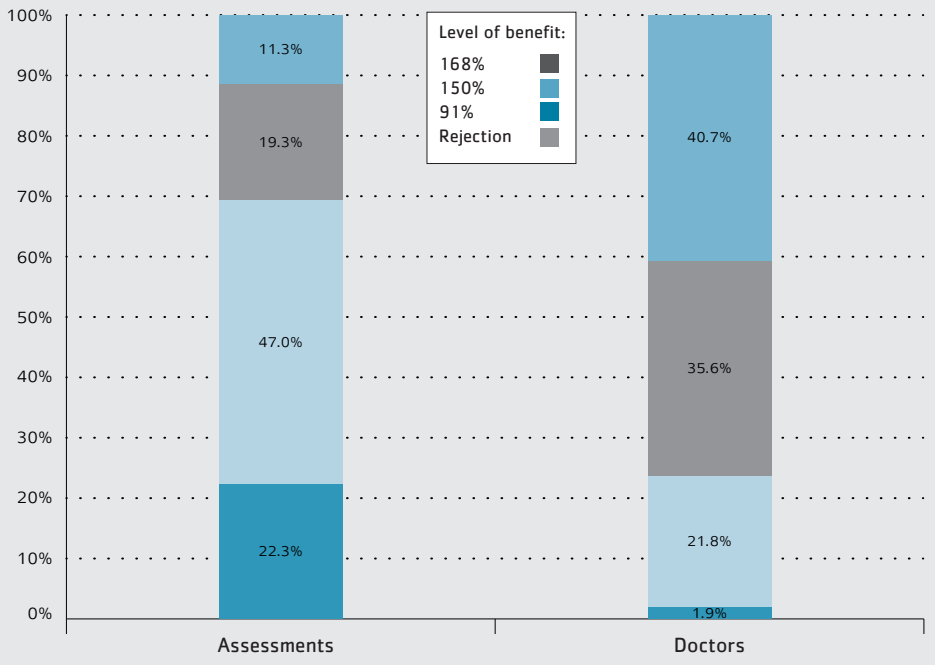


Table 3
Examinations by Level of Benefit

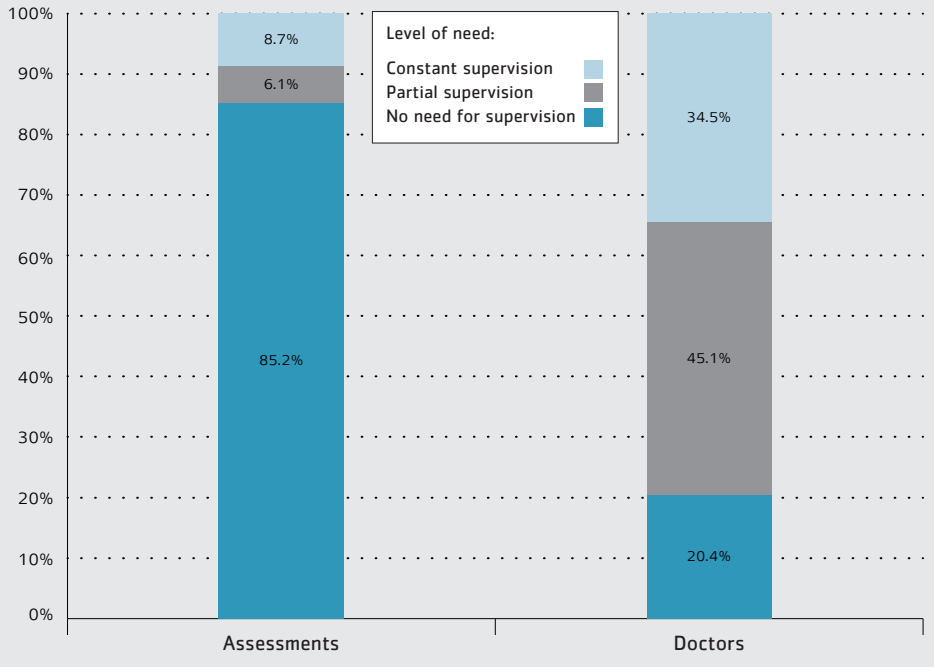
	Second wave (all branches)		First wave		Second wave (veteran branches)	
Benefit level	Assessors	Physicians	Assessors	Physicians	Assessors	Physicians
Rejection	22.3%	1.9%	17.8%	0.9%	19.9%	1.6%
91%	47.0%	21.8%	48.0%	21.1%	47.1%	24.3%
150%	19.3%	35.6%	21.2%	24.6%	21.1%	31.8%
168%	11.3%	40.7%	13.1%	53.5%	11.9%	42.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

physicians and ensuing recommendations were incomplete. The long-term care benefit claimants were required to submit the physician's assessment together with the claim form, and it can be estimated that some of them chose not to attach the form if the doctor had determined that they were not dependent on others or not in need of supervision. On the other hand, other examinations, which may have entailed recommendations for entitlement to the benefit, were not registered as a claim because the forms were not filled in as required.

