Long-Term Care Insurance

Long-term care insurance is designed to enable the elderly to continue living in the community for as long as possible, by providing personal care to those who need help with daily functioning or supervision, thus assisting the families caring for them. The law applies to anyone who is insured with old-age and survivors' insurance, to housewives (married women who do not work outside their home) and to new immigrants who are not insured with old-age and survivors' insurance. The long-term care insurance plan was approved by the Knesset in 1980 under the National Insurance Law and came into effect in April 1988.

Long-Term Care Benefit - General

Every resident of Israel who reached the age of eligibility[1] and lives in the community (at home, with a family member, in sheltered housing or in a nursing home, either in an independent or mentally frail ward) is entitled to a long-term care benefit, if he is physically or cognitively impaired and meets the means test under the Regulations. A person who stays in a nursing ward, in a ward for the mentally frail, in a geriatric hospital, or in an institution where most of the maintenance expenses are financed by a public body, is not entitled to a benefit. Only the income of the elderly and their spouse is examined in the means test. The benefit is given in kind (services), or in money or in a combination of services and money.

When it is not possible to provide personal care at home, the benefit is paid in cash, and provided that a family member resides with the eligible person. The value of the benefit in this case is 80% of the value of the equivalent benefits in kind (since the beneficiary is not subject to payments that apply to service providers such as VAT and overhead payment).

Eligibility for a regular benefit or an increased benefit following a deterioration application – starts from the eighth day after submitting the claim or application (until March 2016 – from the 1st of the month following the month of submission of the claim / application).

[1] The age of eligibility for long-term care benefit is retirement age – 62 for women and 67 for men.

The Reform in Long-Term Care Insurance

In November 2018, the reform in long-term care insurance came into force, according to which 6 new benefit levels were set, and the option was given to convert the services into money in full (level 1) or in part (levels 2-6). From level 2, up to 4 service units can be converted into money and from level 3 up to one third of the service units, subject to the approval of a social worker on behalf of the Institute. The value of the benefits in cash at levels 2-6 is 80% of the value of the units according to the rate paid to a private company, and at level 1 it is 100%. The "close caregiver" arrangement, i.e. who treats 6 days a week for at least 12 hours a day, remains unchanged (see box)

Until October 2018, the long-term care benefit was generally given as in-kind benefit and not in cash – services provided by organizations and financed by the National Insurance Institute (NII): personal care or supervision at home, transportation and personal care in a day center, supply of absorbent products, laundry services and the use of panic buttons. From October 2015, the eligible people can choose a cash benefit if they have employed a "close caregiver". From March 2008 to June 2015, an experimental program was introduced to choose a cash benefit for those who have "close caregiver" (employed six days a week, at least 12 hours a day) who are not family members. From June 2014, those who are entitled to a cash benefit can receive additional services as part of it ("combined benefit").

Past benefit levels

In January 2007, three levels of benefit were set according to the level of dependence: low level benefit, at a rate of 91% of full disability pension for an individual, to finance 9.75 hours of home care per week; medium level benefit at a rate of 150% for 16 hours, and high level benefit at a rate of 168% for 18 hours of care per week. From March 2009, additional hours were granted at the two higher levels to those who did not have a valid permit to employ a foreign caregiver (3 hours at the medium level and 4 hours at the high level). As of June 2016, 90-year-olds are automatically entitled to a high-level benefit.

From July 2016, benefit levels are defined in terms of **service units** – (hours of nursing care per week) – instead of a percentage of disability pension, in order to establish in law the benefit values of care hours. The other services offered are also defined in these terms and are deducted from the number of hours of care in the home according to the value of the service units.

With the change to the definition as service units, the cash benefit is defined as the number of service units at the corresponding level of service benefit, multiplied by the hourly rate paid to private companies

(which is slightly higher than the rate for non-profit organizations, due to tax rules). The cash benefits are updated according to the rate of hourly care provided by the private companies (for example, according to the minimum wage). In April 2018, the value of the service units was updated by a rate of 2.1% considering the increase in the rates of nursing companies (the number of service units remained the same).

Dependency Test

The dependency test (ADL) examines the extent to which a person needs **assistance** in daily activities or **supervision** due to impaired cognitive ability, deterioration in mental health or due to physical conditions. Daily activities are bathing, dressing, mobility (moving around the house and avoiding falls), treating secretions and eating (including heating food and drink). The determining score on the dependency test is the highest of two scores (daily activities and the need for supervision). Those who live alone are given an extra score. The dependency test is performed by professional assessors – nurses, occupational therapists and physiotherapists – who undergo appropriate training[2]. Those aged 90 and over can be examined by a geriatrician as part of their public work or at their clinic or at home (from August 2008).

