Long-Term Care Benefit- General

The long-term care insurance plan was approved by the Knesset in 1980 within the framework of the National Insurance Law, and came into effect in April 1988. Long-term care insurance is intended to enable the elderly to continue living in the community for as long as possible by providing personal care to those requiring assistance for daily functions or supervision, and thereby assisting families taking care of them. The Law applies to anyone who is insured under old-age and survivors' insurance, to housewives (married women who do not work outside their homes) and to new immigrants who are not covered by old-age and survivors' insurance.

All elderly, who have reached the age of eligibility and are Israeli residents living in the community (at home, family members' home or in retirement homes), are eligible for the long-term care benefit if their physical or cognitive functioning is impaired and they pass the means test under the Regulations. Those residing in a nursing home or long-term care ward in an old-age home are not eligible for the benefit. The means test examines the income of the elderly person and his/her spouse only. The Law differentiates between those receiving a cash benefit by choice (see below) and those receiving a cash benefit because cannot be provided a service (benefit in kind). The latter undergo a means test similar to that conducted for those receiving the benefit in kind. As a condition of receiving the cash benefit, the income of the relative taking care of and living with the elderly is also examined.

The long-term care benefit is usually a benefit in kind – it is not paid in cash, but is given in the form of services by organizations which the National Insurance Institute (NII): personal care or supervision at home, transportation and personal care at a day center, providing absorbent products, laundry services and funding the use of panic buttons. Since June 2014, those eligible for a cash benefit can receive additional services as part of the benefit.

The Dependency Test

The dependency test (ADL) assesses the degree of assistance from others a person requires to perform basic daily activities: bathing, dressing, mobility (moving about at home and

avoiding falls), toileting and eating (including the ability to heat food and drink). The dependency test also assesses the need for supervision due to impaired cognitive ability, deterioration in mental health or due to a physical condition. The test of dependency on the assistance of others is executed by professional assessors – nurses, occupational therapists and physiotherapists who undergo suitable training.

Those who have reached the age of 90 can undergo a dependency test performed by a geriatric doctor as part of his/her public health work or at his/her clinic or at the claimant's home.

Box 1

"Fast Track" - Assessment of functioning of long-term care benefit claimants based on medical documents

The functioning assessment of long-term care benefit claimants on the basis of medical documents was implemented gradually from 2011 to 2016. In this process ("the fast track"), a claim for the benefit or for re-examination due to medical deterioration is approved when there is a clear connection between the claimant's medical condition and his state of functioning. Documentation-based assessment of dependency reduces the claim's processing time and allows to dispense with dependency test. Documents are forwarded to an adviser, who is herself an assessors supervisor and highly experienced in dependency tests, and provides the claims officer with her recommendations as to whether the claim should be accepted or forwarded to the regular track with a dependency test at the claimant's home. On this track, all other conditions of eligibility of long-term care insurance must also be met in order to receive the benefit.

The fast track was established by the NII as a response to public criticism against dependency tests. Concurrently, the NII continues to perform dependency tests when necessary in order to determine eligibility for the benefit. In April 2011, the fast track was implemented for the first time, for those whose medical condition (physiological or cognitive) is very serious to extreme, with a maximum and permanent degree of dependence on others for daily activities. In May 2012, this option was also expanded to those who, as a result of a sudden medical event, have become extensively dependent on others for a short period, and on several conditions: it shall be claimant's first entitlement to a long-term care benefit, the impairment is temporary (up to two months) and the claimant does not suffer from any permanent psychological, intellectual or cognitive impairment.

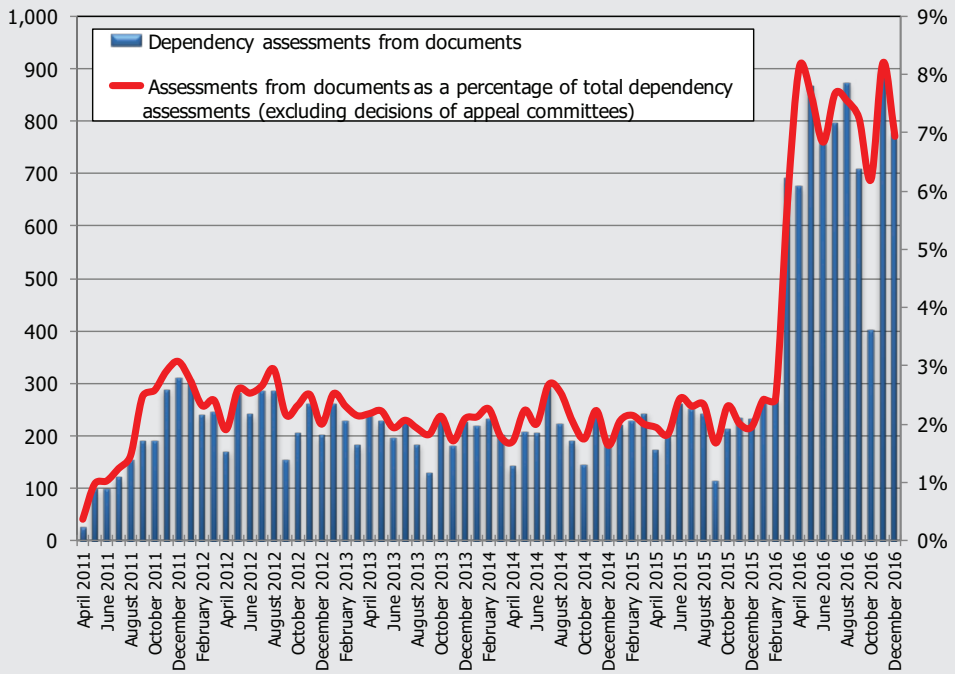
In March 2016, the fast track was expanded further, to claims and deterioration applications at all benefit levels, permanent or temporary, on the basis of medical

documents. For example – a benefit at the high level in very severe and extreme cases from a physiological or cognitive point of view (a score of 11 or less on the **Mini-Mental** or **MoCA** test); an average benefit rate in cases of complete mobility or toileting dependency for those who are not alone; a benefit at the low level in cases of chronic or progressive illness with impaired functioning; a temporary benefit in cases of an acute event or medical condition which can cause great temporary dependence on others in most daily activities.