A central reason for the distribution of benefit levels among those examined by physicians and those inspected by assessors, is the awarding of points regarding need for supervision (Figure 4). In approximately 85% of the assessor examinations, no need for supervision was determined, versus 20% of physician examinations. This difference stems from different focuses of the examinations: the assessors focus on the need for supervision during the examination, while the physicians focus on future need based on medical condition.

As mentioned, the two waves showed significant differences in distributions

Figure 4
Level of Need of Supervision by Examiner Type – Second Wave



between the assessors and physicians in determining the need for supervision. Nevertheless, there were also noticeable differences among physicians in the two

waves: first of all, the percentage of examinations in which a need for supervision was determined decreased from approximately 90% to about 80%, due to the new branches; and second, the percentage of decisions for a need for partial supervision grew (especially in the veteran branches), while decisions for full supervision decreased (Table 4).

Table 4
Examinations by Level of Supervision Need

Level of supervision need	Second wave (all branches)		First wave		Second wave (veteran branches)	
	Assessors	Physicians	Assessors	Physicians	Assessors	Physicians
No need	85.2%	20.4%	84.3%	11.3%	86.6%	12.0%
Partial supervision	6.1%	45.1%	4.8%	41.6%	4.6%	51.0%
Constant supervision	8.7%	34.5%	10.8%	47.1%	8.8%	37.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Box 2
Assessment of Dependency for Long-Term Care Benefits – Different Examination Channels

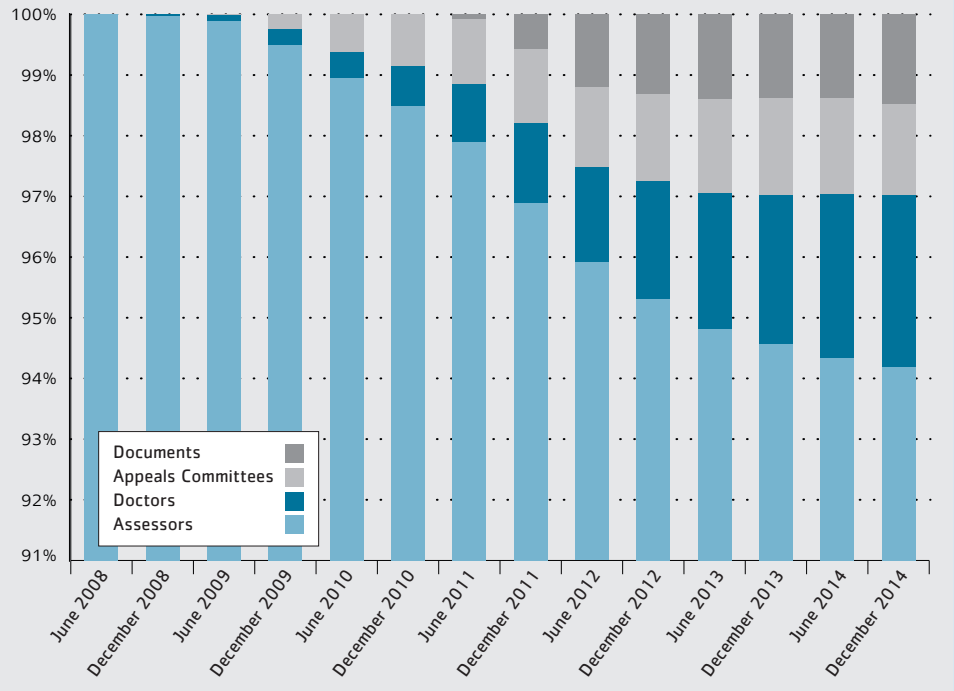
In the last few years there have been changes in the way dependency examinations for long-term care benefits are conducted. The following are the main changes:

- As of August 2008, long-term care benefit claimants aged 90 and older have been able to choose a geriatric specialist physician as examiner for the dependency test instead of an NII assessor. Examinations performed by physicians are carried out in the framework of their public employment at a clinic, hospital, or in the claimant's home. As of May 2012, for 12 months (until April 2013), this possibility was granted in an experimental program to those aged 80-89 in the Tiberias, Jerusalem, and Petah Tikva branches, who were then entitled to choose a physician. Starting in October 2013, for 10 months (until July 2014), the program was expanded to three other branches – Be'er Sheva, Nahariya, and Ramat Gan (see Box 1).
- As of August 2009, long-term care benefit claimants can appeal the NII's decisions to an appeals committee. An appeal can be filed regarding level of dependency or the decision to provide a temporary benefit. Serving on the appeals committees are physicians who are geriatric specialists or physical and rehabilitation medicine specialists, and certified nurses. There are three regional appeal committees.

- As of August 2011, dependency can be assessed through medical documents if the claimant is in a severe long-term care state. The decision to forgo an examination is left to the discretion of the assessors-counselors at the branches.
- As of May 2012, dependency can be assessed through medical documents if the claimant is in need of temporary nursing care after being released from hospital. The time period for entitlement is two months ("short-term") and the benefit level is 91% (or half of that depending on a means test). The decision to forgo an examination is left to the discretion of the assessors-counselors at the branches.