The Reform in Long-Term Care Insurance

In November 2018, the reform in long-term care insurance came into force, and as part of it, the number of benefit levels was increased from three to six, and the possibility of converting a benefit in kind (services) into a benefit in cash was expanded. For the first time, the law also sets the scoring range for the various benefit levels. The determination of the dependency score remains as before in the hands of the NII and is detailed in its procedures.

The Need for Reform

For many years, the NII has believed the method for calculating the level of benefit in long-term care insurance should be changed because it suffers from many distortions. For example, those with low dependence on others received more hours of assistance than those with high dependence, but in a relative calculation (number of service units per point) the situation was the opposite. Another distortion was

[2] Most of these officers are women, hence we use the feminine.

granting the same level of benefit to entitled people, without considering their marital status (e.g., those living alone).

Background

Proposals to increase the number of benefit levels and maximum treatment hours per week arose in the NII as early as the 1990s but were largely rejected due in part to the opposition to reduce treatment hours from the lowest level. Only in 2007, when the economic situation of the state allowed it, the high level was added (at a rate of 168% or 18 weekly service units). Additional proposals in 2011 (by the NII) and in 2016 (by the Ministry of Health) were rejected due to their high costs.

In view of the aging of the population and the growing need for benefits, as well as political changes (e.g. opposition to the abolition of private long-term care group insurance) and economic (economic growth) – it was possible to complete the legislation on long-term care reform in a fairly short period of time.

The reform was a key pillar of the National Long-Term Care Program presented by the Ministries of Finance and Health in November 2017. The program almost fully adopted the Institute's proposal from 2007 to move to six benefit levels and expand the use of cash benefits. In November 2018, the reform proposal was included in Government Decision No. 3379 – The National Long-Term Care Program.

The reform proposal was added to the Arrangements Law (Economic Efficiency Law 2018) on March 14, 2018, after intensive discussions in the Knesset's Committee of Labor, Welfare and Health. The Committee presented positions for and against aspects of the proposal (the extended use of cash benefits, in particular). Due to the long time required from the NII to prepare for the reform, it was agreed that it will begin in November 2018.

Moving from 3 to 6 Levels of Benefits

As mentioned, one of the two main changes in the reform is the transition from three to six benefit levels. The range of entitlement to the benefit was defined in the Law as 2.5-10.5 points in the dependency test (Table 1). It was also determined that the increment for a single person ("alone") at all levels would be uniform – 1.5 points – and would grant the applicant one higher level. In order to encourage the employment of Israelis, the eligibility was increased for those who employ Israeli caregivers at levels 3-4 in 3 service units per week and at levels 5-6 in 4 units. The implementation of the reform will be done in three stages and will be completed in January 2021 (Table 2).

Table 1: New Benefit Levels According to Dependency Points

Benefit level	Minimum points	Maximum points
1	2.5	3.0
2	3.5	4.5
3	5.0	6.0
4	6.5	7.5
5	8.0	9.0
6	9.5	10.5

Table 2: New Benefit Levels (Full Benefit*), by Number of Weekly Service Units.

Benefit level	First stage: November 2018 - December 2019		Second stage: January 2020 - December 2020		Third stage: January 2021 and on	
	With an Israeli caregiver	With a foreign caregiver	With an Israeli caregiver	With a foreign caregiver	With an Israeli caregiver	With a foreign caregiver
1	5.5or 9	5.5or 9	5.5or 9	5.5or 9	5.5or 9	5.5or 9
2	10	10	10	10	10	10
3	15	12	15	12	17	14
4	19	16	20	17	21	18
5	23	19	25	21	26	22
6	28	24	30	26	30	26

Those who are entitled to half the benefit due to the income test will receive half of the number of units specified in the table.

The value of the benefit as a number of units per dependency point has not become equal or progressive, but the problem with previous benefit levels was moderated both among the levels and within them. Thus, three eligible persons with an Israeli caregiver who have 6, 6.5 and 7 points will receive in the third stage 2.6, 3.2 and 3 units per dependency point, respectively. The situation of existing beneficiaries will not worsen, and they will receive the highest score between the two methods.