As a result of the extension of the fast track to all benefit levels and all types of eligibility, there was an increase in the percentage of assessments made without a dependency test out of all assessments. In January-February 2016, approximately 260-270 assessments were made on the fast track, and in March–April – 670-690 such assessments. In March-December 2015, 2,134 decisions were made on the fast track (which constituted approximately 2.1% of all dependency assessments in that period, not including decisions of appeal committees), compared with

Figure 1

Number of Fast Track Dependency Assessments and Their Percentage of the Total Dependency Assessments (Excluding Boards of Appeal), April 2011-December 2016



The figure data appear in the appendix at the end of this file on the Internet.

7,434 decisions in March-December 2016 (representing approximately 7.2% of all dependency assessments, not including decisions of appeal committees). Overall, the average number of fast-track assessments per month increased by almost 3.5 times – from 213 to 743 on average.

The introduction of the fast track in April 2011 led to a rapid increase in the number of dependency assessments in this channel and in their percentage of total assessments – approximately 300 assessments, representing 3.0% of all dependency assessments (not including appeal committees) in December 2011 – January 2012. The extension of the fast track in May 2012 led to a renewed increase – to about 280 assessments per month in the second third of 2012 (except June 2012). Between September 2012 and February 2016, approximately 210 assessments were made per month on average, constituting 2.1% of all dependency assessments (not including appeal committees) per month. The further and greater extension implemented as of March 2016 led to a considerable increase in fast track assessments and in their percentage of all assessments (not including appeal committees) - up to 902 in November 2016, representing 8.2% of all assessments (Figure 1).

The fluctuations in the number of dependency assessments in this period were seasonal: in the religious holiday periods, Passover or the holidays in the month of Tishrei (September-October) for example, the number of fast track assessments tends to be lower.

With the increase in the number of dependency assessments from medical documents, there was a decrease in the number performed by assessors. In the period from March to December 2016, 93,599 tests were performed, in comparison with 97,877 in the corresponding period in 2015 (the number of tests performed by doctors increased slightly, from 1,786 to 1,843). The fast track alleviated the burden on assessors: although overall assessments increased between the two periods, mainly due to a rise in population above retirement age and particularly over 80, the number of examinations by assessors decreased by 4,278 and document-based assessments increased by 5,300.

The percentage of assessments for women in this period was 69.6% of document-based assessments and 70.6% of test-based assessments, and for those aged 80 or older – 31.8% and 45.6% respectively. A particularly noticeable group is women under the age of 70, which constituted 20.9% of all assessments from documents, compared with 11.7% of assessments from tests. The average age of those examined on the fast track was 76.35 (the median – 76.08) and among those examined by assessors 78.78 (the median – 79.17).

From the breakdown of fast track decisions according to benefit level it appears that 67.5% of them were at the low level, 3.9% at the medium level and 28.6%

at the high level1. The addition of the possibility of a temporary benefit, beside a short-term benefit, led, to a situation where in this period 60.9% of all entitlements on the fast track were temporary and short-term, compared with the percentage of temporary entitlements which were not short-term – 45.4%. Temporary or short-term entitlements at the low level constituted 86.0% of all entitlements at this level on the "fast track", in comparison with 36.6% of entitlements at average level and 5.4% of entitlements at the high level.

1. In fact, some of those eligible for an average level received the high one because of their age – 90 or older (See legislative changes in this chapter).

The Benefit Levels

In January 2007 three levels of long-term care benefit were established, which correspond with three levels of dependency: a benefit at a rate of 91% of the full disability pension for a single person – to fund 9.75 hours of home care per week, 150% for 16 hours and 168% for 18 hours of home care per week. Since July 2016 the levels of long-term care are defined in terms of weekly long-term care hours only (see below).

A **single person claimant** is eligible for the full long-term care benefit at the determined level of dependency, if his income does not exceed the average wage (NIS 9,464 in 2016), and for half the benefit, if his income is higher than the average wage and up to 1.5 times the average wage. If his income is higher than 1.5 times the average wage, he is not eligible for a benefit.

A **claimant with a spouse** is eligible for a full benefit if the shared income does not exceed 1.5 times the average wage, and to one-half the benefit if his/her income is higher than 1.5 times the average wage and up to 2.25 times the average wage. A couple whose income is more than 2.25 times the average wage is not eligible for a long-term care benefit. When both spouses submit a claim for a benefit, their shared income is divided by two and a means test is done for each of them as if they were single. In January 2015 and January 2016, the long-term care benefit was not updated since the consumer price index did not increase in 2014 and 2015. In January 2017, the values of long-term care benefits in kind remained unchanged and those of cash benefits were updated by approximately 3.7% in the light of the revision of tariffs for service providers (see below).

Recipients of long-term care benefits at the two highest levels who employ Israeli workers only, and do not hold a valid permit to hire a foreign worker, are entitled to

additional hours per week: three hours for those receiving a benefit at medium level and four hours for those receiving a benefit at high level. Whoever is eligible for one-half the benefit due to income, is eligible for one-half the extra hours according to the determined level of dependency.