Starting from the second half of 2008, and until the end of 2014, the percentage of persons entitled to a long-term care benefit whose entitlement was determined by means other than NII assessors gradually grew to about 6% (Figure 1). In December 2014, 9305 out of 160,203 entitled persons had their entitlement determined by physicians, appeal committees, or medical documents: 4526 – by physicians; 2403 – by appeal committees (in approximately 30% of cases the committee grants a higher benefit level); 2376 – by medical documents. For the sake of comparison, in 2008, all persons entitled to a long-term care benefit were examined by NII assessors versus 94.2% in December 2014.

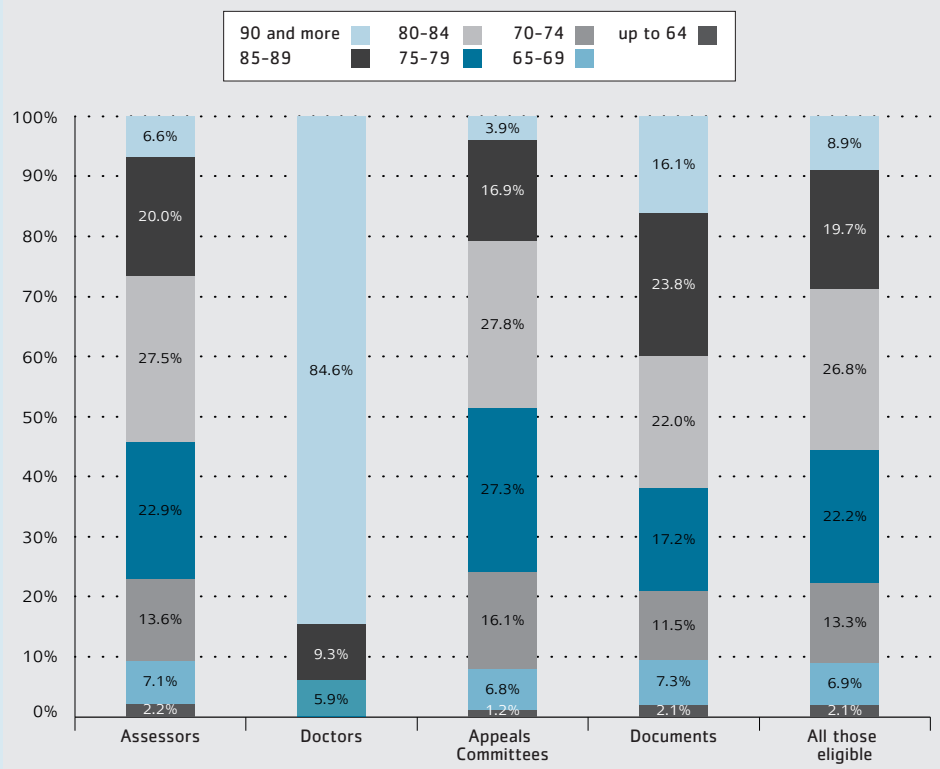
Figure 1
Persons Entitled to Long-Term Care Benefits by Channel of Examination



In each of the groups, change can be observed over time. The growth in number of entitled persons examined by physicians in the years 2009-2011 is related to the heightened awareness among those 90 and older of the option for a physician examination. Further growth in 2012-2013 and the first half of 2014, is among other things, the result of granting the right to those aged 80-89 in some branches to choose physicians. In the second half of 2014, the growth rate in number of entitled persons examined by physicians slowed, as the experimental program for those aged 80-89 came to an end (see Box 1).

In the years 2009-2010, the number of entitled persons whose level of dependency was determined by an appeals committee grew, as an expression of the institutionalization of the reform in long-term care insurance rules. In the years 2011-2013, there was a gradual growth, though at a slower rate, in the number of entitled persons whose level of dependency was determined by an appeals committee. In 2014, there was a reduction in the number of entitled persons examined by an appeals committee versus

Figure 2
Persons Entitled to Long-Term Care Benefits by Channel of Examination and Age at Time of Examination, December 2014