Some groups have been excluded and will automatically receive a higher level:

- New eligible people aged 90 and over with 6 dependency points will receive level 4 instead of 3 in order to maintain their pre-reform status as much as possible (they received then a high level – 16 or 19 service units) (Table 2).
- Individual (single) blinds will be eligible for at least level 2.
- Those in need of constant supervision due to cognitive impairment, complex medical condition or incurable disease will be eligible for Level 6 (from February 2019).

Converting the Benefit to a Cash Benefit

Following the reform, the possibility of converting the benefit, in whole or in part, into money was expanded. Prior to that, eligibility to convert was granted only when the home care could not be provided or when a close caregiver was employed (at least 6 days a week, 12 hours a day).

Level 1 benefit options: 5.5 in kind service units (including personal care at home); 5.5 service units as a combined benefit (services and personal care at home); 9 in-kind service units (without personal care at home). Those entitled to half the benefit due to the income test will receive half of the units according to their choice.

Starting at Level 2, up to 4 of the service units can be converted into money and starting at level 3 about one third of the units can be converted (subject to the approval of a social worker on behalf of the Institute). Thus, an eligible person at level 6 who employs an Israeli caregiver will be able to receive 10 out of 28 units as a cash benefit in the first stage. The value of the cash benefits at levels 2 to 6 is 80% of the rate paid to a private company, and at level 1 – 100% of the rate.

It is sometimes possible to determine the level of dependence according to medical documents, for example in a severe nursing case that may qualify for a high-level benefit (from April 2011), or when a temporary nursing assistance is needed (for two months) after release from hospitalization (from May 2012). From March 2016, the possibility of assessing dependency according to documents in certain situations at all benefit levels was expanded. The decision whether to waive the examination is at the discretion of the advisory committee at local branches of the NII.

It is possible to appeal to the advisory committees against the level of dependency or the matter of a temporary benefit (from June 2009). The three existing committees are staffed by specialist doctors in geriatrics or physical medicine and rehabilitation, and certified nurses.

Means test

An **individual claimant** whose income does not exceed the average wage (NIS 9,906 for the determining period in 2018) and a **claimant who has a spouse** and their joint income does not exceed 1.5 times the average wage, are entitled to a full benefit. An individual whose income is higher than the average wage, and a couple whose income is higher than 1.5 times and up to 2.25 times the average wage are entitled to half the benefit. An individual whose income is higher than 1.5 times the average wage and a couple whose income is higher than 2.25 times the average wage are not entitled to a benefit. When both spouses file a benefit claim, their joint income is divided into two and the means test is done per each person as if it was an individual.

Temporary benefit

When improvement in function is expected (e.g. after hip replacement surgery or after a stroke that occurred shortly before the examination), a temporary benefit is given for a period of 2-12 months. Those aged 80 and over are re-examined near the end of the period, and those under 80 are examined at their request. Like the fixed benefit, eligibility for the temporary benefit also begins on the eighth day after the claim is filed.

Legislative and Administrative Changes in 2018

Approval of employing a family member as a caregiver

From April 22, 2018, it is possible to employ a caregiver who is a family member, even a first-degree one, if the beneficiary belongs to a local committee that has introduced a telephone reporting system for caregivers ("Remote Attendance Registration System"). The caregiver must register as an employee with the nursing company that should provide personal care services at home, according to the plan set for him, and report working hours in the registration system, and must be of age as stipulated in the contract with the service provider. A family member who receives a long-term care benefit or an attendance allowance cannot be a paid caregiver.

Extra hours for employers of an Israeli caregiver

From 1st of June 2018, additional service units (weekly nursing care hours) have been provided to those entitled to the high benefit levels (medium and high until October 2018 and levels 3-6 from November

2018) who do not employ a foreign caregiver, even if they have a valid permit. Until then, the supplement was paid only to those who did not have a valid permit, or whose permit was suspended (frozen).

Easing during deterioration application

In cases of aggravation of the condition, the benefit will be increased after 7 days from the date of submission of the application (instead of the 1st day in the month following the submission of the application as it was until now). Even if the examination finds that the situation has improved up to a level justifying reduction or denial of the benefit – there will be no change in the level of eligibility (for holders of a fixed benefit).

Reform in the long-term care insurance: six benefit levels and expansion of the eligibility for cash benefit

See box in this chapter.

Benefit Claims and Deterioration Application

Benefit claims

The number of claims for long-term care benefits (including pending claims) increased in 2018 by 0.5% in comparison with 2017 and reached 91 thousand; 42.5% of which were initial claims and 57.5% repeat claims (Table 1). The number of initial claims increased by 5.6% and almost 60% of them were approved. The number of repeat claims decreased by 3.0%, less than half of which were approved.