Temporary Eligibility

The long-term care benefit is given to those eligible as a permanent or temporary benefit. When an improvement in functioning is expected (for example after a hip replacement operation or after a stroke that happened a short time before the test), a temporary benefit is given for six months. For those aged 80 or older a new dependency test is performed again around the end of the temporary period; for those under 80 eligibility ends at the end of the period without a test, unless they asked to be tested. When in doubt, the benefit is given temporarily. Similar to the permanent benefit, the temporary benefit starts on the 1st of the month after the claim was submitted.

Those discharged from hospital, usually due to orthopedic problems or operations, and not eligible for a long-term care benefit in the past, may claim and receive a benefit for two months, on the basis of the documents submitted (**short-term fast track**) or if they are found to be dependent on others, according to the dependency test. Eligibility in such a case begins near the date of claim submission, even during the course of the month. Unlike regular temporary eligibility, this benefit is given when a significant improvement is expected in the short-term, and therefore no additional dependency test is performed at the end of the eligibility period. An eligible person whose functioning has, in his/her opinion, not improved, may submit a claim again at any time, even during the period of eligibility for the short-term benefit.

Legislative and Administrative Changes

Increase in benefit level for those aged 90 or older

Those aged 90 or older, who are eligible for a benefit at medium level according to the dependency assessment, will receive a high level benefit. Those eligible for medium level are automatically eligible for high level benefit upon reaching the age of 90.

Changeover to service units

In July 2016, benefit levels were redefined in terms of service units instead of percentages of full disability pension for a single person (a service unit is equal to a weekly care hour

at the entitled's home). In fact, the new definition did not change the scope of eligibility in long-term care insurance, but was intended to anchor in the Law long-term care benefit values in terms of care hours. Other services provided as part of long-term care benefit are also defined in terms of service units and are deducted from the number of home care hours according to the value of the service units.

With the changeover to a service units definition, a cash benefit is defined as a number of service units at corresponding level of in-kind benefit (= services) multiplied by the hourly tariff paid to private companies (a slightly higher tariff than the tariff paid to non-profit organizations due to taxation rules). This means that cash benefit value is approximately 80% of the monetary value of in-kind benefit provided by private long-term care companies, and more than 80% of the monetary value of the benefit provided by long-term care companies which are non-profit organizations. It is important to emphasize that in both cases – private companies or non-profit organizations – those eligible receive the same scope of services. Cash benefits are updated in accordance with the revision of the tariff for a home care hour provided by the private companies (for example, updating of the minimum wage).

Treasury participation in funding long-term care benefit

Since 2016, the Ministry of Finance does not compensate the NII for payment of benefits to immigrants who are not insured with old-age and survivors' insurance, but participates in funding the Long-Term Care Division under Section 32(a) of the National Insurance Law. The amount of participation is determined as a certain percentage of the receipts collected by the NII for all insurance divisions. In addition, the Ministry of Finance compensates the NII for the increase in expenditure on long-term care benefits arising from demographic changes: the gap between the rate of increase in the number of those eligible for the benefit and the growth rate of the total population (**demographic coefficient**).

Supportive community service

As of September 2016, the **supportive community** service has been added to the basket of services of the long-term care benefit. This service is operated experimentally by a number of local committees[1] at the Holon, Kfar Saba, Nazareth and Ramle branches, and in this framework home supervision, cleaning and shopping services are provided, including purchase of medicines. A "superintendent" and a "community coordinator", who are employed by a non-profit organization or private company, are in charge of supervision and purchase, and for this purpose they establish contact with pharmacies and supermarkets in various towns.

1 Within the framework of long-term care insurance, local committees (composed of a NII claims officer, a representative of the local welfare services and a nurse from Clalit Health Services) operate in towns, and determine services basket for eligible individual and the identity of service providers.

Cleaning assistance, which is beyond the basic maintenance currently offered in the basket of services, is provided by a cleaning company in order to create a separation between caregiver's caring work and cleaning work, to have them performed by different people. Communication with the cleaning company is carried out by a body selected to that end by the NII.

Claims for a Benefit and Deterioration Applications

Claims for a benefit

The number of long-term care benefit claims (including pending claims) increased by 0.3% in 2016 in comparison with 2015, and reached 85.7 thousand; 39.2% of which were initial claims and 60.8% repeat claims (Table 1). The number of initial claims increased by 1.0% and more than half of them were approved. The number of repeat claims increased by 0.3% and approximately 40% of them were approved.

Table 1
Claims Filed, Claims Approved, Initial and Repeat Claims*, 2012-2016

Year	Total claims (absolute numbers)	Annual increase (%)	Claims approved (%)	Initial claims approved (%)	Repeat claims (%)	Repeat claims approved (%)
2012	80,767	1.6	46.8	55.0	59.5	41.3
2013	82,874	2.6	44.4	53.4	59.4	38.2
2014	82,993	0.1	43.0	51.6	60.6	37.4
2015	85,354	2.8	43.1	52.2	61.2	37.3
2016	85,721	0.3	46.2	55.4	60.8	40.3

* Initial eligibility claims are presented. Total claims do not include claims by those who died or whose eligibility was suspended, but includes claims still pending in 2016. The percentages of claims according to their results only include those dealt with in 2016.

The percentage of futile claims by those ineligible for the benefit before filing the claim (claims receiving a score of 0 or 0.5 in the ADL section of the dependency test[2], where no eligibility was determined for supervision) of all claims for which a dependency test was performed, decreased from 37.5% in 2015 to 36.4% in 2016. The percentage of those receiving 2.5 points in the dependency test - the eligibility threshold for the benefit – of all claims increased from 17.1% to 17.3% between the two years. The percentage of futile

2 See Annual Survey 2011, p. 125.

initial claims remained 32.2%, and that of futile repeat claims decreased from 40.8% to 38.9%. Those receiving 2.5 points in the dependency test in initial claims decreased from 18.1% to 18.0%, and in repeat claims increased from 16.4% to 16.9%.