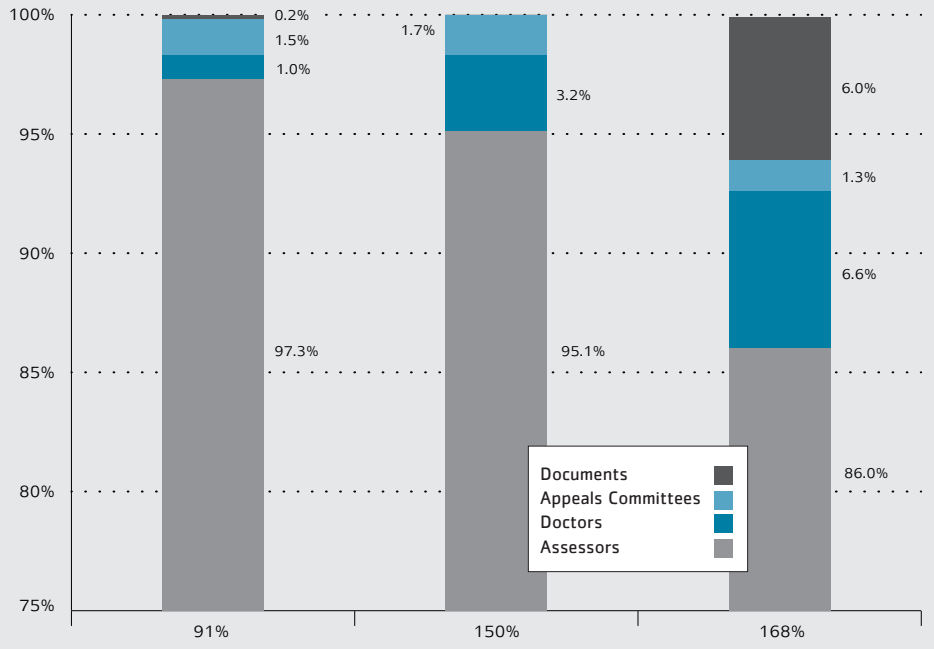


previous years, apparently due to the additional examination channels and changes and adjustments made in assessor examinations.

The years 2011-2012 showed accelerated growth in the number of entitlements determined by medical documents, but in 2013-2014 there was a significant slowdown, apparently due to the institutionalization of the rules and their application by assessor-counselors.

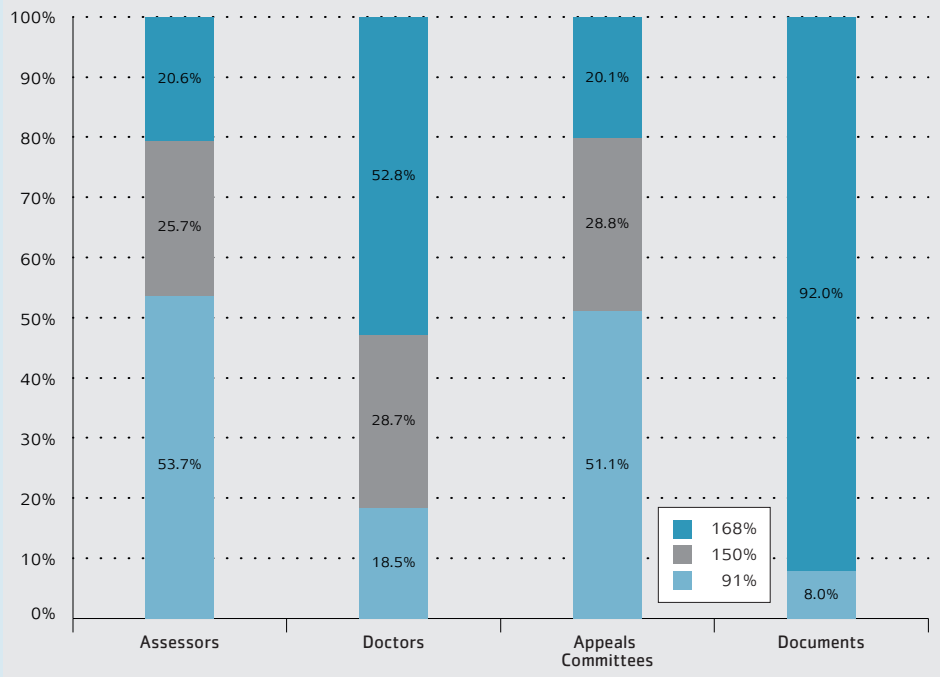
While the age distribution of those examined by assessors is similar to that among all entitled persons – due to their share of all entitled persons – those whose dependency was assessed by appeals committees tended to be younger, while those assessed by medical documents tended to be older (as mentioned, a decision based on documents is carried out under severe medical conditions and following release from hospitalization). The vast majority of those examined by physicians were aged 90 and older (Figure 2).[1] The dependency level that is determined affects the benefit level, and the means test

Figure 3A
Persons Entitled to Long-Term Care Benefits by Benefit Level and Examination Channel, December 2014



1 The age distribution of those entitled persons in December 2014 was as follows: 0.7% aged 62-64, 4.3% aged 65-69, 9.0% aged 70-74, 18.6% aged 75-79, 25.7% aged 80-84, 24.8% aged 85-89, and 16.9% aged 90 and up.

Figure 3B
Persons Entitled to Long-Term Care Benefits
by Examination Channel and Benefit Level, December 2014



determines its rate – full, half, or rejection. Figures 3A and 3B present the relationship between the deciding party and the level of benefit among entitled persons in December 2014[2]. These figures indicate that the examination channels that have been added have increased the number of persons entitled to the benefit at higher levels.