Table 1: Submitted Claims, Approved Claims, Initial claims and Repeat claims*, 2014-2018

Year	Total claims (absolute numbers)	Yearly growth (%)	Approved claims (%)	Initial claims approved (%)	Repeat claims (%)	Repeat claims approved (%)
2014	82,993	-0.2	42.9	51.2	60.4	37.4
2015	85,346	2.8	43.0	51.7	61.0	37.4
2016	85,724	0.4	46.1	55.0	60.8	40.4
2017	90,562	5.6	48.3	56.9	59.6	42.5
2018	90,989	0.5	52.0	59.6	57.5	46.5

* Claims are presented according to the first eligibility decision. Total claims include pending claims. The percentages of claims according to their results include only claims that have been settled.

The reform in long-term care benefit levels and the expansion of the use of the benefit in cash led to an increase in the number of claims between 2017 and 2018. In September-October 2018, their number decreased by 1.7% compared to the same period in 2017, but in November it increased by 2.3% and in December 2018 by 18.7%.

Deterioration applications

Those with permanent eligibility at levels 1 to 5 following the reform (low and medium levels before the reform) who believe that their dependence on others has increased and they need more help, can file an application for deterioration. In 2018, the number of applications increased compared to 2017 (Table 2), most of which were submitted in November 2018 after the reform was implemented. In November and December 2018, the number of deterioration applications increased by 53.0% and 133.5%, respectively, in comparison with November and December 2017. In January-October, their number increased by only 3.1%.

53.0% of the applications in 2018 were approved and 47.0% were rejected compared to 49.0% and 51.0% respectively in 2017. The increase in the number of applications, which caused a raise in the benefit, is due to the change in benefit levels, since the qualifying score ranges in the various benefit levels were reduced (see Box 1).

Table 2: Deterioration Application and their Outcomes*, 2014-2018

Year	Total deterioration applications (absolute numbers)	Annual growth (%)	Approved deterioration applications (%)	Declined deterioration applications ** (%)	Total (%)
2014	38,668	-0.1	46.3	53.7	100.0
2015	38,428	-0.6	48.2	51.8	100.0
2016	39,208	2.0	49.1	50.9	100.0
2017	41,300	5.3	49.0	51.0	100.0
2018	49,088	18.9	53.0	47.0	100.0

* The total number of applications includes applications from people who have died and pending applications. The percentages of applications according to their outcomes include only applications that have been settled.

** Including cases where the applicant moved to an institution or died.

Dependency Tests

Most of the dependency tests for receiving long-term care benefits are done by assessors according to an agreement between them and the NII. The assessors – mostly nurses and a minority of physiotherapists – do not work for the Institute but act according to its guidelines and are autonomous in performing the tests.

In the years 2006 to 2008, following public scrutiny and to facilitate the claimants, three channels were added in order to assess the level of dependence: (a) For those aged 90 and older – an examination by geriatricians as part of their work in the public sector (e.g. health maintenance organizations and public hospitals). (b) A request an advisory committee (formerly called appeal committee) consisting of doctors and nurses, to appeal decisions made. (c) Assessment according to medical documents obtained by NII's employees who are experienced assessors and supervise the assessment tests.

The number of dependency tests increased between 2007 and 2018 by 24.3% (Table 3). This increase is due in part to the increase in the number of the elderly and the number of elderly in long-term care, and in part to the increase in awareness of tests and subsequently in the number of requests for tests.

Table 3: Dependency Tests, by Type of Examination[1], 2007-2018

Year	Assessors [2]	Doctors[3]	Appeal of advisory committees[4]	Documents	Total	Change from last year(%)	Assessors as percent of total(%)
2007	120,227	0	0	0	120,227	10.0	100.00
2008	117,000	64	0	0	117,064	-2.6	99.95
2009	118,121	484	476	0	119,081	1.7	99.19
2010	119,684	957	3,202	0	123,843	4.0	96.64
2011	113,964	1,832	4,760	1,432	121,988	-1.5	93.42
2012	117,054	2,199	4,259	2,925	126,437	3.6	92.58
2013	118,877	2,195	4,971	2,508	128,551	1.7	92.47
2014	118,809	2,430	4,366	2,512	128,117	-0.3	92.73
2015	124,127	2,141	4,718	2,611	133,597	4.3	92.91
2016	122,322	2,213	4,769	7,979	137,283	2.8	89.10
2017	124,436	1,995	4,378	12,627	1,434,361	4.5	86.75
2018	121,050	2,019	3,869	22,515	149,453	4.4	81.00

1. According to the date of the examination (assessors / doctors) or the date of the appeal / advisory committee or the decision of the claims officer (documents).
2. Only completed tests.
3. Only the tests submitted with the claim form.
4. Appeals that have been accepted or rejected but not canceled or discontinued appeals. Appeals returned to processing following decisions of the Labor Courts, were counted as new.