Deterioration Applications

Those eligible for a long-term care benefit at low and medium level who believe that their dependence on others has increased to such a degree that necessitates the benefit level to be increased, may file a deterioration application. In 2016, 40,014 deterioration applications in respect of permanent eligibility decisions were filed (including applications that were still pending) – an increase of 1.6% in comparison with 2015 (Table 2). In approximately one-half of the cases, the benefit was not changed, and in the other half it was increased. In approximately 1% of the cases, it was decided to reduce or cancel the benefit.

Table 2
Deterioration Applications and Their Results*, 2012-2016

Year	Total deterioration applications (absolute numbers)	Annual increase (%)	Benefit increased (%)	Benefit unchanged (%)	Benefit reduced (%)	Benefit canceled (%)	Total (%)
2012	37,670	6.3	47.9	51.0	0.3	0.7	100.0
2013	39,320	4.3	45.8	52.9	0.4	0.9	100.0
2014	39,454	0.3	47.0	51.6	0.4	1.0	100.0
2015	39,372	-0.2	48.7	50.0	0.4	0.9	100.0
2016	40,014	1.6	49.7	49.5	0.2	0.6	100.0

* The total number of applications does not include those from people who have died or whose eligibility was suspended, and includes applications still pending in 2016. The percentages of applications according to their results only include those whose handling ended in 2016.

Scope and Characteristics of the Eligible

Scope of those Eligible

The number of people eligible for the long-term care benefit continued to increase in 2016 and reached 164.2 thousand on average per month – an increase of 2.4% (Table 3). In 1991-2016, the number increased 5.2 times notwithstanding the higher eligibility age. This is a very high growth rate, considerably higher than the growth in the number

of elderly at that time. A possible explanation for this may be a rise in uptake of rights to the allowance in light of an increase in awareness.

The share of persons eligible for the long-term care benefit among the elderly in the population increased by approximately 6% in the first years of the implementation of the Law up to a peak of 17.6% in 2012, and since then it has been in a declining trend: to 17.0% in 2014 and 16.2% in 2016 (according to an estimate). Factors for this decline are an accelerated growth in recent years in the number of younger elderly (aged 60+ reaching retirement age), their relative proportion of all elderly, and the fact that they are not eligible for the long-term care benefit since they are healthy and functioning well.

Table 3

Those Eligible for the Long-Term Care Benefit, Elderly in Israel and the Cover Rate, 2012-2016

Year	Eligible for long-term care*		Elderly in Israel **		Cover Rate*** (%)
	Numbers (thousands)	Annual increase (%)	Numbers (thousands)	Annual increase (%)	
2012	152.1	4.9	862.0	2.6	17.6
2013	156.2	2.7	895.4	3.9	17.4
2014	159.2	1.9	934.3	4.3	17.0
2015	160.3	0.7	972.7	4.1	16.5
2016	164.2	2.4	1,013.6****	4.2	16.2

* Monthly average.
** The data for the years 2012-2016 are for men aged 67 or older, and women aged 62 or older, according to Central Bureau of Statistics data.
*** Number of those eligible for the benefit as a percentage of the number of elderly.
**** Estimate.

Characteristics of Those Eligible

Gender, Age and Family Composition

Women constitute most of those eligible for the long-term care benefit – 70% of those eligible are women, and their rate of all persons eligible decreased slightly in comparison with 2015 (Table 4).

The aging trend of benefit recipients continues: like 2015, in 2016 the main increase in the number of eligible persons occurred among those aged 85 or older, whose percentage of the total number of recipients increased from 43.1% to 43.7%, while the share of those aged 84 or younger continuously declined. For comparative purposes, in 2001 those aged 85 or older constituted less than one-third (32.1%) of those eligible.

This trend reflects the aging trend in Israeli society, and particularly the growth in proportion of older persons.

In 2016, family composition remained stable in comparison with 2015: nearly one-half of those eligible live alone, two out of five live with a spouse, and one out of every nine lives with someone else – usually a son or daughter.

Seniority in Israel

Stability between 2015 and 2016 was also maintained in relation to seniority in Israel: the percentage of those who immigrated after 1989 of all those eligible remained approximately 25%, and the percentage of those who immigrated after 1999 increased from 3.9% to 4.2%.

The Ministry of Finance funds the long-term care benefit for those who immigrated to Israel at the age of 62 or older. In recent years, the relative proportion of the eligible whose benefits are funded by the State Treasury has declined: Their average monthly number dropped in 2016 by approximately 1,000 in comparison with 2015, and their average monthly rate dropped from 18.2% to 17.2% between the two years.

Benefit Level

With the aging of eligible population, there has been a trend for change in the composition of those eligible according to benefit level, expressed between 2015 and the first five months of 2016: the weight of low level benefit recipients decreased, from 51.3% to 50.6%, while that of high level benefit recipients increased, from 23.3% to 24.0%. The portion of those entitled to a benefit at the highest level increases continuously – from 17.6% in 2008.

As a result of transferring those aged 90 or older from medium to high level benefit, the absolute number and percentage of those eligible at the two high levels changed from June 2016: the share of recipients at the high level increased from 24.0% to 31.4%, whereas at medium level there was a decrease from 25.4% to 18.4%. The share of benefit recipients at a low level continued to drop, reaching 50.2% in the last seven months of 2016.