2 Each benefit level also includes the rate granted due to a means test.

E. Claims for Long-Term Care Benefit

The number of claims for a long-term care benefit decreased in 2014 by 0.1% versus 2013, equaling 83,000.[7] 39.6% of the claims were initial ones (versus 40.7% in 2013) and 60.4% were repeat claims (versus 59.3% in 2013). The number of initial claims went down 2.9% while the number of repeat claims rose 1.8% versus 2013 (Table 1). 51.7% of initial claims in 2014 were approved (versus 53.4% in 2013), and 48.3% were rejected (versus 46.6% in 2013). In contrast to this, 37.5% of repeat claims in 2014 were approved (versus 38.2% in 2013), and 62.5% were rejected (versus 61.8% in 2013). In 2014 a total

7 Including claims for which handling has not been completed.

Table 1
Claims Submitted, Claims Approved, Initial and Repeat Claims* (Absolute Numbers and Percentages), 2010-2014

Year	Total of all claims (numbers)	Ann-ual grow-th rate	% claims approved	% initial claims approved	% repeat claims	% repeat claims approved
2010	77,860	1.2	44.0	51.5	60.6	39.0
2011	79,468	2.1	44.9	52.0	61.1	40.3
2012	80,780	1.7	46.9	55.0	59.5	41.3
2013	83,086	2.9	44.4	53.4	59.3	38.2
2014	82,982	0.1-	43.1	51.7	60.4	37.5

* (1) The data does not take into account those who submitted claims and died and those whose entitlement was suspended. (2) Claim results presented here are for the first entitlement decision. (3) The total of all claims includes those whose handling was not completed in 2013. The percentage of claims approved, initial claims, repeat claims, repeat claims approved include only those whose handling was completed in 2013.

of, 43.1% of claims for long-term care benefits were approved, and 56.9% were rejected (versus 44.4% and 55.6% in 2013, respectively).

The rate of **false claims** (for which a score of 0 or 0.5 was received in the ADL part of the dependency test[8] and no entitlement for supervision was determined) within total claims rose from 25.5% 2013 to 31.9% in 2014. The rate within total claims of those receiving 2.5 points in the dependency assessment – the point threshold for entitlement to the benefit – decreased from 18.4% to 17.4% between the two years.[9] The rate of false claims in initial claims rose from 23.1% to 28.4%, and in repeat claims – from 26.5% to 34.3%. The rate of those receiving 2.5 points in the dependency assessment in initial claims dropped from 19.4% to 18.1%, and in repeat claims – from 17.3% to 17.0%.[10]

F. Sum Total of Persons Entitled to a Long-Term Care Benefit

The number of persons entitled to a long-term care benefit continued to rise in 2014, and reached a monthly average of 159.4 thousand – an increase of 2.0% (Table 2). Between the years 1991 and 2014, the number increased fivefold despite the raised age of entitlement. This is an extremely high rate of growth, and it is significantly higher than the growth rate in number of elders during the same period. A possible explanation for this may be a growth in the rate of exercising rights to the benefit resulting from a growing awareness over the years. In 2009, the age of entitlement for women reached 62, and this will remain in force until the end of 2016. Also in 2009, the age of entitlement for men was raised to 67. In 2014 as in 2013, the age of entitlement for women and men did not change throughout the year. The percentage of persons entitled to the benefit

8 See Annual Survey – 2011, p. 125.
9 The threshold for entry into the long-term care system is 2.5 points in the dependency assessment for a person who is not single, or two points with the addition of 0.5 points for an individual.
10 The data in this section are relevant to all claims for which a dependency test was performed and a decision was made, and the claim was not rejected due to a means test.

among elders in the population rose by a significant amount, from approximately 6% in the first years the law was in effect, to 17.6% in 2012 and 17.2% in 2014 (estimated). This rate of entitled persons was calculated through estimating the number of elders in the ages of eligibility for the benefit (62 for women and 67 for men).

Table 2
Eligible Persons for Long-Term Care Benefit, Elders in Israel, and Coverage Rate, 2010-2014

Year	Persons entitled to long-term care*		Elders in Israel**		Coverage rate
	Numbers (thousands)	Annual rate of growth	Numbers (thousands)	Annual rate of growth	
2010	141.1	3.4	812.7	3.1	17.4
2011	144.9	2.7	840.3	3.4	17.2
2012	152.1	5.0	861.9	2.6	17.6
2013	156.2	2.7	895.3	3.9	17.4
2014	159.4	2.0	928.7****	3.7	17.2

* Monthly average
** Data for the years 2010-2014 are for men age 67 and older and women age 62 and older, according to data of the Central Bureau of Statistics.
*** The number of persons entitled to the benefit as a percentage of the number of elders.
**** Estimate.