The number of tests performed by assessors have increased by about 800 – an increase of only 0.7% between the two years. Although the share of tests by assessors dropped from 100.0% in 2007 to 81.0% in 2018, they still make up the bulk of the tests. The share of document-based assessments has steadily increased with the expansion of this channel, from 1.2% in 2011 to 15.1% in 2018.

Number of Eligible People

The number of those eligible for a long-term care benefit continued to grow in 2018 and reached an average of 176.9 thousand per month – an increase of 4.5% in comparison with 2017 (Table 4). In total, their number increased 5.6 times between 1991 and 2017, despite an increase in the age of eligibility. The rate of increase, which is higher than the 3increase in the number of elderly people in that period, is due, among other things, to the rising awareness of the benefit and the increase in the rate of utilization of entitlement.

Among all the elderly in the population, the rate of eligibility rose from about 6% in the first years of the law's implementation, up to a peak of 17.6% in 2012, and has since dropped to 17.0% in 2014 and 16.2% in 2017. The rate of eligibility by estimate is 16.3% in 2018. The reasons for the decline in recent years are the accelerated increase in the number of younger seniors (60+ who have reached retirement age) and their relative share among all the elderly, as well as the fact that, being healthy and well-functioning, they do not need a benefit.

Table 4: Those Eligible for Long-Term Care Benefit, Elderly in Israel and Coverage Rate, 2014 – 2018

Year	Eligible for long-term care benefit[1]		Elderly in Israel[2]		Coverage rate[3] (%)
	Number (thousands)	Annual growth(%)	Number (thousands)	Annual growth(%)	
2014	159.2	1.9	934.3	4.3	17.0
2015	160.5	0.8	972.7	4.1	16.5
2016	164.0	2.2	1008.4	3.7	16.3
2017	169.2	3.2	1046.0	3.7	16.2
2018	176.9	4.5	[4]1084.7	3.7	16.3

1. Monthly average.
2. The data for 2014-2018 relate to men aged 67 and above, and women aged 62 and above, according to the Central Bureau of Statistics data.
3. The number of people eligible for the benefit as percent of the number of the elderly.
4. An estimate.

Characteristics of the Eligible People

Demographic characteristics

- **Gender:** Women constitute the majority of those entitled to a long-term care benefit – 69.7%, and their percentage of all eligible persons decreased slightly compared to 2017 (Table 5A).
- **Age:** In 2018, too, the trend of aging benefit recipients continues as in 2017. The main increase in the number of eligible was among those aged 85 and over, whose share in the total number of recipients increased from 44.2% to 44.4% (compared to less than a third in 2001), while the share of those aged 84 or less is steadily declining.
- **Family composition** remains stable compared to 2017 – almost half of those eligible live alone, two out of five live with a spouse, and one in ten live with someone else – usually a son or daughter.
- **Seniority in the country:** remains stable compared to 2017 – the share of those who immigrated after 1989 is generally 25% of all eligible, and the share of those who immigrated after 1999 increased from 4.4% to 4.8%.

The Ministry of Finance partially finances the long-term care benefit for those who immigrated to Israel at the age of 62 or older under section 32 of the National Insurance Law. In recent years, the relative share of this group in all those eligible has decreased – their average number per month decline by about 600, and their average monthly rate dropped from 16.2% to 15.2% between 2017 and 2018.

Level of benefit

With the aging of the eligible population, the trend of a change in the composition of those eligible according to the benefit level continues: the share of recipients in the low level decreased, from 49.3% in 2017 to 48.1% in January-October 2019, and recipients in the high level increased, from 32.3% to 33.5%, respectively. The rate of those eligible at the medium level remains 18.4%.