In March 2009, care hours were added for eligible individuals who employ an Israeli worker. The number of medium level benefit recipients, who received extra hours, increased by approximately 600 between January and May 2016, and the number of those entitled to a high level benefit - by approximately 500. In the last seven months of 2016, the rate of medium level benefit recipients, who received extra hours, decreased by approximately 5,700, while that of high level benefit increased by approximately 6,900.

Table 4

Persons Eligible for the Long-Term Care Benefit by Demographic Characteristics and Benefit Level (Monthly Average), 2016

Characteristics	Absolute numbers	Percentages
Total	**164,154**	**100.0**
Gender		
Men	49,012	29.9
Women	115,142	70.1
Age		
Up to 64*	1,113	0.7
65-69	7,130	4.3
70-74	14,283	8.7
75-79	28,837	17.6
80-84	41,044	25.0
85-89	40,968	25.0
90-94	24,162	14.7
95-99	5,569	3.4
100+	1,048	0.6
Family composition		
Live alone	80,229	48.9
Live with spouse	66,771	40.7
Live with their children or with others	17,154	10.4
Seniority in Israel		
Veterans	122,868	74.8
Immigrants** - Total	41,286	25.2
Of whom: Immigrated after 1999	6,813	4.2
Benefit funding source		
National Insurance	135,940	82.8
State Treasury	28,214	45.4
Benefit level		
January – May 2016		
Low (91%)	82,194	50.6
Medium (150%)	41,268	25.4
High (168%)	38,891	24.0
June-December 2016		
Low (91% or 9.75 hours)	83,071	50.2
Medium (150% or 16 hours)	30,502	18.4
High (168% or 18 hours)	51,869	31.4
Eligibility for supplement		
January – May 2016		
3 hours	26,029	63.1***
4 hours	17,175	44.2***
June – December 2016		
3 hours	20,360	66.7***
4 hours	24,032	46.3***

* Age group include only women.
** Immigrants to Israel from 1990 and onwards.
*** Eligible for extra hours as a percentage of all those eligible at the benefit level.

Benefit in Cash

Since October 2015, recipients of the benefit at the two highest levels may choose to receive it in cash, provided their long-term care services are provided by a caregiver who is not a relative for six days a week, 12 hours a day at least. They may revert to receiving a benefit in kind at any time they please. A cash benefit is also granted to eligible individuals who do not have available services or services that can be rendered on the dates specified in the Law, at a rate of 80% of the in-kind benefit rates[3]. Those eligible may receive additional long-term care services, and then from the value of their full benefit, additional services are deducted and from the difference, 20% is deducted.

A professional committee determines a treatment plan – which services are to be provided to the elderly and who will provide them, and also checks that the services are indeed being provided, or determines that the services are not available.

The committee may refuse to grant an application for a cash benefit if it believes that the elderly person and his family are not competent to use the money for the intended purpose, and may determine whether the caregiver is suitable and whether the long-term care services received by the elderly are adequate. The committee may also revoke the payment of the benefit in cash and impose receipt of the benefit in kind.

Table 5

Select Data on Recipients of the Long-Term Care Benefit in Cash, December 2016

	Absolute numbers	Percentage of total number eligible	Of whom: Received cash benefit + services – Absolute numbers	Of whom: Received cash benefit + services- percentage of reference group
Total number eligible	**166,663**			
Chose and received cash benefit	2,701	1.6	524	19.4
Received cash benefit without available personal care services at home	423	0.3	66	15.6
Eligible persons at two highest levels hiring a foreign caregiver	38,507	23.1		
Of whom: Chose and received cash benefit	2,529	6.6	496	19.6

* The data in the last row of the third column refers to all eligible in the "potential group" and all those eligible.

3 The gap between the value of the long-term care benefit in kind and its cash value derives from the costs applying to long-term care companies, which individuals are not required to pay (payment of VAT and costs of employing professionals such as social workers).

In December 2016, 3,124 of all entitled received a cash benefit (1.9%). Most of them (95.3%) were among those eligible for one of the two highest benefit levels who employ a foreign caregiver, the main potential group. Namely, 6.6% of this group chose a cash benefit, as opposed to 5.6% in December 2015 (Table 5).

127 of those eligible for the cash benefit (4.7%) received the low benefit level, 589 (21.8%) received the medium level and 1,985 (73.5%) the high level (compared with 71, 721 and 1,385 respectively in December 2015). The number recipients at high level rose considerably in comparison with December 2015, while at the medium level their number decreased due to the transfer of people aged 90 or older to high level benefit. Out of 2,701 eligible persons who opted for a benefit in cash and received it in December 2016, only 47 did not have a valid permit to employ a foreign caregiver (1.7%) – 30 of them at the high level, 15 at the medium level and 2 at the low level.

Provision of Services

Services that are provided within the framework of long-term care insurance, are supplied through companies based on an agreement between them and the NII. At the end of 2009, the results of the last public tender were published with the names of the authorized providers.

During 2016, there were 116 long-term care service providers: 47 non-profit organizations and 69 private companies. In total, they provided approximately 8.522 million care hours on average per month in 2016 – 74.1% by private companies and 25.9% by non-profit organizations (Table 6). The monthly average of home care hours increased by 3.0% between 2015 and 2016: 3.8% for private companies and 0.9% for non-profit organizations.

Nearly all those eligible (excluding those refusing) received personal care at home from an Israeli or foreign caregiver. 7.2% received care at day centers, 18.6% received

Table 6

Hours of Personal Care Provided, by Type of Service Provider (Monthly Average), 2015-2016

Provider	Number of hours (millions)		Percentage	
	2015	2016	2015	2016
Total	**8.271**	**8.522**	**100.0**	**100.0**
Private organization	6.085	6.317	73.6	74.1
Non-profit organization	2.186	2.205	26.4	25.9

absorbent products and 10.7% received a panic button[4] (Table 7). Recipients of personal care at day centers increased by 58 in December 2016 in comparison with December 2015, and that of incontinence products increased by 984, while for panic button their number decreased by 773. 67.8% of home care recipients received it as a single item and the rest received it with other services.