G. Characteristics of Entitled Persons

- **Men versus women –** An examination of the demographic characteristics of entitled persons in 2014 indicates that 7 out of every 10 are women, and that their percentage within all entitled parties dropped slightly in comparison to 2013. Divided by age, approximately 2/5 are 85 and older and 2/3 are 80 and older. As in 2013, in 2014 the main growth in number of entitled persons was also among people aged 85 and older, whose share within total recipients rose from 40.5% to 41.7%, while the share of people aged 84 or younger is continually dropping.
- **Age and family makeup** – The ageing trend of benefit recipients is continuing: thus, for example, in 2001 people aged 85 and older represented less than one third (32.1%) of those entitled, and people aged 80 and older represented less than 3/5 (55.2%). This tendency reflects the ageing trends in Israeli society, and especially the growth in share of the more elderly, and it stems partially from the higher retirement age: the group of women aged up to 64 entitled to the benefit is getting smaller, as is the group of entitled persons (men and women) aged 65-69, due to the higher retirement age for men.

  In the area of family composition[11], stability was maintained in 2014 in comparison with 2013: nearly half of entitled persons live by themselves, two out of five live with a spouse, and one out of eight live with someone else – generally a son or daughter.

11 As of 2011, a change has taken effect in definitions of persons living with spouse, living with children, or living with others – the definition of living with a spouse now also includes someone living with a spouse and other people.

- **Length of Time in Israel** – Stability was maintained between the years in respect to length of time in Israel also: one of every four entitled persons immigrated to Israel after 1989, and one of eight immigrated after 1999. The share of those who immigrated after 1989 out of all entitled persons remained stable – 25.2%, while the share of those who immigrated after 1999 rose from 3.5% to 3.7%. Among entitled parties, a monthly average of 856 immigrated to Israel after 2009. The Ministry of

Table 3
Persons Entitled to Long-Term Care Benefit by Demographic Characteristics and Benefit Level (Monthly Average), 2014

Characteristics	Absolute numbers	Percentages
Total	**159,441**	**100.0**
Gender		
Men	46,999	29.5
Women	112,442	70.5
Age		
Up to 64*	1,116	0.7
69-65	6,614	4.1
74-70	14,428	9.0
79-75	29,614	18.6
84-80	41,196	25.8
85+	63,473	41.7
Family composition		
Lives alone	76,705	48.1
Lives with spouse	63,780	40.0
Lives with children or others	18,956	11.9
Length of time in Israel		
Veteran citizens	119,259	74.8
Immigrants**– total	40,182	25.2
of whom: immigrated after 1999	5,845	3.7
Source of benefit financing	128,986	80.9
NII	128,986	80.9
Finance Ministry	30,455	19.1
Benefit level		
Low (91%)	84,012	52.7
Middle (150%)	40,461	25.4
High (168%)	34,968	21.9
Entitled to additional 3 hours	24,896	61.5***
Entitled to additional 4 hours	15,599	44.6***

* The age group includes only women.
** Those who immigrated to Israel from 1990 and on.
*** Entitled to additional hours as percent of all persons entitled to that level of benefit.

Finance underwrites the long-term care benefit for those who immigrated to Israel at age 62 and older In 2014, the benefits of 19.1%, by monthly average, were paid for by the Ministry of Finance, versus 19.9% in 2013. In recent years the relative share among all entitled persons whose benefits are financed by the Ministry of Finance has grown smaller, with their average monthly number dropping in 2014 by approximately 650 versus 2013.

- **Benefit level** – With population ageing, there has been a change in the distribution of entitled persons by benefit level, which can also be seen between 2013 and 2014: the percentage of recipients of a low level benefit (91% of a full disability pension for an individual) decreased from 53.4% to 52.7%; the percentage of those receiving a middle level benefit (150%) increased from 25.2% to 25.4%; and the percentage of those receiving the highest level benefit (168%) also rose from 21.4% to 21.9% between the two years (Table 3).

  The share of persons entitled to the highest level benefit is continually rising – from 17.6% in 2008 to 21.9% in 2014. This group's rate of growth is the highest. In comparison with 2013, the number of low level benefit recipients grew in 2014 by 0.4%, middle level recipients – by 2.6%, and highest level recipients – by 4.3%.

  In March 2009, care hours were added only for those employing an Israeli worker. The number of middle level benefit recipients employing Israeli caregivers grew by approximately 1000, while the number of high-level recipients grew by approximately 500. The main cause of this is the relative lack of foreign long-term caregivers – as of June 2010 the government applied quotas to the long-term care industry[12]. The effect of the extra hours in encouraging employment of Israeli caregivers apparently exists, but it is more limited.[13]

H. Benefit in Cash – The Experimental Program

In March 2008, the NII began running an experimental program providing cash benefit in areas served by the Ashkelon, Bnei Brak, Nahariya, and Ramat Gan branches. In May 2010, the program was expanded to cities served by branches in Ashdod, Tiberias, and Jerusalem, and in June 2011 – also to cities served by branches in Holon and Netanya. In this format, the program ended in April 2013.