As mentioned above, in March 2009 hours of care were added to those eligible who did not have an actual permit to employ a foreign caregiver, and from June 2018 the additional hours were only given to those who didn't employ a foreign caregiver. The rate of individuals entitled to an additional 3 hours increased slightly in January-May 2018 compared to 2017 (from 67.0% to 67.4%), and the rate of those entitled to an additional 4 hours decreased slightly (from 46.0% to 44.8%). In both groups, the average number of eligible people per month increased between the two periods by about 700 in each. Along with the change to the

condition of entitlement to additional hours in June 2018, the number of those entitled thereto increased in June-October 2018 by 2700 for 3 hours and by 6,300 for 4 hours – 74.0% and 53.3% of all eligible persons in both groups, respectively.

Table 5A: Persons Eligible for Long-Term Care Benefit, by Demographic Characteristics (Monthly Average), 2018.

Characteristics	Absolute numbers	Percentages
Total	**176,854**	**100.0**
Gender		
Men	53,499	30.3
Women	123,355	69.7
Age		
Up to 64(1)	1,245	0.7
69 – 65	7,377	4.2
74 – 70	17,148	9.7
79 – 75	27,687	15,7
84 – 80	44,924	25.4
59 – 85	43,886	24.8
94 – 90	26,310	14.9
99 – 95	7,233	4.1
+ 100	1,044	0.6
Family composition		
Live alone	87,424	49.4
Live with a spouse	73,109	41.3
Live with children or others	16,321	9.2
Seniority in Israel		
Seniors	131,943	74.6
New immigrants(2) – Total	44,911	25.4
Of whom immigrated after 1999	8,427	4.8
Benefit funding source		
National Insurance Institute	150,018	84.8
State Treasury	26,836	15.2

Following the reform (November-December 2018), the composition of those entitled changed according to the level of benefit: 40.7% of eligible persons were at levels 1-2, 31.9% at levels 3-4 and 26.6% at levels

5-6. A new level has not been assigned yet to 0.8% of all eligible persons, and they remained at the old level until their case is settled (Table 5B and box).

Table 5B: Persons Eligible For Long-Term Care Benefit, by Benefit Level and Entitlement to Additional Hours (Monthly Average), 2018

Characteristics	Absolute numbers	Percentages
Level of benefit		
January – October 2018		
Low (9.75 service units)	84,768	48.1
Medium (16 service units)	32,357	18.4
High (18 service units)	59,018	33.5
November – December 2018		
1	42,614	23.6
2	30,903	17.1
3	16,358	9.1
4	41,165	22.8
5	28,300	15.7
6	19,704	10.9
In process of converting to the new levels[3]	1,369	0.8
Eligibility for an increment		
January – May 2018		
3 service units	21,503	[4]67.4
4 service units	25,877	[4]44.8
June – October 2018		
3 service units	24,252	[4]74.0
4 service units	32,141	[4]53.3
November – December 2018		
3 service units	42,780	[4]74.1
4 service units	24,717	[4]51.3

1. Women only.
2. Those who immigrated to Israel from 1990 onwards.
3. As of the end of 2018.
4. As a percentage of total number of eligible at the benefit level.

Of all those entitled to additional hours due to the employment of an Israeli caregiver, 74.1% were at levels 3-4 and 51.3% at levels 5 -6 (an increase of 1-4 hours per week, respectively).

The average benefit increased in 2018 by 2.6% - from 14.03 to 14.38 units per week, compared to an increase of 1.2% annually in 2016 and 2017 (13.87 units and 14.03 units respectively). The large increase in 2018 was due to the increase in benefits for those who had not actually used their permits to employ a foreign caregiver (from June 2018) and since the reform came into force (from November 2018).

Cash benefit

As stated, from October 2015, beneficiaries were able to choose a cash benefit under certain conditions (see above "Long-Term Care Benefit – General"). With the introduction of the reform in November 2018, it was possible to convert the benefit into money, in full (level 1) or in part (levels 2-6), without the condition of receiving care services (for more information, see Box 1).

The value of the benefit in cash is 80% of the value of the benefit in kind calculated in service units (except for level 1 – whose value is 100%), and its value is an unweighted average value of an hour provided by a private company. This value is multiplied by the number of units per week and then by 4.33 (weeks per month on average). Eligible people can receive additional long-term care services, and then the value of their additional services is deducted from the full benefit value and the difference is reduced by 20% (except for level 1).

Until May 2019 the decision on the provider and treatment plan was in the hands of the local professional committee which also checked whether the services were provided or not. The committee was entitled to reject an application for a cash benefit if it thought that the beneficiary and his family might use the money for other purposes, and was entitled to require receiving in-kind benefit or to determine that the caregiver was unsuitable or that the services were not sufficient. From June 2019, the committee's prerogatives were transferred to the NII – to the social workers in the long-term care departments of local branches.