Box 2

Persons eligible for the long-term care benefit visiting a day center

Visiting a day center is one of the services supplied to those eligible for the long-term care benefit. At a day center, an eligible person receives services identical to those at home – supervision and personal care, including bathing, feeding (at least one hot meal every full visit) and changing absorbent products. At day centers there are also social activities and group activities suited to the visitors' condition. They are entitled to transport from home and back[1]. The centers operate every day (except Saturdays and religious holidays).

An eligible person may visit a day center up to six times a week, in accordance with the care plan determined for him/her. Each visit is for 6 hours (not including transportation time) and half-visits are also possible. Each visit has a value in terms of "service units" (or "long-term care hours"): a six-hour visit by a person eligible for a benefit at the low level is equal to two service units (which are equal to two weekly home care hours), and by a person eligible at the medium or high level – 2.75 service units (which are equal to 2.75 home care hours).

For a full visit NII pays the day center a basic tariff amounting to NIS 111 for eligible persons at low benefit level, or NIS 162 at medium or high level (in July 2016). Each eligible person pays NIS 15 per visit[2].

Visitors, visits and expenditure on day centers

The number of those eligible for day center visits has increased over the years, but their share of all eligible persons has remained similar: 9,376 in December 2008 and 11,919 in December 2016, representing 7.0% and 7.2% of all eligible persons respectively (Figure 1).

1 NII (2007)- Briefing for Service Providers – Day Centers, p. 3-4, 13.
2 NII (2016): Letter 322: New Tariffs for Day Centers – July 2016, 27 July.

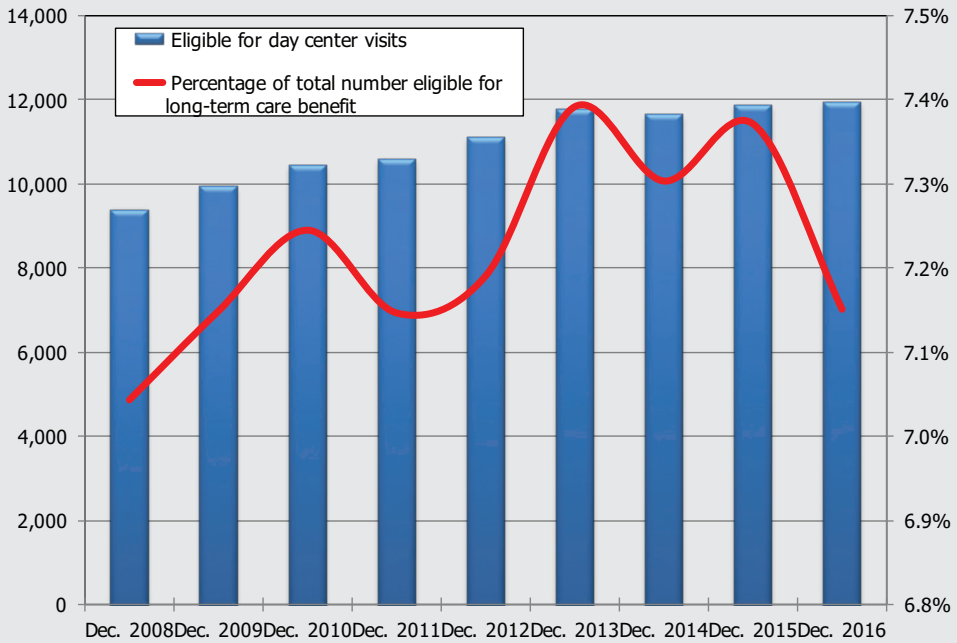
4 Excluding those refusing to receive services and including recipients of a cash benefit. Out of all eligible persons (including those refusing), their percentages are 7.2%, 18.5% and 10.6% respectively.

The average monthly percentage of those actually visiting day centers out of all entitled thereto was 96.7% (11,358 out of 11,748). Total visits approved in care plans reached 1.870 million, of which 1.698 million were really utilized – 90.8%. Among the grounds for unused visits were health condition on a particular day, removal from the long-term care system (moving to an institution or death), reasons related to the day center (such as non-operation due to religious holidays) or transport issues.

In 2016, expenditure on visits to day centers was NIS 232.6 million, which is approximately 4.2% of the total expenditure on long-term care benefits, in comparison with 4.4% in 2015. In 2011-2014 visits expenditure rose from 3.9% to 4.6% of total expenditure, and in 2015-2016 its share declined (due to an increase in minimum wage and a revision of tariffs paid to the long-term care companies for provision of personal care at home).

Figure 1

Persons Eligible for Day Center Visits as Part of the Long-Term Care Benefit



The figure data appear in the appendix at the end of this file on the Internet.

Entitlement to day center, by NII branches

The number and share of those eligible for day center visits in December 2016 were not similar among all NII branches. The highest figures in terms of number were found at branches located in Rehovot, Petah Tikva, Beersheba and Ramat Gan, and the lowest in Carmiel, Nahariya, Ashdod and Bnei Brak. Among other factors, the number individuals eligible for day center visits is influenced by the overall number of long-term care benefit recipients (Table 1).

In terms of share of all those eligible to long-term care benefit, the highest percentages of persons entitle to day center visits (more than 10.0%) were registered in Bnei Brak, Rehovot, Petah Tikva and Afula, and the lowest (less than 5.0%) in Ashdod, Nahariya, Carmiel, Jerusalem, Tel Aviv, Holon and Jaffa. As a rule, their percentage (and number) tend to be lower in branches located in the periphery (Table 1).