In the framework of this program, elders in the cities who were entitled to a benefit at a rate of 150% or 168% of a full disability pension (or to half because of a means test), could choose a cash benefit on condition that they received their long-term care services

12 If 1% or more of legal foreign workers engaged in long-term care are not employed over the course of the year, approval is not granted to bring in additional foreign caregivers. Private offices with a permit are allowed to increase the number of foreign workers by 10% each year, if their placement rates are not lower than the threshold set in the guidelines of the Immigration and Population Authority in the Ministry of the Interior (97%).

13 Regarding the effect of the extra hours in encouraging the employment of Israeli caregivers, see the chapter Long-Term Care in the Annual Report – 2010.

from a caregiver who was not a relative, for at least six days a week, 12 hours per day. They could choose to transfer to a cash benefit or to return to a benefit in kind any time they wanted. This program was studied to examine the characteristics of those choosing the cash benefit compared to all entitled persons, and quality control was performed for recipients in these and other areas. From March 2014 to June 2015 (due to early elections the law was extended for six months), the experiment was expanded over all of Israel (see Section E below).

A local authority professional committee, which determines the treatment program, is authorized to refuse a request for cash long-term care benefits in the framework of the experimental program, if it believes that the elder and his/her family are not capable of using the money for its intended purpose. It is also authorized to determine whether the full-time caregiver is suitable, and whether the long-term care services received by the elder are sufficient. The committee may cancel payment of the cash benefit in favour of the in-kind benefit instead.

At the end of 2014, 1,775 entitled persons (1.1% of the entitled population) had received the cash benefit (Table 4). It was chosen mainly by those receiving the benefit at the levels of 150% or 168% (as well as those receiving half these levels according to a

Table 4
Recipients of Long-Term Care Benefits in Cash by Veteran and New Branches in the Experimental Program, December 2014

	Veteran branches	New branches	All branches
Persons entitled to all benefit levels	62,733	97,469	160,202
Recipients of the cash benefit in the framework of the experimental program	1,200	575	1,775
% of all entitled persons	1.9%	0.6%	1.1%
Of which: only recipients of the cash benefit, in the framework of the experimental program	1,130	445	1,575
Of which recipients of the cash benefit + services, in the framework of the experimental program	70	130	200
% Recipients of the cash benefit in the experimental program	5.8%	22.6%	11.3%
Persons entitled to the two highest levels of benefit holding a permit to employ a foreign caregiver	13,527	22,118	35,645
% of all entitled persons	21.6%	22.7%	22.3%
Persons entitled to the two highest benefit levels receiving cash and holding a permit to employ a foreign caregiver in the framework of the experimental program	1,167	542	1,709
% of persons entitled to the two highest levels of benefit holding a permit to employ a foreign caregiver	8.6%	2.5%	4.8%
Recipients of the cash benefit not in the framework of the experimental program	108	159	267
% of all entitled persons	0.2%	0.2%	0.2%

means test) with a permit for employing a foreign caregiver. At the end of 2014, 1,709 of those entitled to the two highest levels of benefit had permits to employ foreign workers and received the benefit in cash – representing 4.8% of all persons entitled to the two highest levels of benefit (Table 4).

Those who received the cash benefit were entitled to receive other long-term care services in exchange for deduction of their value from the benefit. At the end of 2014, 200 entitled persons (11.3%) also received other services. The rate in the 'new' branches was nearly 4 times higher than that in the 'veteran' branches (Table 4).

There are differences between the branches that participated in the experimental program in previous years and those that joined in 2014, as well as differences between the branches in each of the groups (Table 4). Among the 'veteran' branches, rates of choosing the cash benefit among persons entitled to levels of 150% or 168% with permits for employing a foreign worker, ranged at the end of 2014 between 3.8% in the Netanya branch and 14.6% in Ramat Gan. This compares with the 'new' branches -Krayot 0/9% and Ramle 4.6% .

I. Organizations Providing Long-Term Care Services and the Services Provided

The services provided in the framework of long-term care insurance are provided through authorized service organizations recognized by the Ministry of Welfare and Social Services, by way of a contract between the organizations and the NII. At the end of 2009, the results of the latest tender were published, with the names of the authorized companies.

A long-term care service provider may be a public nonprofit organization such as Matav, or Mercaz Yom, or a private one operating as a commercial venture. At the end of 2013, 119 long-term care service providers were operating: 50 nonprofits (42% of all the companies) and 69 private companies (58% of all the companies). In 2014 in total, the service providers furnished a monthly average of 8.171 million hours of personal care in the homes of persons entitled to a long-term care benefit: 5.976 million hours (73.1%) were provided by private organizations, and 2.195 million hours were provided by nonprofits (Table 5).

Table 5
Hours of Personal Care Provided by Type of Service Provider (Monthly Average), 2014

Type of service provider	Number of hours (thousands)	Percent
Total	8,171	100.0
Private organization	5,976	73.1
Nonprofit	2,195	26.9

The overall monthly average of care hours increased between 2013 and 2014 by 1.9% – from 8.021 million to 8.171 million. The number of hours provided by private companies grew by 2.2% – from 5.848 million in 2013 to 5.976 million in 2014. And those provided by nonprofits grew by 1.0% – from 2.173 million to 2.195 million. The share of private companies in total hours grew from 72.9% to 73.1% between the two years (Table 5).