Recipients of cash benefit and combined benefit

In October 2018, on the eve of the reform, 2.9% of all those eligible (5,227 persons) received a cash benefit – 79.9% by their own choice and the rest due to the absence of available services. Most of those who chose a cash benefit (85.5%) were entitled to one of the two highest benefit levels who employ a foreign caregiver

[3] The difference between the value of the benefit in kind and the value in money stems from the costs that apply to nursing companies that individuals are not required to pay (VAT payment and the employment of professionals such as social workers).

– the main group to potentially receive a cash benefit. Among this group, 9.8% chose a cash benefit (Table 6).

6.6% of those who chose a cash benefit (276 persons) received a low level benefit, 20.6% (860) the medium level, and 72.8% (3,039) a high level. Only 8.5% of them didn't hold a valid permit to employ a foreign caregiver.

Following the reform, the number of recipients of a combined benefit increased to 13,488 persons (7.4%) and the number of recipients of a cash benefit reached 7,989 eligible people (4.4%) (Table 7). 45.1% of those receiving a cash benefit (3,602 persons) were entitled to level 1. 90.2% of those receiving a combined benefit (12,165 persons) received it after the reform. The number of recipients of a full or combined cash benefit under the "full time caregiver" arrangement increased from 4,175 in October 2018 to 4,538 in December 2018 (76.2% of whom received a cash benefit and 23.8% a combined benefit). The number of recipients due to the lack of services available in the home increased between the two months from 1,052 to 1,172 (79.3% of whom received a cash benefit and 20.7% a combined benefit).

Table 6: Selected Data on Recipients of Cash and Combined Long-Term Care Benefit, October 2018

	Recipients of cash benefit		Of whom: also receive services	
	Total absolute numbers	Percentage of all eligible*	Absolute numbers	Percentage
Recipients of cash benefit – Total	**5,227**	**2.9**	**1,203**	**23.0**
Chose the benefit	4,175	2.3	1,005	24.1
Received due to lack of possibility for treatment at home	1,052	0.6	198	18.8
Eligible at the highest levels who employed a foreign caregiver	3,568	9.8**	893	25.0

* All eligible people for long term care benefit – 178,648

** Out of the total group – 36,415

Table 7: Selected Data on Recipients of Cash and Combined Long-Term Care Benefit, December 2018

Level	Eligible in the benefit level	Received cash benefit		Received combined benefit	
		Numbers	Percentage of all eligible in the benefit level	Numbers	Percentage of all eligible in the benefit level
1	42,786	3,821	8.9%	150	0.4%
2	31,471	263	0.8%	2,817	9.0%
3	16,824	300	1.8%	2,392	14.2%
4	40,941	1,165	2.8%	2,952	7.2%
5	28,361	1,058	3.7%	2,677	9.4%
6	20,248	1,351	6.7%	2,498	12.3%
Total*	181,180	7,989	4.4%	13,488	7.4%

* 549 of those eligible did not receive a conversion to the new benefit levels in December 2018, and 31 of them received a cash benefit and 2 received a combined benefit.

Provision of Long-Term Care Services

Long-term care services are provided to most eligible people through nursing service companies under an agreement between them and the NII (at the end of 2009 the results of the last public tender were published for nursing companies providing personal care at home and the names of authorized providers). In 2018, there were 111 providers – 46 non-profit organizations and 65 private companies, and they provided an average of 9,110 million hours of care per month – 75.2% of them by private companies and 24.8% by non-profit organizations (Table 8). The number of home care hours has increased between 2017 and 2018 by an average of 4.1% per month: for private companies by 5.0% and for non-profit organizations by 1.5%.

In October 2018, before the reform, almost all those eligible (99.2%) received personal care at home by a caregiver, 7.0% received care in day care centers, 19.1% received absorbent products and 9.8% received a panic button[4] (Table 9). 70.0% of home care beneficiaries received it exclusively while the remaining received other services too.

With the implementation of the reform, the rate of those eligible to receive services decreased, as some of those eligible at level 1 could choose to receive the full benefit in cash. Most of the decline occurred among home care recipients from a nursing company (Table 10), probably because this service can be purchased independently.

[4] Excluding those who refuse services and including recipients of cash benefit and combined benefit.