Table 1

Persons Eligible for Day Center Visits and Their Percentage of Total Number of Persons Eligible for Long-Term Care Benefit, by Branch, December 2016

Branch	Eligible for long-term care benefit	Eligible for day center visits	Percentage of total number of persons eligible for long-term care benefit
Bnei Brak	2,059	237	11.5
Rehovot	10,055	1,121	11.1
Petah Tikva	8,471	944	11.1
Afula	4,014	437	10.9
Ramat Gan	8,349	805	9.6
Kfar Saba	7,775	732	9.4
Tiberias	4,463	408	9.1
Ramle	6,902	621	9.0
Nazareth	5,905	494	8.4
Haifa	7,918	620	7.8
Beersheba	11,489	821	7.1
Ashkelon	6,060	426	7.0
Hadera	7,111	482	6.8
Rishon LeZion	5,572	376	6.7
Krayot	7,067	474	6.7
Netanya	8,877	561	6.3
Jaffa	8,870	431	4.9
Holon	7,581	351	4.6
Tel Aviv	8,537	388	4.5
Jerusalem	16,796	743	4.4
Carmiel	1,855	75	4.0
Nahariya	4,349	148	3.4
Ashdod	6,588	224	3.4
Total	**166,663**	**11,919**	**7.2**

Various characteristics of those eligible for a day center

In December 2016, women accounted for 67.6% of visitors to day centers, in comparison with their share of all persons eligible for the long-term care benefit – 70.0%. The percentage of visitors aged up to 84 increased with age, and that of those aged 85 or older decreased with age (Table 2).

Table 2

Persons Eligible for Long-Term Care Benefit and Visitors to Day Centers, by Age, December 2016

Age group	Eligible for long-term care benefit	Receive day center service	Percentage
Up to 69	8,428	309	3.7
70-74	14,781	972	6.6
75-79	29,018	2,212	7.6
80-84	41,856	3,698	8.8
85-89	41,024	2,967	7.2
90-94	24,794	1,440	5.8
95-99	5,755	278	4.8
100+	1,007	43	4.3
Total	**166,663**	**11,919**	**7.2**

The percentage of those aged under 80 and those aged 90 or older was low in comparison with their percentage of all eligible persons (29.3% and 14.8% compared with 31.3% and 18.9% respectively). Those living alone had a higher share than their percentage of all eligible persons (50.9% compared with 48.8%). In December 2016, the proportion of veterans who visited day centers among eligible veterans reached more than twice the percentage of immigrants who immigrated in the 1990s and afterwards – 8.4% compared with 3.4% respectively. Among visitors, immigrants share was 11.9% compared with their percentage of all eligible persons – 25.1% – i.e. less than half.

From a distribution by benefit level, it appears that 50.5% of visitors received a low benefit level, 17.8% at medium level, and 31.6% at high level. This distribution is fairly similar to the distribution among all eligible persons (49.9%, 18.4% and 31.7% respectively).

Of all holders of permit to hire foreign caregiver, 6.2% were eligible for day center visits in December 2016, in comparison with 7.5% of eligible persons without such a permit. 78.5% of visitors did not hold a permit to employ a foreign caregiver, in comparison with 75.1% of long-term care benefit recipients. Apart from the benefit

level and its rate (full or half), a connection was also found between the identity of the caregiver – Israeli or foreign – and visits to day centers. The share of visitors holding a foreign caregiver permit was lower than that of those without a permit, at all benefit levels (except recipients at full low level), particularly among recipients of half the medium benefit, half high benefit and full high benefit (Table 3).

Table 3

Persons Eligible for Long-Term Care Benefit and Day Centers Visitors, by Benefit Level and Foreign Caregiver Employment Permit, December 2016

Benefit level	Hold a permit to employ a foreign caregiver	Eligible for long-term benefit	Receive service at day center	Percentage
Low, half	No	4,441	226	5.1
Low, half	Yes	616	31	5.0
Low, full	No	75,686	5,567	7.4
Low, full	Yes	2,359	200	8.5
Medium, half	No	1,132	74	6.5
Medium, half	Yes	1,168	44	3.8
Medium, full	No	19,373	1,385	7.1
Medium, full	Yes	9,024	622	6.9
High, half	No	1,186	134	11.3
High, half	Yes	2,686	163	6.1
High, full	No	23,363	1,972	8.4
High, full	Yes	25,629	1,501	5.9
No permit- Total		**125,181**	**9,358**	**7.5**
Hold a permit- Total		**41,482**	**2,561**	**6.2**
Eligible persons – Total		**166,663**	**11,919**	**7.2**

The number of day center visits depends on the number of service units to which an individual is entitled, i.e. the more service units he accumulates the more times he can visit a day center. Service units number is derived from the benefit level, its rate (full or half, because of the means test), and for the two highest levels – whether the eligible person has a valid permit to employ a foreign caregiver or not. In December 2016, the average number of weekly visits of all eligible whose care plan included day center visits was 3.08 (the median – 3).

However, as the overwhelming majority of those eligible do not visit day centers as part of the services basket of the long-term care benefit, weekly visits average by all eligible persons is only 0.07-0.36 visits per week on average (those ineligible for day center visits in the care plan are given a value of 0).

Scope of Payments

In addition to direct benefit payments, National Insurance Law compels payment for additional items relating to long-term care insurance. Fifteen percent of the annual receipts (for each item) are allocated to the Ministry of Health and the Ministry of Welfare and Social Services, to fund an increasing number of persons institutionalized. In practice, the Ministry of Health usually utilizes the full allocation and, in recent years, the Ministry of Welfare did not utilize this allocation at all. Monies are also allocated to the development of community and institutional services for the elderly fund. Expenditure in the long-term care division also includes administrative expenses such as payments to local committee members and for dependency tests.