The overwhelming majority (99.2%) of entitled persons[14] in December 2014 received personal care at home provided by a local or foreign caregiver, 7.4% received personal care at a day center, 18.3% received absorbent products, and 11.8% received a personal alarm unit (Table 6).[15] For 68.5% of those receiving personal care at home, this was their only item in the basket of services. Only 5.8% of those receiving personal care at a day center received it as a single item, with the others combining it with additional services. It should be remembered that a person entitled to the benefit may receive more than one type of service, and that thus the total of all long-term care service recipients is greater than the number of persons entitled to the benefit.

Table 6
Recipients of Long-Term Care Services by Type of Service, December 2014[16]

Service type	Number of recipients	Percent of recipients	
		Out of total benefit recipients	As only item of recipients of this service
Total	217,849	-	-
Personal home care	157,846	99.2	68.5
Personal care at day center	11,705	7.4	5.8
Absorbent products	29,107	18.3	0.6
Personal alarm unit	18,741	11.8	0.6
Laundry services	450	0.3	2.0

* An entitled person may receive more than one type of service. Thus the total of all long-term care service recipients in this table is greater than the number of benefit recipients (not including those who refused services) - as of December 2014 – 159,168.

14 Out of all entitled persons not including those refusing to receive services (entitled elders who were offered a basket of services but refused it, or refused to accept service from a particular provider). 98.5% of all entitled persons (including those who refused service), 160,203 received personal care at home as part of their entitlement to a long-term care benefit.

15 Out of all entitled persons not including those refusing services, and including recipients of a cash benefit. Out of all entitled persons (including refusers), the percentages were 7.3%, 18.2%, and 11.7%, respectively.

16 Until the 2013 Annual Survey, the data was published for number of absorbent product services provided – in other words, if an entitled person received two types of these services, they were considered as two different recipients. The present report records the number of recipients such that an entitled person who receives more than one type of service is counted only once. In 2013, X types were given to Y entitled persons.

J. Sum Total of Payments

Concurrent with direct benefit payments, National Insurance Law mandates payment for additional articles related to long-term care insurance. 15% of the annual receipts (for each article) are budgeted to the Ministry of Health and Ministry of Welfare and Social Services, for financing an increase of institutionalized persons. In practice, the Ministry of Health uses the entire budget, while the Ministry of Welfare uses only a very small portion of theirs. Money is also budgeted for the Fund to develop communal and institutional services for elders. The long-term care Division expenses include administrative ones also, such as payments to members of local committees, and for dependency tests.

In 2014, the sum total of payments transferred for the financing of long-term care insurance reached approximately NIS 5.3 billion (in 2014 prices): approximately NIS 5 billion for provision of services to entitled persons, and the rest for development of institutional and community services, and the performance of dependency tests (Table 7). NIS 121 million were transferred to the Ministries of Health and Welfare for increasing the number of persons institutionalized in long-term care facilities, and NIS 104 million were transferred to the Ministry of Welfare, the health funds, the assessors for preparation of care plans for entitled persons, and for performance of dependency tests.

Table 7
Payments for Long-Term Care Insurance by Type of Payment (millions of NIS, 2014 prices), 2010-2014

Year	Total	Long-term care benefits	Transfer to external parties*	Development of services	Persons institutionalized in long-term care institutions	For agreements with the Ministry of Finance
2010	4,289.3	4,055.1	91.4	47.0	92.2	3.6
2011	4,371.0	4,145.9	93.4	31.5	97.6	2.5
2012	4,772.9	4,549.6	99.7	26.3	94.4	2.9
2013	5,073.0	4,828.9	102.3	31.0	107.5	3.3
2014	5,282.4	5,020.3	104.2	33.4	120.5	3.9

* Transfers to the Ministry of Welfare and Social Services and the Clalit Health Fund for preparation of care programs for entitled persons, and transfers for performance of dependency tests.

In 2014, payments for long-term care insurance grew by 4.1% at fixed prices (2014 prices). The benefit payments grew by 4.0% as a result of the growth in number of persons entitled to the benefit, especially those entitled to the highest level of benefit. The average benefit level[17] at fixed prices rose in 2014 by 2.0% in real terms.

17 Average benefit, if long-term care benefits were paid to all entitled persons for all hours in a given month of entitlement. The long-term care benefit payments are lower by a few percentage points since some of the entitled persons do not receive them for part of the month because: the entitled person died, moved to a long-term-care institution, or was hospitalized for more than 14 days; the long-term-care company failed to provide all long-term-care hours required of it because the caregiver could not come and no substitute was found; different rates and various dates of update for the benefit and various payment rates such as care hours. The long-term-care companies receive payment for care hours or other services actually provided. The data in Table 7 relating to expenditure on long-term care benefits is for actual expenditure.