Table 8: Personal Home Care Hours Provided and Paid For, by Type of Provider (Monthly Average), 2017-2018

Provider	Number of hours (Millions)		Percentage	
	2018	2017	2018	2017
Total	**9.110**	**8.753**	**100.0**	**100.0**
Private organization	6.854	6.530	75.2	74.6
Non-profit organization	2.256	2.224	24.8	25.4

Table 9: Recipients of Long-Term Care Services, by Type of Service*, October 2018

Type of service	Number of recipients	Percentage of recipients	
		Of all benefit recipients	As a single item, of those receiving that service
Total	**239,265**	**-**	**-**
Personal care at home**	175,977	99.2	70.0
Out of whom: by a nursing company	170,746	96.3	69.3
Personal care at a day center	12,580	7.1	5.1
Absorbent products	33,783	19.1	0.3
Panic buttons	17,322	9.8	0.5
Laundry services	405	0.2	1.0
Supportive community (an experimental program)	327	0.2	0.6

* An eligible person may receive more than one type of service, hence the total number of recipients in the table is greater than the number of benefit recipients (excluding those who refuse services). In October 2018 – 177,322.

** Including recipients of benefit in cash or combined benefit without home care according to their choice or due to the absence of available care form a nursing company.

Table 10: Recipients of Long-Term Care Services, by Type of Service*, December 2018

Type of service	Number of recipients	Percentage of recipients	
		Of all benefit recipients	As a single item, of those receiving that service
Total	**239,260**	-	-
Personal care at home**	175,062	97.0	65.1
Out of whom: by a nursing company	158,014	87.6	60.7
Personal care at a day center	12,546	6.9	4.4
Absorbent products	33,898	18.7	0.1
Panic buttons	17,230	9.5	0.2
Laundry services	409	0.2	0.5
Supportive community (an experimental program)	354	0.2	0.3

* An eligible person may receive more than one type of service, hence the total number of recipients in the table is greater than the number of benefit recipients (excluding those who refuse services). In October 2018 – 180,461.

** Including recipients of benefit in cash or combined benefit (attached caregiver).

Scope of payments

In addition to financing benefits, the NII transfers, by law, 15% of annual receipts to the Ministry of Health and 15% to the Ministry of Social Affairs and Social Services to finance the increasing number of patients in institutions. The Ministry of Health usually utilizes the full allocation, while the Ministry of Social Affairs and Social Services did not utilized it at all in recent years. Additional funding is transferred to the Foundation for the Development of Services for the Elderly in the Community and Institutions. Expenditure in the Long-Term Care Division also includes administrative expenses for operating the program such as payments to local committee members and payments for dependency tests.

In total, the expenditure on long-term care insurance in 2018 was approximately NIS 7.03 billion: approximately NIS 6.78 billion for those eligible and the rest for the development of services in the community and in institutions and for dependency tests (Table 11). Approximately NIS 77 million was transferred to the Ministries of Health and Social Services to increase the number of inpatients in nursing institutions, and approximately NIS 118 million to the Ministry of Social Services and the sick funds, to prepare treatment plans for those eligible and control their operation, and to the assessors who perform dependency tests.

In 2018, payments in long-term care insurance, including benefit payments, increased in real terms, by 9.9% compared to 2017. There are several reasons for this increase: a raise in the number of eligible persons (Table 4); the higher benefits (see Table 5 and the discussion that follows); the increment for the employment of an Israeli caregiver (from June 2018 and under certain conditions); the increase in the total number of units following the reform (albeit moderate, since the reform was only at its commencement in November and December); the increase in the minimum wage and the minimum wage per hour (December 2017 and April 2018, respectively).

Table 11: Payments in Long-Term Care Insurance, by Type of Payment (Millions of NIS, 2018 prices), 2014-2018

Year	Total	Long-term care benefits	Transfer to external parties*	Development of services	Inpatients in nursing homes	On account of agreements with the Ministry of Finance **	Administrative payments to external parties***
2014	5,278.4	5,013.5	104.5	33.4	120.4	3.9	2.7
2015	5,623.3	5,343.7	113.9	36.6	120.9	5.2	3.0
2016	5,897.6	5,669.3	115.2	36.3	67.1	6.6	3.1
2017	6,395.3	6,148.0	121.0	43.8	73.8	5.3	3.3
2018	7,025.8	6,772.5	117.7	48.3	76.8	7.0	3.4

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

** Pensions for new immigrants who became eligible in the first year after arriving in Israel.

*** Including legal assistance and research.