In 2016, the total payments remitted to fund long-term care insurance amounted to approximately NIS 5.8 billion (in 2016 prices): approximately NIS 5.6 billion for services to those eligible and the remainder for the development of institutional and community services and to conduct dependency tests (Table 8). Approximately NIS 66 million was transferred to the Ministries of Health and Welfare to increase the number of beds in long-term care institutions, and approximately NIS 112 million to the Ministry of Welfare, to health maintenance organizations, to prepare care plans for the eligible and supervise their implementation, and assessors to conduct dependency tests.

Table 8

Payments in the Framework of Long-Term Care Insurance, by Type of Payment (Millions of NIS, 2016 Prices), 2012-2016

Year	Total	Long-term care benefits	Transfer to foreign entities*	Service development	Hospitalization in long-term care institutions	Agreements with the Ministry of Finance
2012	4,716.9	4,496.2	98.5	26.0	93.3	2.9
2013	5,013.4	4,772.2	101.1	30.6	106.2	3.2
2014	5,220.4	4,961.3	103.0	33.1	119.1	3.9
2015	5,560.2	5,288.1	111.0	36.2	119.6	5.2
2016	5,831.4	5,610.4	112.3	35.9	66.4	6.5

* Transfers to the Ministry of Welfare and Social Services and to the Clalit Health Maintenance Organization to prepare care plans for the eligible and transfers to conduct dependency tests.

In 2016, long-term care insurance payments increased by 4.9% in real terms in comparison with 2015, and benefit payments increased by 6.1%. There are several reasons for the increase in benefit payments: the rising number of eligible for the highest benefit, particularly those aged 90 or older who previously received a medium benefit; the total of eligible persons increased compared with their rise in 2015 (Table 3), and payments for

benefits in kind rose as a result of an increase in minimum wage in July 2016. However, growth rate dropped between the two years: the value of the average benefit increased by 3.7% in real terms in 2016, in comparison with a real increase of 5.7% in 2015[5].

5 Until the 2015 Annual Survey, the average benefit was determined in accordance with the average of benefits received by those eligible, as specified in the Law, as percentages of a single person's full disability pension. From that report the value of an average benefit is the value obtained by dividing total actual annual expenditure on long-term care benefits by the number of eligible persons during the year (average monthly number eligible multiplied by 12).

Appendix: Figure Data

Data for Figure 1 in Box 1

Number of Fast Track Dependency Assessments and Their Percentage of Total Dependency Assessments (Excluding Appeal Committees), April 2011-December 2016

	Dependency assessments from documents	Assessments from documents as percentage of total dependency assessments (excluding decisions of appeal committees)
April 2011	24	0.4%
May 2011	97	1.0%
June 2011	98	1.0%
July 2011	118	1.2%
August 2011	151	1.5%
September 2011	188	2.5%
October 2011	190	2.6%
November 2011	286	2.9%
December 2011	306	3.1%
January 2012	304	2.8%
February 2012	238	2.3%
March 2012	242	2.4%
April 2012	168	1.9%
May 2012	281	2.6%
June 2012	239	2.5%
July 2012	282	2.7%
August 2012	282	2.9%
September 2012	152	2.2%
October 2012	201	2.3%
November 2012	259	2.5%
December 2012	199	2.0%
January 2013	260	2.5%
February 2013	227	2.3%
March 2013	180	2.2%
April 2013	241	2.2%
May 2013	226	2.2%
June 2013	195	1.9%
July 2013	226	2.1%
August 2013	181	1.9%
September 2013	128	1.8%
October 2013	233	2.1%
November 2013	178	1.7%

Data for Figure 1 in Box 1 (*Continued*)

Number of Fast Track Dependency Assessments and Their Percentage of Total Dependency Assessments (Excluding Appeal Committees), April 2011-December 2016

	Dependency assessments from documents	Assessments from documents as percentage of total dependency assessments (excluding decisions of appeal committees)
December 2013	224	2.1%
January 2014	217	2.1%
February 2014	230	2.3%
March 2014	200	1.8%
April 2014	139	1.7%
May 2014	204	2.2%
June 2014	202	2.0%
July 2014	294	2.7%
August 2014	222	2.5%
September 2014	188	2.1%
October 2014	144	1.8%
November 2014	245	2.2%
December 2014	191	1.6%
January 2015	218	2.1%
February 2015	226	2.2%
March 2015	240	2.0%
April 2015	169	2.0%
May 2015	196	1.8%
June 2015	259	2.4%
July 2015	248	2.3%
August 2015	241	2.3%
September 2015	111	1.7%
October 2015	210	2.3%
November 2015	232	2.0%
December 2015	228	2.0%
January 2016	262	2.4%
February 2016	267	2.4%
March 2016	689	5.8%
April 2016	673	8.1%
May 2016	866	7.6%
June 2016	758	6.8%
July 2016	794	7.7%
August 2016	871	7.5%
September 2016	707	7.2%
October 2016	399	6.2%
November 2016	902	8.2%
December 2016	775	6.9%

Data for Figure 1 in Box 2

Persons Eligible for Day Center Visits as Part of the Long-Term Care Benefit

	Eligible for day center visits	Percentage of total number eligible for long-term care benefit
December 2008	9,376	7.0%
December 2009	9,922	7.1%
December 2010	10,422	7.2%
December 2011	10,571	7.1%
December 2012	11,081	7.2%
December 2013	11,761	7.4%
December 2014	11,641	7.3%
December 2015	11,860	7.4%
December 2016	11,919	7.2%